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Pepperdine University

Graduate School of Education and Psychology

EFFECTS OF THE PROTECTIVE FACTOR SOCIAL SUPPORT AND RISK FACTOR OF COCAINE ABUSE/DEPENDENCE AMONG RACIALLY DIVERSE FEMALE SURVIVORS OF SEXUAL VICTIMIZATION

A dissertation submitted in partial satisfaction

of the requirements for the degree of

Doctor of Psychology

by

Carissa L. Gustafson

November, 2016

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This dissertation, written by

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DOCTOR OF PSYCHOLOGY

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TABLE OF CONTENTS

Page

LIST OF TABLES…………….………………………………………….…………….…….…vi

ACKNOWLEDGMENTS……………………….……………………..…………..……....vii

VITA…………………………………………………………………..……………..……..…viii

ABSTRACT……………………………………………………………………..…..…………ix

INTRODUCTION……………………………………………………………....…………...1

Background Literature and Current Status of Theory and Research …..…………….…………1
Critique and Need for Further Study…………………………………….……..………...…11
Focus and Scope of the Proposed Project……………...……….…………………………...11

METHODOLOGY……………………………………………………………................….13

Participants and Procedures………………………………………………………….……..13
Measures………………………………………………...……………….……....…….…15
Specific Aims……………………………………………………….……..……......……20
Hypotheses……………………………………………………………………………….20

RESULTS………………………………………………………………………………...21

Analysis……………………………………………………………………………...…...21
Outcomes………………………………………………………………………..…..... 22

DISCUSSION ……………………………………………………………………………..27

Findings………………………………………………………………………..…....27
Relation to Prior Research………………………………………………………...….....28
Implications……………………………………………………………………..……..31
Limitations..33
Future Directions………………………………………………………………….......34

REFERENCES…………………………………………………………………...…………...35

APPENDIX A: Demographics I…..………..………………………………………...……….66

APPENDIX B: Demographics II...………..……………………………………...…………..68

APPENDIX C: Sexual Assault I…..……………………………………………...………...70

APPENDIX D: Sexual Assault II...……………………………………………………...72

APPENDIX E: Sexual Assault III……………………………………………………………..74

APPENDIX F: PTSD I…………………………………………………………………..76

APPENDIX G: PTSD II………………………………………………………………….78

APPENDIX H: PTSD III…………………………………………………………………80

APPENDIX I: PTSD IV ………………………………………………………………….82

APPENDIX J: MDD I ……………………………………………………………………85

APPENDIX K: MDD II…………………………………………………………………..87

APPENDIX L: MDD III………………………………………………………………….89

APPENDIX M: ID I ……………………………………………………………………..91

APPENDIX N: ID II………………………………………………………………………94

APPENDIX O: Substance Abuse…………………………………………………………96

APPENDIX P: Substance Dependence…………………………………………………..98

APPENDIX Q: Social Support………………………………………………………….102

APPENDIX R: Certificate of Completion………………………………………………106

APPENDIX S: IRB Letter I……………………………………………………………108

APPENDIX T: IRB Letter II……………………………………………………………110

APPENDIX U: IRB Letter III...112

APPENDIX V: Review of the Literature……………………………………………….114

LIST OF TABLES

Page

Table 1. Characteristics of NCS-R Respondents……………………..……………………..……..…...14

Table 2. Characteristics of NCS-R Respondents who Endorsed Sexual Victimization..… .. …..… …23

Table 3. Protective, Risk, and Outcome Variables……………………………….………....…...26

Table 4. Outcomes by Race……………………...……………………………….……......….26

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ABSTRACT

This study examined the role of protective factors (i.e., social support) and risk factors (i.e., cocaine abuse/dependence) in psychological outcomes (i.e., major depressive disorder, irritable depression, and posttraumatic stress disorder) among racially diverse female survivors of sexual victimization. Archival data from a subsample of participants (n = 1115), those who endorsed experiences of sexual victimization, from the National Comorbidity Survey-Replication, a cross-sectional survey of mental disorders of the general population of the United States, were examined. Logistic regression analyses were used to determine if the predictor variables (i.e., social support and cocaine abuse/dependence) were related to the outcomes variable (i.e., major depressive disorder, irritable depression, and posttraumatic stress disorder) and then to determine if the moderating variable (i.e., race) changed the relationship between the predictor variables and the outcomes variables. Respondents who endorsed sexual victimization and reported experiencing less positive support were more likely to have PTSD. Respondents who endorsed sexual victimization and also met criteria for cocaine abuse/dependence were more likely to have PTSD. Compared to Caucasians, Asian American Pacific Islanders and Latinas were significantly more likely to have experienced PTSD. Limitations and implications are discussed.

Keywords: sexual abuse, sexual assault, rape, social support, cocaine abuse, cocaine dependence, race, ethnicity, major depressive disorder, irritable depression, posttraumatic stress disorder, revictimization

Introduction

Background Literature and Current Status of Theory and Research

Sexual victimization. Sexual victimization and revictimization of women, across racial groups, is a common phenomenon that has been associated with various negative mental health outcomes (Bryant-Davis, Chung, & Tillman, 2009; Bryant-Davis, Ullman, Tsong, Tillman, & Smith, 2010; Levitan et al., 1998; Turner & Muller, 2004).

The term sexual victimization is used broadly to include individuals who have experienced any type of sexual victimization. Sexual victimization can be defined as experiences of "violent, coercive, and developmentally inappropriate sexual experiences including incest, rape, and other forms of sexual abuse such as fondling, and sexual exposure; use of physical force, authority or age differentials to obtain sexual contact; and verbally coerced sexual contact" (as cited in Santos-Iglesias & Sierra, 2012, p. 3469).

Race and ethnicity. It is also important to define or differentiate race and ethnicity. Race is a social construct based on biological differences whereas ethnicity reflects cultural differences, such as religious beliefs and customs. Sadly, due to the complexity of ethnicity it is difficult to capture in research. For this reason, the word race is used throughout to signify that the many nuances of culture are not reflected in this study, due in large part to the nature of the archival database and the way in which the variable of race was collected.

Urquiza and Goodlin-Jones (1994) indicate that the prevalence rates for CSA were roughly similar for African-American and Caucasian survivors (44.8% and 38.0%, respectively), with relatively lower rates for Latina survivors (25.6%). The prevalence rates for adult rape revealed a different pattern, with African-American survivors disclosing the highest rate (37.9%), followed by Caucasian survivors (25.5%). Latina survivors reported lower rates

(17.9%). Additionally, analyses within each ethnic group revealed differing prevalence rates of CSA and later adult rape. More than half (61.5%) of the African American women who were sexually abused in childhood reported ASA, with lower rates for Caucasian and Latinas survivors (44.2% and 40.0% respectively).

Major depressive disorder. Major depressive disorder (MDD) is a significant psychological consequence of sexual victimization (Basile et al., 2015; Caetano & Cunradi, 2003; Campbell et al., 2002; Clear, Vincent, & Harris, 2006; Elliott, Mok, & Briere, 2004; Gonzalez-Guarda, Peragallo,Vasquez, Urrutia, & Mitrani 2009; Mennen, 1994; Sciolla et al., 2011; Smith & Breiding, 2011; Temple, Weston, Rodriguez, & Marshall, 2007; Ullman & Brecklin, 2003; Ullman & Filipas, 2005; Pillay & Schoubben-Hesk, 2001; Ulibarri, Ulloa, & Salazar, 2015; Warner, Alegria, & Canino 2012). Research suggests that a history of sexual victimization is a key risk factor for depression among women (Gladstone et al., 2004; Gladstone, Parker, Wilhelm, Mitchell, & Austin, 1999). Evidence supports the idea that depressive symptoms may be caused by sexual victimization (Becker, Skinner, Abel, Axelrod, & Treacy, 1984; Burgess, 1983; Burgess & Holmstrom, 1979; Ellis, Atkeson, & Calhoun, 1981; Ellis, 1983; Frank, Turner, & Duffy, 1979; Kilpatrick, Saunders, Veronen, Best, & Von, 1987; Kilpatrick, Veronen, & Resick, 1981; Kilpatrick, Veronen, & Best, 1985; Nadelson, Notman, & Zackson, 1982; Resick, Calhoun, Atkeson, & Ellis, 1981; Santiago, McCall-Perez, Gorcey, & Beigel, 1985). Further, individuals who have been repeatedly victimized report more severe depressive symptoms than those experiencing a single episode of victimization (Pillay & Schoubben-Hesk, 2001; Najdowski & Ullman, 2011).

Irritable depression. Cultural views of depression and different levels of acceptability of the expression of sadness may lead to different symptom presentations across racial groups in the

diagnosis of MDD (Escobar, Rubio-Stipec, Canino, & Karno, 1989). In a literature review, Baker (2001) found that African American culture discourages the expression of sadness leading African Americans to display greater irritability and anger. Supporting this notion, depressed African Americans are less likely to endorse sadness than Caucasians (Iwata, Turner, & Lloyd, 2002), and in contrast, experience greater anger and irritability as part of their depression (Baker, 2001). Although it is not in the diagnostic and statistical manual, these cultural differences in the expression of symptoms of MDD have resulted in what is known as irritable depression (ID).

Posttraumatic stress disorder. Researchers have also found a strong relationship between sexual victimization and posttraumatic stress disorder (PTSD; Arata, 2000; Basile et al., 2015; Bolstad & Zinbarg, 1997; Boney-McCoy & Finkelhor, 1995; Elliott et al., 2004; Gonzalez-Guarda et al., 2009; Sciolla et al., 2011; Temple et al., 2007; Ullman & Brecklin, 2002; Ulibarri et al., 2015; Warner et al., 2012). Women who are revictimized suffer more PTSD symptoms (Arata, 1999a, 1999b; Banyard, Wiliams, & Siegel, 2001; Gibson & Leitenberg, 2001; Koverola, Proulx, Battle, & Hanna, 1996). Not only can PTSD be an outcome of sexual victimization, it is also a risk factor. Noll, Horowitz, Bonanno, Trickett, and Putnam (2003) found that PTSD symptoms mediated the relationship between child sexual assault (CSA) and subsequent revictimization while Acierno, Resnick, Kilpatrick, Saunders, and Best (1999) found that a diagnosis of PTSD increased women's risk for adult sexual assault (ASA). Wilson, Calhoun, and Bernat (1999) found that numbing symptoms were associated with less risk recognition, which can lead to revictimization. Similarly, Ullman, Najdowki, and Filipas (2009) found that PTSD numbing symptoms directly predicted revictimization.

Although survivors experience similar rates of depression following experiences of sexual victimization, research suggests that women from minority groups experience more

symptoms of PTSD (Jacques-Tiura, Tkatch, Abbey, & Wegner 2010; Littleton, Grills-Taquechel, Buck, Rosman, & Dodd 2013; Scott, Lefley, Hicks, 1993). Some research suggests that African American women have more symptoms of PTSD following assault compared to Caucasian survivors (Jacques-Tiura et al., 2010). Further, research suggests that Latinas have significantly higher rates of PTSD when compared to both African American and Caucasian survivors (Littleton et al., 2013; McFarlane et al., 2005; Scott et al., 1993). Many studies have found Latinas more likely to develop PTSD after sexual victimization (Phillips-Sanders, Moisan, Wadlington, Morgan, & English, 1995; Pole, Best, Metzler, & Marmar, 2005; Rosenheck & Fontana, 1994). There are several possible explanation for this finding. One possible explanation is that Latinas present a different symptom profile with more "positive" symptoms such as hypervigilance (Marshall, Schell, & Miles, 2009); another possibility or that it is due to expressive style (Marshall et al., 2009; Ortega & Rosenheck, 2000). Alternatively, Pole et al. (2005) found other factors relevant to explaining the elevation of PTSD symptomatology found among Latinas, including self-blame, in addition to lower social support, and the effects of racism. The most significant factor however was peritraumatic dissocation, an acute response to trauma, which may increase the risk of developing PTSD (McDonald et al., 2013). Peritraumatic dissocation may be related to the culture-bound syndrome, *ataque de nervios*, which has been found to increase dissociative symptoms (Lewis-Fernandez, 2002; Ozer, Best, Lipsey, & Weiss, 2003; Weller, Baer, de Alba Garcia, & Rocha, 2008).

Comorbid MDD and PTSD is of particular concern since comorbidity may increase symptom severity, lower global functioning of the affected individual (Shalev & Sahar, 1998), and contribute to PTSD chronicity (Freedman, Brandes, Peri, & Shalev, 1999). There is evidence to suggest that the relationship between MDD and PTSD can be reciprocal, with pre-existing

MDD increasing the risk of exposure to traumatic events and PTSD and vice versa (Breslau, Davis, Peterson, & Schultz, 1997).

Revictimization. Many studies have found that revictimization is more strongly associated with negative psychological outcomes (e.g., MDD, PTSD) than a single sexual assault alone (Arata, 2002; Classen, Palesh, & Aggarwal, 2005; Follette, Polusny, Bechtle, & Naugle, 1996; Messman-Moore, Long, & Siegfried, 2000; Miner, Flitter, & Robinson, 2006). Multiple sexual assaults may have a cumulative effect, increasing the severity of psychological sequelae with each assault (Nishith, Mechanic, & Resick, 2000). These outcomes may increase an individual's vulnerability to additional assaults, which may in turn exacerbate the existing psychological distress (Grauerholz, 2000; Messman-Moore & Long, 2003). Increased risk of sexual victimization in women previously sexually assaulted in childhood, adolescence, or adulthood is a phenomenon now well-documented in the literature (Classen et al., 2005; Collins, 1998; Gidycz, Hanson, & Layman, 1995; Krahé, Scheinberger-Olwig, Waizenhöfer, & Kolpin, 1999; Messman-Moore & Long, 2000), yet limited research has examined mechanisms underlying increased risk. Although, in addition to a diagnosis of PTSD, and perhaps specifically numbing symptoms, substance use (problem drinking and/or illicit drug use) has been found to increase the risk of sexual revictimization (Abbey, Zawacki, Buck, Clinton, & McAuslan, 2003; Koss, Dinero, Seibel, & Cox, 1989; MacGreene & Navarro, 1998; Rich, Combs-Lane, Resnick, & Kilpatrick, 2004; Ullman, 2003); this is thought to be due to either self-medication or as a function of being in high-risk environments (Walsh et al., 2014). Ullman et al. (2009) found that PTSD numbing symptoms directly predicted revictimization, whereas other PTSD symptoms (e.g., re-experiencing, avoidance, and arousal) were related to problem drinking, which in turn predicted revictimization.

Unfortunately, research examining race and revictimization is limited; Urquiza and Goodlin-Jones' study (1994) is one of the few that explicitly examined this relationship. Urquiza and Goodlin-Jones' study (1994) found that rates of revictimization were highest for African American survivors (61.5%), followed by Caucasian survivors (44.2%), and Latina survivors (40%). Therefore, there is some preliminary evidence that race is associated with revictimization, with African American survivors being at the highest risk.

Social support. Social support is defined as assistance provided to people following stressful events (Thoits, 1986). House (1981) identified four types of functional support including: emotional (e.g., caring and concern), instrumental (e.g., providing tangible goods), informational (e.g., knowledge and advice), and appraisal (e.g., feedback). Literature has primarily focused on three sources of social support: support from family, support from friends, and support from significant others (Wilson & Scarpa, 2013).

Women who have supportive networks cope much better with sexual victimization and its aftermath than those who do not (Ruch & Chandler, 1983). Many studies have highlighted the degree to which social support following sexual victimization serves as a buffer against development of adverse psychological adjustment (Holstrom & Burgess, 1979; Hyman, Gold & Cott, 2003). Adaptive coping strategies, such as seeking social support, have been found to be related to faster recovery and less MDD and PTSD (Burgess & Holmstrom, 1979; Frazier & Burnett, 1994; Frazier, Mortensen, & Steward, 2005; Gutner, Rizvi, Monson, & Resick, 2006; Meyer & Taylor, 1986; Valentiner, Riggs, Foa, & Gershuny, 1996). However, the type of support may play a role. Results from Hill, Kaplan, French, and Johnson (2010), indicate that the effects of sexual victimization are buffered by emotional but not instrumental support.

Unfortunately, Ellis (1983) found that it is common for social support networks to be

severely strained or to collapse completely following sexual victimization leaving survivors isolated and distressed. The very nature of sexual victimization as an interpersonal trauma might compromise an individuals ability to form or maintain relationships. This may be especially true of CSA, which has been found to result in poor social adjustment, difficulty trusting others, and social isolation (Barnett, Miller-Perrin, & Perrin, 1997). Furthermore, psychological outcomes frequently seen in individuals who have experienced sexual victimization such as MDD and PTSD can compromise individual's support systems. It is widely recognized that MDD strains interpersonal relationships. Coyne (1976) proposed a model of depression in which individuals with depression have an aversive relational style which results in negative reactions from others and/or a loss of support. The loss of relationships has also been found to be an important predictor of MDD (Djernes, 2006). Research also supports a bidirectional relationship between loss of relationships and PTSD (Benotsch, Brailey, Vasterling, & Sutker, 2000; Hobfoll, 1991; King, King, Foy, Keane, & Fairbank, 1999).

Interestingly, it appears that when it comes to sexual victimization disclosure, negative social reactions have a stronger detrimental effect on survivors' mental health than positive social reactions have for bolstering well-being (Borja et al., 2006; Campbell, Ahrens, Sefl, Wasco, & Barnes, 2001; Fowler & Hill, 2004; Ruch & Leon, 1983). Negative social reactions from family, friends, and peers have consistently been found to increase MDD and PTSD (Borja, Callahan, & Long, 2006; Campbell et al., 2001; Davis, Brickman, & Baker, 1991; Moss, Frank, & Anderson, 1990). Alarmingly, studies show that more severe assaults are associated with receiving more negative social reactions from others (Ullman, 2000; Ullman & Siegel, 1995). Ahrens, Campbell, Ternier-Thames, Wasco, and Sefl (2007) revealed that when initial disclosures were negative, survivors refrained from further disclosures and were less likely to

seek further help, which was associated with higher self-reported distress. Expanding on research indicating that negative and positive social reactions are related to survivors' psychological recovery studies suggest that negative social reactions may also be related to revictimization risk, such that negative social reactions may increase and positive social reactions may reduce the risk of revictimization respectively (Atkeson, Calhoun, Resick, & Ellis 1982; Campbell et al., 2001; Ullman, 1996a; 1996b). Receipt of negative disclosure reactions has also been associated with self-blame (Littleton & Breitkopf, 2006; Ullman & Filipas, 2001; Ullman, Townsend, Filipas, & Starzynski, 2007). Additionally, Ullman (1996a) found that negative social reactions result in more reliance on avoidance coping (e.g., withdrawal, trying to forget the experience of sexual victimization). Both self-blame and avoidance coping by survivors are linked to greater PTSD symptoms (Frazier, 2003; Koss, Figueredo, & Prince, 2002; Valentiner et al., 1996). Higher levels of self-blame are also related to MDD (Feiring, Taska, & Chen, 2002; Spaccarelli & Fusch, 1997). Additionally, revictimization is more likely among survivors who blame themselves for being victimized (Macy, Nurius, & Norris, 2006). Research suggests that minorities are more likely to be subjected to victim-blaming treatment (Campbell et al., 2001). This may in part be explained by differences with respect to rape-myths (Lefley, Scott, Llabre, & Hicks, 1993), which Burt (1980) defined as "prejudicial, stereotyped, or false beliefs about rape, rape victims, and rapists" (p. 217). Sadly, high rape-myth endorsement decreases the likelihood that women who have been sexually victimized will disclose the assault and seek support (Botta & Pingree, 1997; Moor, 2007).

Cocaine use. Research suggests that survivors of sexual victimization are more likely to develop substance use problems compared to those without histories of sexual victimization (Cuellar & Curry, 2007; Molnar, Buka, & Kessler, 2001; Ullman, Filipas, Townsend, &

Starzynski, 2005; Ullman, Relyea, Peter-Hagene, & Vasquez, 2013; Vera, Alegria, Pattatucci-Aragon, & Peña, 2005). Substances may serve as a way to cope with sexual victimization and subsequent symptoms of MDD and PTSD (Ullman et al., 2005; Ullman et al., 2009; Ullman et al., 2013). The self-medication model has received extensive support from psychological research (Dansky et al., 1996; Epstein, Saunders, Kilpatrick, & Resnick, 1998; Grice, Brady, Dustan, Malcolm, & Kilpatrick, 1995; Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995; McFarlane, 1998; Stewart & Israeli, 2002). There is evidence that the relationship between substance use and sexual victimization is bidirectional such that substance use increases the risk of sexual victimization and sexual victimization leads to increased substance use (Wilsnack, Wilsnack, Kristjanson, Vogeltanz-Holm, & Harris, 2004). A study by Ulibarri et al. (2015) indicated significant relationships between a history of sexual victimization, depression, PTSD, alcohol, and drug use. Their results suggested that substance use partially mediated the relationship between sexual abuse and mental health outcomes. Furthermore, violent assault increases substance use (Ireland & Widom, 1994); this increases the likelihood of revictimization (Burnam et al., 1988), which, in turn, increases the likelihood of further substance use. Maladaptive coping strategies, such as substance abuse, are also associated with longer recovery time and higher levels of depression and PTSD (Burgess & Holmstrom, 1979; Frazier & Burnett, 1994; Frazier et al., 2005; Gutner et al., 2006; Meyer & Taylor, 1986; Santello & Leitenberg, 1993; Ullman et al., 2007). Additionally, research suggests that individuals who have PTSD improve less with substance abuse treatment than those who do not, demonstrating faster relapse and heavier use posttreatment (Ouimette, Moos, & Finney, 1998). Severity of PTSD symptoms may also impact drug and alcohol use. Saladin et al. (2003) found that PTSD symptom severity was a predictor of cue-elicited cravings among alcohol and cocaine dependent individuals who

had a history of physical and/or sexual assault. With respect to ethnic differences, Kaukinen and DeMaris (2005) found that minority women who have been sexually victimized are more likely to report alcohol and illicit drug use, which may reflect a lack of access to other sources support such as mental health treatment or be due to additional stressors such as racism and poverty. Approximately 13% to 49% of survivors become dependent on alcohol, whereas 28% to 61% use other illicit substances (Frank & Anderson, 1987; Ullman & Brecklin, 2002; Ullman, 2007).

There is a significant relationship between cocaine use and psychological outcomes, particularly PTSD, in individuals who have experienced sexual victimization. In a study by Back et al. (2000), which compared individuals with and without PTSD who were participating in a outpatient cocaine treatment study marked discrepancies in rates of sexual victimization emerged between the two groups, with 71.8% of PTSD positive group, compared to only 17.3% of the PTSD negative group, experiencing some form of sexual victimization. Comparison of completed rape revealed that 62.2% of the PTSD positive, compared to only 3.8% of the PTSD negative group, had a history of completed rape. In this study only two individuals with a history of completed rape did not meet criteria for PTSD. The relationship between cocaine use and psychological outcomes like PTSD in women who have been sexually victimized may be due to an increased risk of exposure to traumatic events as well as vulnerability to developing PTSD. A study a Cottler, Compton, Mager, Spitznagel, and Janca (1992) revealed an increasing relationship between use of more addictive drugs, such as cocaine, and reports of events that lead to PTSD, as well as vulnerability to PTSD once exposed. Similarly, Afful, Strickland, Cottler, and Bierut, (2010) found that cocaine dependence is strongly associated with an increased risk of exposure to traumatic events and PTSD. Najavits et al. (1998) found that “harder” substances like cocaine consistently show a higher association with trauma and the diagnosis of PTSD than

other substances such as alcohol or marijuana (Cottler et al., 1992; Dansky, Saladin, Brady, Kilpatrick, & Resnick, 1995; Goldenberg et al., 1995; Grice et al., 1995; Kilpatrick, Edmunds, & Seymour, 1992; Miller, Downs, & Testa 1993; Schnitt & Nocks, 1984). Furthermore, in a longitudinal study on the effects of alcohol and illicit drug use on sexual and physical assault in women, Kilpatrick, Acierno, Resnick, Saunders, and Best (1997) found that use of drugs but not alcohol abuse increased the odds of a new assault reciprocally; the odds of a new assault for both alcohol and drug abuse were significantly increased even among women with no previous use or assault history. They also found that women of minority status who abused substances were at an increased risk of revictimization.

Critique and Need for Further Study

Racial differences in response to sexual assault are important to examine because sociodemographic factors impact the way events are interpreted, emotions are experienced and expressed, as well as how others respond (Ellsworth, 1994; Mesquite & Frijda, 1992). Although there is ample research available examining the degree to which social support moderates maladjustment following sexual victimization, sociodemographic factors have been largely ignored. It is also important to investigate the differences in mental health outcomes for racially diverse women who have been sexually victimized that engage in substance use.

Focus and Scope of the Proposed Project

In examining the literature, it is essential to recognize the lack of attention on racially diverse women with a history of sexual victimization. There is limited research available on the impact of protective and risk factors of adverse psychological outcomes and victimization in racially diverse women. Research is even more limited in the area of understanding the impact of race as moderators for these established relationships. By assessing how race plays a role we will

gain deeper understanding of the impact of these moderators. Specifically, information will be gained on how social support plays a role against the development of mental health outcomes such as MDD, ID, and PTSD, as well as revictimization among racially diverse female survivors of sexual victimization. This study further attempts to understand the role of risk factors, such as cocaine abuse/dependence, that are associated with psychological outcomes and revictimization among racially diverse female survivors of sexual victimization.

Methodology

The National Comorbidity Survey (NCS) is a nationally representative sample of the United States (Kessler et al., 1994). The National Comorbidity Survey-Replication (NCS-R) is a new, cross-sectional survey of mental disorders of the general population of the United States carried out a decade after the original NCS (Kessler & Merikangas, 2004). Designed to examine time trends and their correlates over the 1990s, the NCS-R reiterated many of the questions from the NCS and also broadened the questioning to include assessments based on the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) diagnostics system (Kessler & Merikangas, 2004).

Participants and Procedures

A total of 9,282 interviews were completed in the main survey and an additional 554 short, non-response interviewers were completed with initial non-respondents (Peterlin et al., 2011). Participants were selected from a multistage area probability sample of the United States civilian population and received a letter describing the purpose and investigators of the study. Recruitment and consent procedures were approved by the human subjects committees of Harvard Medical School and the University of Michigan. Response rate for the data collection was 70.9% (N = 7,693) among those receiving the primary interview and 80.4% (N = 1,589) among secondary pre-designated respondents (Peterlin et al., 2011). NCS-R was administered in two different parts. In Part I, demographic and core diagnostic assessments were given to all 9,282 respondents. Part II included additional questions administered to all respondents who met criteria for at least one mental disorder during the Part I interview and a 25% probability subsample of other Part I respondents (n = 5,692), aged 18 and older. This sample was weighted in order to adjust for differential probabilities of selection within households and from the Part I

samples (Kalaydjian et al., 2009). The data were weighted to adjust for differential probabilities of selection, differential non-response, and residual differences between the sample and tract-level 2000 Census population on sociodemographic characteristics (Kalaydjian et al., 2009). The unweighted and weighted sociodemographic characteristics of the NCS-R respondents can be referenced in Table 1.

Table 1

Characteristics of NCS-R Respondents

Sex		Unweighted frequency	Weighted frequency	%
	Female	3309	3019	53
	Male	2,382	2,673	47
Age				
	18-34	1938	1795	31.5
	35-49	1831	1757	30.9
	50-64	1213	1188	20.9
	65+	709	952	16.7
Race				
	Latino	527	630	11.1
	African American	717	704	12.4
	Other	268	217	3.8
	Caucasian	4179	4141	72.8
Education				
	0-11 years	848	954	16.8
	12 years	1712	1851	32.5
	13-15 years	1709	1568	27.5
	≥16 years	1422	1319	23.2
Marital Status				
	Married/cohabitating	3235	3184	55.9
	Separated/widowed/divorced	1239	1184	20.8
	Never married	1217	1323	23.2
Income				
	$0-$19,999	1182	1250	22

(continued)

Income		Unweighted frequency	Weighted frequency	%
	$20-34,999	920	905	15.9
	$35-$69,999	1811	1744	30.6
	$70,000	1778	1793	31.5
Insurance				
	None	813	813	14.3
	Public	715	715	12.8
	Private	4163	4163	72.9

The NCS-R was administered face-to-face in the homes of the respondents who were selected from a nationally representative bevy of sample households (Kessler et al., 2004). The survey was conducted using a laptop computer-assisted personal interview (CAPI) method, provided by a professional survey interview to ensure accuracy of screening procedures, coverage of an area probability sample, and higher response rate (Kessler et al., 2004). Data was collected from February 2001 to April 2003 (Peterlin et al., 2011).

This study employs a cross-sectional, ethnographic, quantitative design. The participants included in the study were all females who experienced some form of sexual victimization (i.e., rape or molestation). Respondents with no history of sexual victimization were excluded from this study.

Measures

The NCS-R interview schedule was a version of the World Health Organization (WHO) Composite International Diagnostic Interview (CIDI) that was developed for the WHO World Mental Health (WMH) Survey Initiative and referred to as the WMH-CIDI (Kessler et al., 2004). All participants were administered a core diagnostic interview; Part I included mood disorders, as well as drug and alcohol abuse. A probability subsample of respondents were administered the lifetime non-patient version of the Structured Clinical Interview for DSM-IV (SCID) to validate

CIDI diagnoses (Fava et al., 2010). All participants who screened positive for any disorder in Part I, plus approximately a one-in-three probability subsample of other Part I participants, received a Part II interview, which included questions about correlates and additional disorders (Peterlin et al., 2011). The WMH Survey Initiative version of the structured CIDI (Kessler & Ustun, 2004) was used to diagnose DSM-IV mental disorders; the CIDI evidences excellent inter-rater reliability, good test-retest reliability, good validity, and adequate convergence with other similar measures (Andrews & Peters, 1998; Haro et al., 2006).

Sociodemographic factors. Sociodemographic information obtained during the NCS-R administration, included age at the time of the interview (18-29 years, 30-44 years, 45-59 years, and 60 years), sex, and race (non-Hispanic African American, non-Hispanic Caucasian, Hispanic/Latino, and Other). Other sociodemographic factors assessed included region of the country (Northeast, Midwest, South, and West), educational attainment (<12 years, 12 years, 13-14 years, and > 16 years), and income as a percentage of the federal poverty level for 2001 (low income, <150% of the poverty level; low-average, 150%-299%; high average, 300%-599; and high, > 600%). Additional categories included marital status, employment status, and religious affiliation (Protestant, Catholic, and no identified religious affiliation; Shim, Compon, Rust, Druss, & Kaslow, 2009).

In order to assess for racial identity, interviewers used the 2-question format recommended by the US Census Bureau on the basis of the Race and Ethnic Targeted Test (United States Census Bureau, 1997). Consistent with this approach, respondents were first asked if they were “of Hispanic or Latino descent” (see Appendix A). Respondents were then asked, “Which of the following best describes your race: American Indian, Alaska Native, Asian, Black or African American, Native Hawaiian, Pacific Islander, or White?” (see Appendix B).

The racial groups included in this study were Caucasian, African American, and Latina. All individuals who endorsed Hispanic or Latino, regardless of country of origin or racial background, were considered Latina. For analysis purposes, the variable Other was used to capture those that did not identify as Caucasian, African-American, or Latino and included predominately Asian American Pacific Islanders and at least one participant who identified as Native American.

Sexual victimization and revictimization. Sexual victimization questions were embedded within the section measuring for PTSD (Molnar et al., 2001). Respondents were provided a list of traumas and asked about each by number. Those who reported rape and molestation were asked how old they were during the first occurrence and whether it was chronic. Respondents who reported that their first experience of rape or molestation occurred before 18-years of age, were seen as experiencing CSA (Molnar et al., 2001). The present study collected data related to sexual victimization based on questions related to rape (see Appendix C) and being molested or inappropriately touched (see Appendix D).

Data collected on revictimization was gathered with the question: "Was it a one-time occurrence, or did it happen repeatedly over a period of days, weeks, months, or even years?" The number of occurrences was counted with "And how long it continued" (see Appendix E). A binary score was calculated for revictimization based on more than one experience of rape or sexual assault.

Social support. A global measure of social support, composed of 16 items was included within the NCS-R (Alegria, Jackson, Kessler, & Takeuchi, 2007). Respondents were asked questions that assessed various sources of social support including relatives, friends, and significant others. Respondents were asked questions such as, "How often do you talk on the

phone or get together with relatives who do not live with you?"; "How much can you rely on relatives who do not live with you?"; "How much can you open up to relatives who do not live with you about your worries?"; "How often do your relatives make demands on you?"; and "How often do your relatives argue with you?" These same questions were asked about friendships. In regards to significant others respondents were asked "When you have a problem or worry, how often do you let your (husband/wife/partner) know about it?" Additionally, respondents were asked how often they let someone know when they are having a problem or worry and questions related to attachment style (see Appendix Q). In the analysis of social support there were two steps. First an exploratory factor analysis was conducted and two factors emerged: 1. NegativeSN, which indicated demands made by family and friends (SN4, SN5, SN9, SN10, SN11, SN15, SN16) and 2. PositiveSN, which indicated ability to rely on, desire to talk to, and frequency of contact made with family and friends (SN1, SN2, SN3, SN6, SN7, SN8, SN12, SN13, SN14). PositiveSN was used for further analysis. Second, an internal reliability analysis was conducted on PositiveSN (Cronbach α=0.73). In this study, more frequent seeking of support, more openness, and greater ability to rely on friends/family is indicated by the lowest interval on each item. Least frequent seeking of support, less openness, and lower ability to rely on friends/family is indicated by the highest interval on each item. In other words, low scores on positiveSN indicate having the most positive social support, whereas high scores on positiveSN indicate having the least social support.

Cocaine use. Substance abuse and dependence were assessed using version 3.0 of the World Health CIDI (Kessler & Ustun, 2004). The substance module of the CIDI was administered to the entire Part II sample. An initial screening question inquired about the use of marijuana or hashish, cocaine in any form, prescription drugs either without the recommendation

of a health professional or for any reason other than what a health professional said they should be used for, or other illicit drugs. If respondents endorsed use of any of the aforementioned drugs they were subsequently asked questions concerning the presence of DSM-IV criteria for drug abuse (see Appendix O) and dependence (see Appendix P). The CocaineAD code was based on a binary score for individuals who met criteria for substance abuse or dependence and indicated use of cocaine.

Major depressive disorder. The CIDI assessment for a major depressive episode (MDE) asked about symptoms in the worst lifetime episode of the respondent and included symptoms added to those specified in the DSM-IV (see Appendix J, Appendix K, and Appendix L). A binary score was calculated for individuals who met criteria for MDD without hierarchy or MDE.

Irritable depression. NCS-R data distinguishes between different manifestations of depression, including a specific subset of questions related to ID. Including irritability as a component of depression or a manifestation of depression is an important consideration, which has been substantiated in research (Fava et al., 2010). The ID inventory consisted of 72-items aimed at identifying patterns of irritability, level of functioning impairment, mood disturbance, and familial history of chronic irritability and grouchiness (see Appendix M and Appendix N). A binary score was calculated for those who met criteria for MDD/MDE and at least a 2-week moderate episode of MDE.

Posttraumatic stress disorder. PTSD was assessed with the WHO-CIDI. In the NCS-R database, if participants met criteria for a disorder that was best related to another disorder, only the primary disorder was coded (Peterlin et al., 2011). Participants were first asked about a variety of specific traumatic events meeting DSM-IV PTSD criterion (see Appendix F). PTSD

was assessed for those endorsing at least one traumatic event; in the NCS-R, the most upsetting trauma occurrence was used (see Appendix H). Respondents were assessed for symptoms of PTSD specified in the DSM-IV (see Appendix H and Appendix I). A binary score was used for PTSD worst experience.

Specific Aims

This study aimed to expand past research in two ways. The first objective was to examine social support as a protective factor against psychological outcomes (i.e., MDD, ID, and PTSD) and revictimization. While the current literature demonstrates that social support buffers against psychological outcomes (Holstrom & Burgess, 1979; Hyman et al., 2003) and that satisfaction with social relationships is a significant predictor of revictimization (Collins, 1998), there has been a lack of attention within the literature to possible racial differences. Secondly, although there is link between cocaine use, psychological outcomes (Cottler et al., 1992) and revictimization (Kilpatrick et al., 1997) there has been a similar lack of attention to potential racial differences. Therefore, the current study also examined if cocaine abuse/dependence, was a risk factor for psychological outcomes (i.e., MDD, ID, and PTSD) and revictimization with respect to possible racial differences.

Hypotheses

The current study made the following hypotheses: 1. less positive social support will be associated with psychological outcomes (i.e. MDD, ID, and PTSD) and revictimization across racial groups and 2. cocaine abuse/dependence will be associated with psychological outcomes (i.e. MDD, ID, and PTSD) across racial groups.

Results

Analysis

Logistic regression analyses were used to determine if the predictor variables (i.e., social support and cocaine abuse/dependence) are related to the outcomes variables (i.e., MDD, ID, PTSD, as well as revictimization) and then to determine if the moderating variable (i.e. race) changed the relationship between the predictor variables and the outcomes variables. Each logistic model had two predictors (listed as x^2).

The first step was to represent one of the predictor variables, cocaine abuse/dependence, and the moderator variable, race, with code variables. Cocaine abuse/dependence was a categorical variable with two levels (cocaine abuse/dependence positive, cocaine abuse/dependence negative). Caucasian was used as the reference category for the variable of race in all of the regressions. The x^2 in every equation represented the likelihood of the outcome for that race. Because the number of code variables depended on the number of levels minus one, one code variable was needed. Race, which was a categorical variable with three levels (i.e., Caucasian, African-American, and Latina), required two code variables. Contrast coding was used to make comparisons between groups (i.e., Caucasian, African American, and Latina).

The next step in formulating the regression equation involved centering the moderator variable that was measured on a continuous scale, social support. After code variables were created to represent categorical variables (i.e., race and cocaine abuse/dependence) and the variable measured on a continuous scale (i.e., social support) was centered, product terms were created that represented the interaction between the predictor variables (i.e., social support and cocaine abuse/dependence) and moderator variable (i.e., race). To form product terms, the predictor variables (i.e., social support and cocaine abuse/dependence) and moderator variable

(i.e., race) were multiplied using the newly coded categorical variables and centered continuous variable. A product term was created for each coded variable (i.e., cocaine abuse/dependence and race).

After product terms were created, everything was in place to structure a hierarchical multiple regression equation using standard statistical software to test for moderator effects. The variables were entered into the regression equation through a series of specified steps. The first step included the code variables (i.e., cocaine abuse/dependence and race) and centered variable (i.e., social support) representing the predictor variables (i.e., social support and cocaine abuse/dependence) and moderator variable (i.e., race). All individual variables contained in the interaction terms were included in the model. Product terms were entered into the regression equation after the predictor and moderator variables from which they were created.

The Omnibus Test of Models Coefficients (Omnibus Chi-Square) was used to indicate whether predictors in the model taken together were significant predictors of the outcome. The Wald Statistic was used to indicate whether a coefficient was significantly different from 0 or not.

Outcomes

Demographic factors. In the current study, a total of 1115 participants in the NCS-R dataset endorsed experiences of sexual victimization. Of those participants 72.7% were Caucasian, 13.6% were African American, 9.5% were Latina, and 4.2% were Other. There was a large range in income, $0 - $150,000 – $199,999, with a median income of $12,000 - $12,999. Half of the respondents had an income of less than the $12,000 - $12,999 income level. There was no significant difference in the distribution of income by race $F(3, 874) = 0.92$, Mean Squared Error = 103.60, $p = 0.43$. In regards to marital status, 50.5% of the sample were

married/cohabitating, 27.5% were divorced/separated/widowed, and 22.0% were never married. There were significant differences in marital status by race x^2 (6) = 69.56, $p < 0.001$. Compared to every other group, African American respondents were more likely to have never been married. In terms of education, 13.9% had 0-11 years, 28.2% had 12 years, 33.6% had 13-15 years, and 24.3% had greater than or equal to 16 years. Sociodemographic characteristics of NCS-R respondents who endorsed sexual victimization can be referenced in Table 2.

Table 2

Characteristics of NCS-R Respondents who Endorsed Sexual Victimization

Characteristic	*n*	%
Race		
White	784	72.7
Black	147	13.6
Latino	102	9.5
Not White, Black or Latino	45	4.3
Income		
Less than $0	13	1.2
$0	180	16.1
$1 - $999	38	3.4
$1,000 - $1,999	18	1.6
$2,000 - $2,999	13	1.2
$3,000 - $3,999	20	1.8
$4,000 - $4,999	23	2.1
$5,000 - $5,999	22	2
$6,000 - $6,999	19	1.7
$7,000 - $7,999	11	1
$8,000 - $8,999	13	1.2
$9,000 - $9,999	14	1.3
$10,000 - $10,999	27	2.4
$11,000 - $11,999	15	1.3
$12,000 - $12,999	20	1.8
$13,000 - $13,999	13	1.2
$14,000 - $14,999	9	0.8

(continued)

Characteristic	*n*	%
$15,000 - $15,999	13	1.2
$17,000 - $17,999	12	1.1
$18,000 - $18,999	15	1.3
$19,000 - $19,999	12	1.1
$20,000 - $24,999	73	6.5
$25,000 - $29,999	69	6.2
$30,000 - $34,999	55	4.9
$35,000 - $39,999	35	3.1
$40,000 - $44,999	30	2.7
$45,000 - $49,999	28	2.5
$50,000 - $74,999	51	4.6
$75,000 - $99,999	11	1
$100,000 - $149,999	2	0.2
$150,000 - $199,999	1	0.1
Marital Status		
Married/Cohabitating	563	50.5
Divorced/Separated/Widowed	307	27.5
Never Married	245	22
Years of Education		
0-11	155	13.9
12	314	28.2
13-15	375	33.6
Greater than or equal to 16	271	24.3

Social support.

Depression associated with social support and race. In examining depression associated with social support and race, the model was not significant (x^2 = 3.68, *p* = 0.45).

Irritable depression associated with social support and race. In examining irritable depression associated with social support and race, the model was not significant (x^2 = 6.32, *p* = 0.18).

Revictimization associated with social support and race. In examining revictimization associated with social support and race, the model was not significant (x^2 = 7.68, *p* = 0.10).

PTSD associated with social support and race. In examining PTSD associated with social support and race, the model was significant (x^2 = 18.90, p = 0.002). Social support was significant (x^2 = 10.51, p = 0.00) with sexual assault victims who reported experiencing less positive support being more likely to have PTSD.

Cocaine use.

Depression associated with cocaine use and race. In examining depression associated with cocaine use and race, the model was not significant (x^2 = 6.67, p = 0.15).

Irritable depression associated with cocaine use and race. In examining ID associated with cocaine use and race, the model was marginally significant (x^2 = 8.02, p = 0.09).

Revictimization associated with cocaine use and race. In examining revictimization associated with cocaine use and race, the model was not significant (x^2 = 5.89, p = 0.21).

PTSD associated with cocaine use and race. In examining PTSD associated with cocaine use and race, the model was significant (x^2 = 25.21, p < 0.001). Race was significantly associated with PTSD (x^2 = 7.62, p = 0.05). Compared to Caucasians, there was a trend for those who were identified as Other to have experienced more PTSD, whereas Latinas were significantly more likely to have experienced PTSD. Those who were identified as Other were more than twice as likely than Caucasians to experience PTSD (x^2 = 3.35, p = 0.07). Latinas were twice as likely than Caucasians to experience PTSD (x^2 = 5.18, p = 0.02). Cocaine abuse/dependence was significantly associated with PTSD (x^2 = 21.06, p < 0.001). Participants who met criteria for cocaine abuse or dependence were more than three times as likely to have PTSD than those who did not meet criteria for cocaine abuse/dependence.

Table 3 provides an overview of the protective and risk factors as well as the outcome variables. Table 4 provides an overview of the logistic regression model.

Table 3

Protective, Risk, and Outcome Variables

Characteristic	*n*	%	*Min*	*Max*	*M*	*SD*
Social Support	1107		1	4.5	2.2562	0.64389
Cocaine Abuse/Dependence	116	10.4				
Revictimization	491	44				
Posttraumatic Stress Disorder	102	9.1				
Major Depressive Disorder	474	42.5				
Irritable Depression	8	0.7				

Table 4

Outcomes by Race

	Revictimization		PTSD		MDD		ID	
Social Support								
	B	Wald	B	Wald	B	Wald	B	Wald
Caucasian	-0.028	0.024	-0.019	0.003	-0.19	1.021	-16.14	0
African-American	0.309	2.136	0.65	4.555	-0.13	0.342	0.451	0.167
Latina	-0.55	2.758	0.575	0.437	0.304	0.971	2.012	5.426
Cocaine Abuse/Dependence								
Caucasian	-0.048	0.069	0.12	0.14	-0.16	0.734	-16.16	0
African-American	0.286	1.842	0.697	5.177	-0.12	0.32	0.466	0.179
Latina	-0.582	3.105	0.799	3.349	0.351	1.303	1.936	5.159

Discussion

Findings

This study examined the role of protective factors (i.e., social support) and risk factors (i.e. cocaine abuse/dependence) in psychological outcomes (i.e. MDD, ID, PTSD, and revictimization) among racially diverse female survivors of sexual victimization. There were two main findings. First, as hypothesized individuals who endorsed sexual victimization that reported experiencing less positive support were more likely to have PTSD. These findings are consistent with the robust literature on the buffering impact social support has on psychological outcomes like PTSD following sexual victimization (Burgess & Holmstrom, 1979; Frazier & Burnett, 1994; Frazier et al., 2005; Gutner et al., 2006; Meyer & Taylor, 1986; Valentiner et al., 1996). Second, as hypothesized individuals who endorsed sexual victimization who also met criteria for cocaine abuse/dependence were more likely to have PTSD than those who did not meet criteria for cocaine abuse/dependence; in fact, they were more than three times as likely to have experienced PTSD. These results are consistent with other studies that suggest a strong relationship between exposure to traumatic events, substance use, and PTSD; for example the studies by Cottler et al. (1992) and Afful et al. (2010) that found substance use is associated with an increased risk of exposure to traumatic events and vulnerability to the development of psychological outcomes like PTSD. Additional findings suggest that race has an impact on the relationship between cocaine use and PTSD in women who have been sexually victimized. Among those who met criteria for cocaine abuse/dependence, respondents that were identified as Other, who were predominately Asian American Pacific Islander, were more than twice as likely than Caucasians to experience PTSD and Latinas were twice as likely than Caucasians to experience PTSD.

Relation to Prior Research

There is a scarcity of research on sexual violence as it relates to minorities in general but particularly for Asian American Pacific Islanders and Latinas; this makes it difficult to determine prevalence rates of sexual violence within these communities. However, The National Violence Against Women Survey found that 6.8% of Asian American Pacific Islanders and 21.2% of Latinas reported sexual violence (United States Department of Justice, 2000). Although, it should be noted that these rates are most likely higher in actuality due to the underreporting of sexual violence in general and cultural beliefs in these communities that may further discourage reporting. This may be especially true for Asian American Pacific Islanders as some studies have found Asian American Pacific Islander the least likely to report rape across racial groups (Tjaden & Thoennes, 1998). The lack of research on sexual violence within the Asian American Pacific Islander and Latina communities makes these findings significant.

Additional research is needed to explain why Asian American Pacific Islanders and Latinas who have experienced sexual victimization and are abusing or dependent on cocaine would be more likely than Caucasians to experience PTSD. However, there are many things that might contribute to these findings; for example factors related to migration, acculturation, and racism, which impact both of these groups, have been found to contribute to distress following trauma (Araújo & Borrell, 2006; Cuevas, Sabina, & Bell, 2012; Leong, Leach, Yeh, & Chou, 2007; Ortega, Rosenheck, Alegria, & Desai, 2000; Sabina, Cuevas, & Schally, 2013; Yeh, 2003).

Racism continues to be a pervasive issue for both the Asian American Pacific Islander and Latina communities. According to the Pew Research Center (2012), despite the “model minority” stereotype 61% of Asian American Pacific Islanders express the belief that

discrimination is a problem for their community and one-in-five Asian American Pacific Islanders say they have been treated unfairly in the past year due to their race. Additionally, the Pew Research Center (2010), found that six-in-ten Latinos say discrimination against their community is a "major problem" with 34% of those surveyed saying they themselves or a close family member or friend has experienced discrimination in the past five years.

There are factors in addition to racism that may account for the higher rates of PTSD in Asian American Pacific Islanders and Latinas who have experienced sexual victimization and are abusing or dependent on cocaine; for example, religious traditions common among Asian American Pacific Islanders and Latinas promote values that might increase shame and/or self-blame. The Pew Research Center (2012) found that Christians are the largest religious group among Asian American Pacific Islanders with 42% identifying as Christian, followed by 26% who identified as unaffiliated, and 14% who identified as Buddhist. Additionally, the Pew Research Center (2014), found that 55% of Latinos are Catholic. Christianity can encourage negative self-attributions, or a tendency to attribute negative events to one's self (Lewis, 1992). Furthermore, Buddhism promotes endurance of suffering as reflected in the Four Noble Truths, the first of which can be translated as "life is suffering" (Sue & Sue, 1987). It is essential to note that while certain aspects of religion may lead to negative outcomes such as self-blame, religion can also serve as a protective factor and can be associated with positive mental health outcomes (Hill & Pargament, 2003; Thompson & Gurney, 2003).

There are other factors that might contribute to self-blame, as well as encourage silence rather than seeking either informal or formal resources; for example, Asian American Pacific Islanders might fear shaming one's family (Conrad & Pacquiao, 2005; Xu, Sun, Zhang, & Xu, 2001). Similarly, Latinas may be reluctant to disclose abuse due to values specific to the Latino

population such as *marianismo, familismo, respeto, simpatía, and fatalism*, which prioritize female virginity, family, respect, harmony, and suggest that things are predetermined or unalterable (Fraga, Atkinson, & Wampold, 2004; Ruef, Litz, & Schlenger, 2000). Some research suggests that these values can have negative implications for Latina survivors of sexual victimization (Castro & Hernandez, 2004; Ulibarri et al., 2010). Certainty, there are many positive aspects related to valuing family and community, as reflected in the robust literature on social support; however, there are aspects that may facilitate self-blame, shame, and silence.

There is also a higher endorsement of rape-myths, which Burt (1980) defined rape-myths as “prejudicial, stereotyped, or false beliefs about rape, rape victims, and rapists” (p. 217), among Asian American Pacific Islanders and Latinos. It is possible that in addition to religious views and cultural values, higher endorsement of rape-myths increases distress among Asian American Pacific Islanders and Latinas who have experienced sexual victimization and are abusing or dependent on cocaine.

Racial factors can also affect symptom expression; for example, expressing anxiety may be a more culturally acceptable emotion to express for Latinas consistent with the culturally bound syndrome *ataque de nervios* (Baer et al., 2003; Hinton, Chong, Pollack, Barlow, & McNally, 2008; Lewis-Fernandez et al., 2002; Schechter et al., 2000). Racial factors may also influence coping styles. Pole et al. (2005) found that coping styles such as self-blame contributed to higher rates of PTSD among Latinos, in addition to lower social support and the effects of racism; however the most significant factor was peritraumatic dissocation, an acute response to trauma (McDonald et al., 2013). Results from the study by Pole et al. (2005) also indicated that Latinos cope with trauma by engaging in avoidant coping. Research shows that PTSD symptoms are highest among cultures that promote avoidance as way to manage distress (Marsella,

Friedman, & Spain, 1996; McCall & Resick, 2003). Thus, Latinas who have been sexually victimized and are also abusing or dependent on cocaine may be utilizing more avoidant coping resulting in a greater risk of PTSD. In support of this possibility, research suggests that numbing symptoms may increase susceptibility to substance use, which further increases the risk of revictimization and increased risk of PTSD (Wilson et al., 1999; Ullman et al., 2009).

Implications

While more research is needed to understand how race affects the recovery process from sexual victimization this study in addition to prior research suggests race is an important factor; this has implication as far as meeting the needs of racially diverse female survivors of sexual victimization. First and foremost, there are barriers to treatment that need to be addressed. Women who belong to minority groups may be distrustful of formal support due to historical, institutional racism (Xu et al., 2001). Ongoing discriminatory treatment or cultural insensitivity may further discourage individuals from minority communities from seeking help. Culturally insensitive practices not only contribute to the underutilization of mental health services among these communities but can also result in early termination of treatment (Leong, 1994; Matsuoka, Breaux, & Ryujin, 1997; Snowden & Cheung, 1990; Zhang, Snowden, & Sue, 1998). The lack of access to quality care among minorities is concerning for many reasons, but especially because substandard treatment can result in higher levels of PTSD even compared to those who do not seek services (Campbell & Soeken, 1999; Filipas & Ullman, 2001). There are other obstacles to treatment such as language barriers and a lack of economic resources or insurance (Bauer, Rodriguez, Quiroga, & Flores-Ortiz, 2000; Cabassa, Zayas, & Hansen, 2006; Campbell, 1998; Lipsky & Caetano, 2007). Additionally, many women who belong to minority groups are unaware of what mental health services are available or what constitutes sexual violence

particularly within the context of marriage, highlighting the need for outreach and education (Olive, 2012; Xu, Campbell, & Zhu, 2001). Immigrants may face additional barriers. Undocumented women are often fearful of seeking help following sexual victimization despite the Violence Against Women Act, which offers legal protection, as many are unaware of these policies (Conyers, 2007). These barriers may leave minority women without any sources of support, making them particularly vulnerable.

Even when services are accessible, minorities are less likely to seek them, often citing shame, (Golding, Siegel, Sorenson, Burnam, & Stein, 1989; Lewis, West, Bautista, Greenberg, & Done-Perez, 2005; West, Kaufman Kantor, & Jasinski, 1998). This may be for many reasons, including religious beliefs, cultural values, or higher endorsement of rape-myths. If outreach efforts proved successful, it may enable survivors to utilize their support networks and/or seek formal help. If survivors are able to seek social support and/or treatment, it may further reduce the risk of substance use/abuse, psychological outcomes, and revictimization. Additionally, cultural factors may be promoting problematic coping styles, such as avoidant coping, which is associated with not only psychological outcomes but also substance use and revictimization. This suggests that Latinas who have experienced sexual victimization may benefit from gaining non-avoidant coping skills, which clinicians could emphasize in treatment.

The results also highlight the need for dual diagnosis programs for those who need treatment for both trauma and addiction. It has been suggested that women who have been sexually victimized may represent a subset of those who abuse substances and have unique treatment needs (Roberts, Nishimoto, & Kirk, 2003). Addressing these needs is important as Ouimette et al. (1998) found that hat individuals who have PTSD have faster relapse rates and heavier use posttreatment. Dual diagnosis treatment programs may be especially important for

women who have been sexually victimized who belong to minority groups, as they are more likely to use substances as a way of coping, possibly due to additional stressors related to racism and barriers accessing services (Kaukinen & DeMaris, 2005). Additionally, because of the bidirectional relationship between substances and sexual abuse, women not only turn to substances as a way of coping after sexual victimization but substance use also put women at risk for sexual victimization, substance use prevention efforts should be prioritized.

In sum, it is essential that women from minority communities are made aware of what constitutes abuse, what their rights are, and are able to access both informal and formal culturally sensitive support, so that they can recover rather than turn to substances, thus decreasing the risk of subsequent victimization and psychological outcomes.

Limitations

Despite data being derived from a sizable sample of sociodemographically, diverse respondents, the current study includes inherent limitations. One of the primary limitations relates to the use of archival data. The use of archival data makes it difficult to rule out alternative hypotheses accounting for correlations. Another limitation related to the use of archival data relates to the use of aggregate data as opposed to the availability of individual data. The data is quantitative in nature and as such does not capture nuances of each individual's experience. A mixed-method research design might have provided a more thorough examination of their functioning. Despite the sample being comprised of a diverse population, there are notable sociodemographic limitations. The data does not allow individuals who are biracial or multiracial to select more than one category. It is especially important to note that because race was captured in broad, collapsed categories cultural inferences should not be over interpreted. Additionally, the NCS-R did not ask about factors such as immigration status. Lastly, the data is

normed on the previous version of the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) criterion, which deviates from the current version of the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5). This serves as a notable limitation because it potentially hinders the generalizability and clinical utility of information assessed within the NCS-R study.

Future Directions

While more research is needed to understand racial differences in the recovery process from sexual victimization, the current study suggests that Asian American Pacific Islanders and Latinas who have experienced sexual victimization and are abusing or dependent on cocaine may be more likely than Caucasians to experience PTSD. Future research should examine cultural factors in a way this study could not due to the nature of the dataset and the way that sociodemographic characteristics were captured.

References

Abbey, A., Zawacki, T., Buck, P. O., Clinton, A. M., & McAuslan, P. (2003). Sexual assault and alcohol consumption: What do we know about their relationship and what types of research are still needed? *Aggression and Violent Behavior, 277,*1-33. doi:10.1016/S1359-1789(03)00011-9

Acierno, R., Resnick, H., Kilpatrick, D. G., Saunders, B., & Best, C. L. (1999). Risk factors for rape, physical assault, and posttraumatic stress disorder in women: Examination of differential multivariate relationships. *Journal of Anxiety Disorders, 13*, 541–563. doi:10.1016/S0887-6185(99)00030-4

Afful, S. E., Strickland, J. R., Cottler, L., & Bierut, L. (2010). Exposure to trauma: A comparison of cocaine-dependent cases and a community-matched sample. *Drug And Alcohol Dependence*, *112*(1-2), 46-53. doi:10.1016/j.drugalcdep.2010.05.012

Ahrens, C., Campbell, R., Ternier-Thames, K., Wasco, S., & Sefl, T. (2007). Deciding whom to tell: Expectations and outcomes of rape survivors' first disclosures. *Psychology of Women Quarterly, 31,* 38-49. doi:10.1111/j.1471-6402.2007.00329.x

Alegria, M., Jackson, J. S., Kessler, R. C., & Takeuchi, D. (2007). National comorbidity survey replication (NCS-R). In M. Alegria, J.S. Jackson, R.C., Kesller, & D. Takeuchi (Eds.), *Collaborative Psychiatric Epidemiology Surveys (CPES), 2001-2003 (ICPSR20240)* [Data file]. Ann Arbor: Consortium for Political and Social Research. doi:10.3886/icpsr04438.v1

Andrews G. & Peters L. (1998). The psychometric properties of the Composite International Diagnostic Interview. *Social Psychiatry and Psychiatric Epidemiology, 33,* 80–88. doi:10.1007/s001270050026

Arata, C. M. (1999a). Coping with rape: The roles of prior sexual abuse and attributions of blame. *Journal of Interpersonal Violence, 14,* 62-78. doi:10.1177/088626099014001004

Arata, C. M. (1999b). Repeated sexual victimization and mental disorders in women. *Journal of Child Sexual Abuse, 7*(3), 1-17. doi:10.1300/J070v07n03_01

Arata, C. M. (2000). From child victim to adult victim: A model for predicting sexual revictimization. *Child Maltreatment, 5,* 28-38. doi:10.1177/1077559500005001004

Arata, C. M. (2002). Child sexual abuse and sexual revictimization. *Clinical Psychology: Science and Practice, 9,* 135-164. doi:10.1093/clipsy.9.2.135

Araújo, B. Y., & Borrell, L. N. (2006). Understanding the link between discrimination, mental health outcomes, and life chances among Latinos. *Hispanic Journal of Behavioral Sciences*, *28*, 245–266. doi:10.1177/0739986305285825

Atkeson, B. M., Calhoun, K. S., Resick, P. A., & Ellis, E. M. (1982). Victims of rape: Repeated assessment of depressive symptoms. *Journal of Consulting and Clinical Psychology, 50*, 96-102. doi:10.1037/0022-006X.50.1.96

Back, S., Dansky, B. S., Coffey, S. F., Saladin, M. E., Sonne, S., Brady, K. T. (2000). Cocaine dependence with and without post-traumatic stress disorder: A comparison of substance use, trauma history and psychiatric comorbidity. *American Journal of Addiction, 9*(1)*,* 51–62. doi:10.1080/10550490050172227

Baer, R. D., Weller, S. C., de Alba Garcia, J. G., Glazer, M., Trotter, R., Pachter, L., & Klein, R. E. (2003). A cross-cultural approach to the study of the folk illness nervios. *Culture, Medicine, and Psychiatry, 27*, 315-337. doi:10.1023/A:1025351231862

Baker, F. M. (2001). Diagnosing depression in African Americans. *Community Mental Health Journal, 37*(1)*,* 31–38. doi:10.1023/a:1026540321366

Banyard, V. L., Williams, L. M., & Siegel, J. A. (2001). The long-term mental health consequences of child sexual abuse: An exploratory study of the impact of multiple traumas in a sample of women. *Journal of Traumatic Stress, 14*, 697-715. doi:10.1023/A:1013085904337

Barnett, O. W., Miller-Perrin, C. L., & Perrin, R. D. (Eds.). (1997). *Family violence across the lifespan: An introduction*. Thousand Oaks, CA: Sage. Retrieved from https://us.sagepub.com/en-us/nam/family-violence-across-the-lifespan/book234481

Basile, K. C., Smith, S. G., Walters, M. L., Fowler, D. N., Hawk, K., & Hamburger, M. E. (2015). Sexual violence victimization and associations with health in a community sample of Hispanic women. *Journal Of Ethnic & Cultural Diversity In Social Work: Innovation In Theory, Research & Practice*, *24*(1), 1-17. doi:10.1080/15313204.2014.964441

Bauer, H. M., Rodriguez, M. A., Quiroga, S. S., & Flores-Ortiz, Y. G. (2000). Barriers to health care for abused Latina and Asian immigrant women. *Journal of Health Care for the Poor and Underserved, 11*, 33-44. doi:10.1353/hpu.2010.0590

Becker, J. V., Skinner, L. J., Abel, G. G., Axelrod, R., & Treacy, E. C. (1984). Depressive symptoms associated with sexual assault. *Journal of Sex and Marital Therapy, 10,* 185-192. doi:10.1080/00926238408405944

Benotsch, E. G., Brailey, K., Vasterling, J. J., & Sutker, P. B. (2000). War zone stress, personal and environmental resources, and PTSD symptoms in Gulf War veterans: A longitudinal perspective. *Journal of Abnormal Psychology*, *109,* 205–213. doi:10.1037/0021-843X.109.2.205

Bolstad, B. R., & Zinbarg, R. E. (1997). Sexual victimization, generalized perception of control,

and posttraumatic stress disorder symptom severity. *Journal of Anxiety Disorders, 11,* 523–540. doi:10.1016/S0887-6185(97)00028-5

Boney-McCoy, S., & Finkelhor, D. (1995). Prior victimization: A risk factor for child sexual abuse and for PTSD-related symptomatology among sexually abused youth. *Child Abuse & Neglect , 19,* 1401–1421. doi:10.1016/0145-2134(95)00104-9

Borja, S. E., Callahan, J. L., & Long, P. J. (2006). Positive and negative adjustment and social support of sexual assault survivors. *Journal of Traumatic Stress, 19,* 905–914. doi:10.1002/jts.20169

Botta, R. A., & Pingree, S. (1997). Interpersonal communication and rape: Women acknowledge their assaults. *Journal of Health Communication, 2*(3), 197-212. doi:10.1080/108107397127761

Breslau, N., Davis, G. C., Peterson, E. L., & Schultz, L. (1997). Psychiatric sequelae of posttraumatic stress disorder in women. *Archives Of General Psychiatry*, *54*(1), 81-87. doi:10.1001/archpsyc.1997.01830130087016

Bryant-Davis, T., Chung, H., & Tillman, S. (2009). From the margins to the center: Ethnic minority women and the mental health effects of sexual assault. *Trauma, Violence, & Abuse*, *10*(4), 330-357. doi:10.1177/1524838009339755

Bryant-Davis, T., Ullman, S. E., Tsong, Y., Tillman, S., & Smith, K. (2010). Struggling to survive: Sexual assault, poverty, and mental health outcomes of African American women. *American Journal of Orthopsychiatry, 80*(1), 61-70. doi:10.1111/j.1939-0025.2010.01007.x

Burgess, A. W. (1983). Rape trauma syndrome. *Behavioral Sciences and the Law, 1*, 97-112. doi:10.1007/springerreference_223764

Burgess, A. W., & Holmstrom, L. L. (1979). Rape: Sexual disruption and recovery. *American Journal Orthopsychiatry, 49*, 648-657. doi:10.1111/j.1939-0025.1979.tb02650.x

Burnam, M. A., Hough, R. L., Karno, M., & Escobar, J. I. (1987). Acculturation and lifetime prevalence of psychiatric disorders among Mexican Americans in Los Angeles. *Journal of Health and Social Behavior, 28*, 89-102. doi:10.2307/2137143

Burnam, M. A., Stein, J. A., Golding, J. M., Siegel, J. M., Sorenson, S. B., Forsythe, A. B., & Telles, C. A. (1988). Sexual assault and mental disorders in a community population. *Journal Of Consulting And Clinical Psychology*, *56*(6), 843-850. doi:10.1037/0022-006X.56.6.843

Burt, M. (1980). Cultural myths and supports for rape. *Journal of Personality and Social Psychology, 38*, 217-230. doi:10.1037/0022-3514.38.2.217

Cabassa, L. J., Zayas, L. H., & Hansen, M. C. (2006). Latino adults' access to mental health care: A review of epidemiological studies. *Administration and Policy in Mental Health and Mental Health Services Research, 33*, 316-330. doi:10.1007/s10488-006-0040-8

Caetano, R., & Cunradi, C. (2003). Intimate partner violence and depression among Whites, Blacks, and Hispanics. *Annals of Epidemiology*, *13*(10), 661–665. doi:10.1016/j.annepidem.2003.09.002

Campbell, J. C. (Ed.). (1998). *Empowering survivors of abuse: Health care for battered women and their children.* Thousand Oaks, CA: SAGE Publications, Inc. Retrieved from https://us.sagepub.com/en-us/nam/empowering-survivors-of-abuse/book7179

Campbell, J., Jones, A. S., Dienemann, J., Kub, J., Schollenberger, J., O'Campo, P., . . . Wynne, C. (2002). Intimate partner violence and physical health consequences. *Archives of Internal Medicine*, *162*(10), 1157–1163. doi:10.1001/archinte.162.10.1157

Campbell, J. C., & Soeken, K. L. (1999). Forced sex and intimate partner violence: Effects on women's risk and women's health. *Violence Against Women, 5*(9)*,* 1017-1035. doi:10.1177/10778019922181608

Campbell, R., Ahrens, C., Sefl, T., Wasco, S. M., & Barnes, H. E. (2001). Social reactions to rape victims: Healing and hurtful effects on psychological and physical health outcomes. *Violence & Victims, 16,* 287-302. Retrieved from http://www.ingentaconnect.com.lib.pepperdine.edu/content/springer/vav/2001/00000016/00000003/art00004

Castro, F. G., & Hernandez, N. T. (2004). A cultural perspective on prevention interventions. In R. J. Velasquez, L. M. Arellano, & B. W. McNeill (Eds.), *The handbook of Chicana/o psychology and mental health* (pp. 371–397). Mahwah, NJ: Lawrence Erlbaum Associates. Retrieved from https://books.google.com/books?hl=en&lr=&id=rKyPAgAAQBAJ&oi=fnd&pg=PP1&dq=The+handbook+of+Chicana/o+psychology+and+mental+health&ots=HSdi7pAF3D&sig=sl5ZqAMSFjeSNV-CCejxd2P1Rs4#v=onepage&q=The%20handbook%20of%20Chicana%2Fo%20psychology%20and%20mental%20health&f=false

Classen, C. C., Palesh, G., & Aggarwal, R. (2005). Sexual revictimization: A review of the empirical literature. *Trauma, Violence, and Abuse, 6*, 103–129. doi:10.1177/1524838005275087

Clear, P. J., Vincent, J. P., & Harris, G. E. (2006). Ethnic differences in symptom presentation of sexually abused girls. *Journal of Child Sexual Abuse*, *15*(3), 79–98. doi:10.1300/J070v15n03_05

Collins, M. E. (1998). Factors influencing sexual victimization and revictimization in a sample of adolescent mothers. *Journal of Interpersonal Violence, 13*, 3–24. doi:10.1177/088626098013001001

Conrad, M. M., & Pacquiao, D. F. (2005). Manifestation, attribution, and coping with depression among Asian Indians from the perspectives of health care practitioners. *Journal of Transcultural Nursing, 16*, 32-40. doi:10.1177/1043659604271239

Conyers, J. J. (2007). The 2005 reauthorization of the Violence Against Women Act: Why Congress acted to expand protections to immigrant victims. *Violence Against Women, 13*, 457-468. doi:10.1177/1077801207300650

Cottler, L. B., Compton, W. M., Mager, D., Spitznagel, E. L. & Janca, A. (1992). Posttraumatic stress disorder among substance users from the general population. *American Journal of Psychiatry, 149*(5)*,* 664-670. doi:10.1176/ajp.149.5.664

Coyne, J. C. (1976). Toward an interactional description of depression. *Psychiatry: Interpersonal and Biological Processes, 39*(1), 28–40. doi:10.1521/00332747.1976.11023874

Cuellar, J., & Curry, T. R. (2007). The prevalence and comorbidity between delinquency, drug abuse, suicide attempts, physical and sexual abuse, and self- mutilation among delinquent Hispanic females. *Hispanic Journal of Behavioral Sciences*, *29*(1), 68–82. doi:10.1177/0739986306295796

Cuevas, C. A., Sabina, C., & Bell, K. A. (2012). The effect of acculturation and immigration on the victimization and psychological distress link in a national sample of Latino women.

Journal Of Interpersonal Violence, *27*(8), 1428-1456. doi:10.1177/088626051142579.

Dansky, B. S., Brady, K. T., Saladin, M. E., Killeen, T., Becker, S., & Roitzsch, J. (1996). Victimization and PTSD in individuals with substance use disorders: Gender and racial differences. *American Journal of Drug and Alcohol Abuse, 22,* 75–93. doi:10.3109/00952999609001646

Dansky B., Saladin M., Brady K., Kilpatrick D., & Resnick H. (1995) Prevalence of victimization and posttraumatic stress disorder among women with substance use disorders: a comparison of telephone and in-person assessment samples. *International Journal of Addiction, 30*, 1079–1099. doi:10.3109/10826089509055829

Davis, R. C., Brickman, E. & Baker, T. (1991). Supportive and unsupportive responses of others to rape victims: Effects on concurrent victim adjustment. *American Journal of Community Psychology, 19,* 443-451.Retrieved from http://onlinelibrary.wiley.com/doi/10.1007/BF00938035/abstract

Djernes, J. K. (2006). Prevalence and predictors of depression in populations of elderly: a review. *Acta Psychiatrica Scandinavica. 113*, 372–387. doi:10.1111/j.1600-0447.2006.00770.x

Elliot, D., Mok, D., & Briere, J. (2004). Adult sexual assault: Prevalence, symptomatology, and sex differences in the general population. *Journal of Traumatic Stress, 17,* 203-211. doi:10.1023/B:JOTS.0000029263.11104.23

Ellis, E. M. (1983). A review of empirical rape research: Victim reactions and response to treatment. *Clinical Psychology Review, 3,* 473-490. doi:10.1016/0272-7358(83)90025-9

Ellis, E. M., Atkeson, B., & Calhoun, K. S. (1981). An assessment of long-term reactions to rape.

Journal of Abnormal psychology, 90, 263-266. doi:10.1037/0021-843X.90.3.263

Ellsworth, P. C. (1994). Sense, culture, and sensibility. In S. Kitayama & H.r. Markus (Eds.), Emotion and culture: Empirical studies of mutual influence (pp. 23-50). Washington, DC: American Psychological Association. doi:10.1037/10152-001

Epstein, J. N., Saunders, B. E., Kilpatrick, D. G., & Resnick, H. S. (1998). PTSD as a mediator between childhood rape and alcohol use in adult women. *Child Abuse & Neglect, 22,* 223-234. doi:10.1016/S0145-2134(97)00133-6

Escobar, J. I., Rubio-Stipec, M., Canino, G., & Karno, M. (1989). Somatic Symptom Index (SSI): A new and abridged somatization construct. *The Journal of Nervous and Mental Disease, 177,* 140–146. doi:10.1097/00005053-198903000-00003

Fava, M., Hwang, I., Rush, A. J., Sampson, N., Walters, E. E., & Kessler, R. C. (2010). The importance of irritability as a symptom of depressive disorder: Results from the national comorbidity survey replication. *Molecular Psychiatry, 15,* 856-867. doi:10.1038/mp.2009.20

Feiring, C., Taska, L., & Chen, K. (2002). Trying to understand why horrible things happen: Attribution shame and symptom development following sexual abuse. *Child Maltreatment, 7,* 25-39. doi:10.1177/1077559502007001003

Filipas, H. H., & Ullman, S. E. (2001). Social reactions to sexual assault victims from various support sources. *Violence and Victims, 16*, 673-692. Retrieved from http://crawl.prod.proquest.com.s3.amazonaws.com/fpcache/3e30d139a4f649890afce48c8da313d6.pdf?AWSAccessKeyId=AKIAJF7V7KNV2KKY2NUQ&Expires=1476671092&Signature=ODu%2FDdy1LajiTIBkSMI2LFBN7zk%3D

Follette, V. M., Polusny, M. A., Bechtle, A. E., & Naugle, A. E. (1996). Cumulative trauma: The impact of child sexual abuse, adult sexual assault and spouse abuse. *Journal of Traumatic Stress, 9,* 25–35. doi:10.1002/jts.2490090104

Fowler, D. N., & Hill, H. M. (2004). Social support and spirituality as culturally relevant factors in coping among African American women survivors of partner abuse. *Violence Against Women, 10,* 1267-1282. doi:10.1177/1077801204269001

Fraga, E. D., Atkinson, D. R., & Wampold, B. E. (2004). Ethnic group preferences for multicultural counseling competencies. *Cultural Diversity and Ethnic Minority Psychology*, *10*, 53–65. doi:10.1037/1099-9809.10.1.53

Frank, E., & Anderson, B. P. (1987). Psychiatric disorders in rape victims: Past psychiatric history and current symptomatology. *Comprehensive Psychiatry, 28,* 77-82. doi:10.1016/0010-440X(87)90047-2

Frank, E., Turner, S., & Duffy, B. (1979). Depressive symptoms in rape victims. *Journal of Affective Disorders, 1*(4)*,* 269-277. doi:10.1016/0165-0327(79)90013-2

Frazier, P. (2003). Perceived control and distress following sexual assault: A longitudinal test of a new model. *Journal of Personality and Social Psychology, 84*(6)*,* 1257-1269. doi:10.1037/0022-3514.84.6.1257

Frazier, P. A., & Burnett, J. W. (1994). Immediate coping strategies among rape victims. *Journal of Counseling and Development, 72,* 633-639. doi:10.1002/j.1556-6676.1994.tb01694.x

Frazier, P. A., Mortensen, H., & Steward, J. (2005). Coping strategies as mediators of the relations among perceived control and distress in sexual assault survivors. *Journal of*

Counseling Psychology, 52(3)*,* 267-278. doi:10.1037/0022-0167.52.3.267

Freedman, S. A., Brandes, D., Peri, T., & Shalev, A. (1999). Predictors of chronic post-traumatic stress disorder. A prospective study. *The British Journal of Psychiatry, 174*(4)*,* 353–359. doi:10.1192/bjp.174.4.353

Gibson, L. E., & Leitenberg, H. (2001). The impact of child sexual abuse and stigma on methods of coping with sexual assault among undergraduate women. *Child Abuse and Neglect, 25*(10)*,* 1343-1361. doi:10.1016/S0145-2134(01)00279-4

Gidycz, C. A., Hanson, K., & Layman, M. B. (1995). A prospective analysis of the relationships among sexual assault experiences: An extension of previous findings. *Psychology of Women Quarterly, 19,* 5-29. doi:10.1111/j.1471-6402.1995.tb00276.x

Gladstone, G. L., Parker, G. B., Mitchell, P. B., Malhi, G. S., Wilhelm, K., & Austin, M. P. (2004). Implications of childhood trauma for depressed women: an analysis of pathways from childhood sexual abuse to deliberate self-harm and revictimization. *The American Journal of Psychiatry*, *161*(8), 1417–25. doi:10.1176/appi.ajp.161.8.1417

Gladstone, G., Parker, G., Wilhelm, K., Mitchell, P., & Austin, M. P. (1999). Characteristics of depressed patients who report childhood sexual abuse. *The American Journal of Psychiatry*, *156*(3), 431–7. doi:pdfplus/10.1176/ajp.156.3.431

Goldenberg, I. M., Mueller T., Fierman E. J., Gordon A., Pratt L., Cox K.,… Keller, M. B. (1995) Specificity of substance use in anxiety-disordered subjects. *Comprehensive Psychiatry, 36,* 319–328. doi:10.1016/S0010-440X(95)90112-4

Golding, J. M., Siegel, J. M. Sorenson, S. B. Burnam, M. A., & Stein, J. A. (1989). Social

support sources following sexual assault. *Journal of Community Psychology, 17*, 92-107. doi:10.1002/1520-6629(198901)17:1%3C92::AID-JCOP2290170110%3E3.0.CO;2-E

Gonzalez-Guarda, R. M., Peragallo, N., Vasquez, E. P., Urrutia, M. T., & Mitrani, V. B. (2009). Intimate partner violence, depression, and resource availability among a community sample of Hispanic women. *Issues in Mental Health Nursing*, *30*, 227–236. doi:10.1080/01612840802701109

Grauerholz, L. (2000). An ecological approach to understanding sexual revictimization: Linking personal, interpersonal, and sociocultural factors and processes. *Child Maltreatment, 5*(1), 5-17. doi:10.1177/1077559500005001002

Grice, D. E., Brady, K. T., Dustan, L. R., Malcolm, M., & Kilpatrick, D. G. (1995). Sexual and physical assault history and posttraumatic stress disorder in substance dependent individuals. *American Journal on Addictions, 4*(4)*,* 297-305. doi:10.1111/j.1521-0391.1995.tb00268.x

Gutner, C. A., Rizvi, S. L., Monson, C. M., & Resick, P. A. (2006). Changes in coping strategies, relationship to perpetrator, and posttraumatic distress in female crime victims. *Journal of Traumatic Stress, 19,* 813-823. doi:10.1002/jts.20158

Haro, J. M., Arbabzadeh-Bouchez S., Brugha T. S., De Girolamo G., Guyer M. E., Jin, R., . . . Kessler R. C. (2006). Concordance of the Composite International Diagnostic Interview Version 3.0 (CIDI 3.0) with standardized clinical assessments in the WHO World Mental Health Surveys. *International Journal of Methods in Psychiatric Research 15,* 167–180. doi:10.1002/mpr.196

Hill, T. D., Kaplan, L. M., French, M. T., & Johnson, R. J. (2010). Victimization in early life and mental health in adulthood: An examination of the mediating and moderating influences

of psychosocial resources. *Journal Of Health And Social Behavior*, *51*(1), 48-63. doi:10.1177/0022146509361194

Hill, P. C., & Pargament, K. I. (2003). Advances in the conceptualization and measurement of religion and spirituality: Implications for physical and mental health research. *American Psychologist*, *58*, 64–74. doi:10.1037/0003- 066X.58.1.64

Hinton, D. E., Chong, R., Pollack, M. H., Barlow, D. H., & McNally, R. J. (2008). Ataque de nervios: Relationship to anxiety sensitivity and dissociation predisposition. *Depression and Anxiety, 25*(6), 489-495. doi:10.1002/da.20309

Hobfoll, S. E. (1991). Traumatic stress: A theory based on rapid loss of resources. *Anxiety Research: An International Journal*, *4,* 187–197. doi:10.1080/08917779108248773

Holstrom, L. L., and Burgess, A. W. (1979). Rape: Husbands and boyfriends initial reactions. *The Family Coordinator, 28*(3), 321-330. doi:10.2307/581944

House, J. (1981). *Work, stress, and social support.* Reading, MA: Addison-Wesley. Retrieved from https://www.researchgate.net/profile/Chockalingam_vish_Viswesvaran/publication/255667393_The_Role_of_Social_Support_in_the_Process_of_Work_Stress_A_Meta-Analysis/links/556f30dc08aefcb861dd50f0.pdf

Hyman, S. M., Gold, S. N, Cott, M. A. (2003). Forms of social support that moderate PTSD in childhood sexual abuse survivors. *Journal of Family Violence, 18* (5), 295-300. doi:10.1023/A:1025117311660

Ireland, T., & Widom, C. S. (1994). Childhood victimization and risk for alcohol and drug arrests. *The International Journal of the Addictions, 29,* 235-274. doi:10.3109/10826089409047380

Iwata, N., Turner, R. J., & Lloyd, D. A. (2002). Race/ethnicity and depressive symptoms in community- dwelling young adults: A differential item functioning analysis. *Psychiatry Research, 110,* 281–289. doi:10.1016/S0165-1781(02)00102-6

Jacques-Tiura, A. J., Tkatch, R., Abbey, A., & Wegner, R. (2010). Disclosure of sexual assault: Characteristics and implications for posttraumatic stress symptoms among African American and Caucasian survivors. *Journal of Trauma and Dissociation, 11*(2), 174-192. doi:10.1080/15299730903502938

Kalaydjian, A., Swendsen, J., Chiu, W., Dierker, L., Degenhardt, L., Glantz, M., . . . Kessler, R. (2009). Sociodemographic predictors of transitions across stages of alcohol use, disorders, and remission in the national comorbidity survey replication. *Comprehensive Psychiatry*, *50*(4), 299-306. doi:10.1016/j.comppsych.2008.09.012

Kaukinen, C., & DeMaris, A. (2005). Age at first sexual assault and current substance use and depression. *Journal of Interpersonal Violence, 20,* 1244-1270. doi:10.1177/0886260505277732

Kessler, R. C., Berglund, P., Chiu, W. T., Demler, O., Heeringa, S., Hiripi, E., . . . Zheng, H. (2004). The US national comorbidity survey replication (NCS-R): Design and field procedures. *International Journal of Methods in Psychiatric Research, 13*(2), 69-92. doi:10.1002/mpr.167

Kessler, R. C., McGonagle, K. A., Zhao, S., Nelson, C. B., Hughes, M., Eshleman, . . . Kendler, K. S. (1994). Lifetime and 12-month prevalence of DSM-III-R psychiatric disorders in the United States: Results from the national comorbidity survey. *Archives of General Psychiatry, 51*(1), 8-19. doi:10.1001/archpsyc.1994.03950010008002

Kessler, R. C., & Merikangas, K. R. (2004). The national comorbidity survey replication (NCS-

R): Background and aims. *International Journal of Methods in Psychiatric Research, 13*(2), 60-68. doi:10.1002/mpr.166

Kessler, R. C., Sonnega, A., Bromet, E., Huges, M., & Nelson, C. B. (1995). Posttraumatic stress disorder in the national comorbidity survey. *Archives of General Psychiatry, 52*(12), 1048-1060. doi:10.1001/archpsyc.1995.03950240066012

Kessler R. C., Ustun T. B. (2004). The World Mental Health (WMH) survey initiative version of the World Health Organization (WHO) Composite International Diagnostic Interview (CIDI). *International Journal of Methods in Psychiatry, 13*, 93–121. doi:10.1002/mpr.168

Kilpatrick, D. G., Acierno, R., Resnick, H. S., Saunders, B. E., & Best, C. L. (1997). A 2-year longitudinal analysis of the relationship between violent assault and substance use in women. *Journal of Consulting and Clinical Psychology, 65*, 834-847. doi:10.1037/0022-006X.65.5.834

Kilpatrick, D. G., Edmunds, C. N. & Seymour, A. K. (1992). *Rape in America: A Report to the Nation*. Arlington, VA: National Victim Center. Retrieved from http://victimsofcrime.org/docs/Reports%20and%20Studies/rape-in-america.pdf?sfvrsn=0

Kilpatrick, D. G., Saunders, B. E., Veronen, L. J., Best, C. L., & Von, J. M. (1987). Criminal victimization: Lifetime prevalence, reporting to police, and psychological impact. *Crime and Delinquency, 33,* 479-489. doi:10.1177/0011128787033004005

Kilpatrick, D. G., Veronen, L. J., & Best, C. L. (1985). Factors predicting psychological distress among rape victims. In C.R. Figley (Eds.), *Trauma and its wake: The study and treatment of post-traumatic stress disorder* (Vol. 1, pp.113-141). New York, NY: Brunner/Mazel. Retrieved from

https://books.google.com/books/about/Trauma_and_Its_Wake_The_study_and_treatm.html?id=n_8Rde3s5aAC

Kilpatrick, D. G., Veronen, L. J., & Resick, P. A. (1981). Effects of a rape experience: A longitudinal study. *Journal of Social Issues, 37,* 105-122. doi:10.1111/j.1540-4560.1981.tb01073.x

King, D. W., King, L. A., Foy, D. W., Keane, T. M., & Fairbank, J. A. (1999). Posttraumatic stress disorder in a national sample of female and male Vietnam veterans: Risk factors, war-zone stressors, and resilience-recovery variables. *Journal of Abnormal Psychology*, *108,* 164–170. doi:10.1037/0021-843X.108.1.164

Koss, M. P., Dinero, T. E., Seibel, C. A., & Cox, S. L. (1989). Stranger and acquaintance rape: Are there differences in the victim's experience? *Psychology of Women Quarterly, 12,* 1-24. doi:10.1111/j.1471-6402.1988.tb00924.x

Koss, M. P., Figueredo, A. J., & Prince, R. J. (2002). Cognitive mediation of rape's mental, physical, and social health impact: Test of four models in cross-sectional data. *Journal of Consulting and Clinical Psychology, 70*(4), 926–941. doi:10.1037/0022-006x.70.4.926

Koverola, C., Proulx, J., Battle, P., & Hanna, C. (1996). Family functioning as predictors of distress in revictimized sexual abuse survivors. *Journal of Interpersonal Violence, 11,* 263-280. doi:10.1177/088626096011002009

Krahé, B., Scheinberger-Olwig, R., Waizenhöfer, E., & Kolpin, S. (1999). Childhood sexual abuse and revictimization in adolescence. *Child Abuse & Neglect, 23*(4), 383-394. doi:10.1016/S0145-2134(99)00002-2

Lefley, H. P., Scott, C. S., Llabre, M. & Hicks, D. (1993). Cultural beliefs about rape and victim's responses in three ethnic groups. *American Journal of Orthopsychiatry, 63*(4),

623-632. doi:10.1037/h0079477

Leong, F. T. L. (1994). Asian Americans' differential patterns of utilization of inpatient and outpatient public mental health services in Hawaii. *Journal of Community Psychology*, *22*(2), 82 –89. doi:10.1002/1520-6629(199404)22:2<82::aid-jcop2290220205>3.0.co;2-i

Leong, F., Leach, M., Yeh, C., & Chou, E. (2007). Suicide among Asian Americans: What do we know? What do we need to know? *Death Studies, 31*, 417-434. doi:10.1080/07481180701244561

Levitan, R. D., Parikh, S. V., Lesage, A. D., Hegadoren, K. M., Adams, M., & Kennedy, S. H. (1998). Major depression in individuals with a history of childhood physical or sexual abuse: Relationship to neurovegetative features, mania, and gender. *American Journal of Psychiatry, 155*(12), 1746-1752. doi:10.1176/ajp.155.12.1746

Lewis, M. (1992) *Shame: The exposed self*. New York, NY: Free Press. Retrieved from https://books.google.co.in/books/about/Shame.html?id=e7qYIOlO8X4C

Lewis, M. J., West, B., Bautista, L., Greenberg, A. M., & Done-Perez, I. (2005). Perceptions of service providers and community members on intimate partner violence within a Latino community. *Health Education & Behavior, 32*, 69-83. doi:10.1177/1090198104269510

Lewis-Fernandez, R., Garrido-Castillo, P., Bennasar, M. C., Parrilla, E. M., Laria, A. J., Ma, G., & Petkova, E. (2002). Dissociation, childhood trauma, and ataque de nervios among Puerto Rican psychiatric outpatients. *American Journal of Psychiatry, 159*(9), 1603-1605. doi:10.1176/appi.ajp.159.9.1603

Lipsky, S., & Caetano, R. (2007). The role of race/ethnicity in the relationship between emergency department use and intimate partner violence: Findings from the 2002

National Survey on Drug Use and Health. *American Journal of Public Health, 97*, 2246-2252. doi:10.2105/AJPH.2006.091116

Littleton, H. L., & Breitkopf, C. R. (2006). Coping with the experience of rape. *Psychology of Women Quarterly, 30,* 106–116. doi:10.1111/j.1471-6402.2006.00267.x

Littleton, H. L., Grills-Taquechel, A. E., Buck, K. S., Rosman, L., & Dodd, J. C. (2013). Health risk behavior and sexual assault among ethnically diverse women. *Psychology of Women Quarterly, 37*(1), 7-21. doi:10.1177/0361684312451842

MacGreene, D. M., & Navarro, R. L. (1998). Situation-specific assertiveness in the epidemiology of sexual victimization among university women. *Psychology of Women Quarterly, 22*(4)*,* 589-604. doi:10.1111/j.1471-6402.1998.tb00179.x

Macy, R., Nurius, P., & Norris, J. (2006). Responding in their best interests: Contextualizing women's coping with acquaintance sexual aggression. *Violence Against Women, 12*, 478-500. doi:10.1177/1077801206288104

Marsella, A., Friedman, M., & Spain, E. H. (1996). Ethnocultural aspects of PTSD: An overview of issues and research directions. In A. Marsella, M. Friedman, E. Gerrity, & R. Scurfield (Eds.), *Ethnocultural aspects of PTSD: Issues, research, and clinical applications* (pp. 105–129). Washington, DC: American Psychological Association. doi:10.1037/10555-004

Marshall, G. N., Schell, T. L., & Miles, J. N. (2009). Ethnic differences in posttraumatic distress: Hispanics' symptoms differ in kind and degree. *Journal of Consulting and Clinical Psychology, 77,* 1169–1178. doi:10.1037/a0017721

Matsuoka, J. K., Breaux, C., & Ryujin, D. H. (1997). National utilization of mental health services by Asian Americans/ Pacific Islanders. *Journal of Community Psychology*, *25*,

141– 145.

doi:10.1002/(SICI)1520-6629(199703)25:2%3C141::AID-JCOP3%3E3.0.CO;2-0

McCall, G. J., & Resick, P. A. (2003). A pilot study of PTSD symptoms among Kalahari bushmen. *Journal of Traumatic Stress, 16,* 445–450. doi:10.1023/A:1025702326392

McDonald, P., Bryant, R. A., Silove, D., Creamer, M., O'Donnell, M., & McFarlane, A. C. (2013). The expectancy of threat and peritraumatic dissocation. *European Jounral of Psychotraumatology, 4,* 1-5. doi:10.3402/ejpt.v4i0.21426.

McFarlane, A. C. (1998). Epidemiological evidence about the relationship between PTSD and alcohol abuse: The nature of the association. *Addictive Behaviors, 23,* 813–825. doi:10.1016/S0306-4603(98)00098-7

McFarlane, J., Malecha, A., Watson, K., Gist, J., Batten, E., Hall, I., & Smith, S. (2005). Intimate partner sexual assault against women: Frequency, health consequences, and treatment outcomes. *Obstetrics and Gynecology, 105,* 99-108. doi:10.1097/01.AOG.0000146641.98665.b6

Mennen, F. E. (1994). Sexual abuse in Latina girls: Their functioning and a comparison with White and African American girls. *Hispanic Journal of Behavioral Sciences*, *16*(4), 475–486. doi:10.1177/07399863940164006

Messman-Moore, T. L., & Long, P. J. (2000). Alcohol and substance use disorders as predictors of child to adult sexual revictimization in a sample of community women. *Violence and Victims, 17,* 319-340. doi:10.1891/vivi.17.3.319.33662

Messman-Moore, T. L., & Long, P. J. (2003). The role of childhood sexual abuse sequelae in the sexual revictimization of women: An empirical review and theoretical reformulation. *Clinical Psychology Review, 23,* 537-571.

doi:10.1016/S0272-7358(02)00203-9

Messman-Moore, T. L., Long, P. J., & Siegfried, N. J. (2000). The revictimization of child sexual abuse survivors: An examination of the adjustment of college women with child sexual abuse, adult sexual assault, and adult physical abuse. *Child Maltreatment, 5,* 18-27. doi:10.1177/1077559500005001003

Mesquite, B., & Frijda, N. H. (1992) Cultural variations in emotions: A review. *Psychological Bulletin, 112,* 179-204. doi:10.1037/0033-2909.112.2.179

Meyer, C. B., & Taylor, S. E. (1986). Adjustment to rape. *Journal of Personality and Social Psychology, 50*(6)*,* 1226-1234. doi:10.1037/0022-3514.50.6.1226

Miller B., Downs W., Testa M. (1993). Interrelationships between victimization experiences and women's alcohol use. *Journal of Studies on Alcohol and Drugs, 11,* 109–117. doi:10.15288/jsas.1993.s11.109

Miner, M. H., Flitter, J. M. K., & Robinson, B. E. (2006). Association of sexual revictimization with sexuality and psychological function. *Journal of Interpersonal Violence, 21*(4)*,* 503-524. doi:10.1177/0886260505285913

Molnar, B. E., Buka, S. L., & Kessler, R. C. (2001). Child sexual abuse and subsequent psychopathology: Results from the national comorbidity survey. *American Journal of Public Health, 91*(5), 753-760. doi:10.2105/ajph.91.5.753

Moor, A. (2007). When recounting the traumatic memories is not enough: Treating persistent self-devaluation associated with rape and victim-blaming myths. *Women & Therapy, 30*, 19-33. doi:10.1300/J015v30n01_02

Moss, M., Frank, E., & Anderson, B. (1990). The effects of marital status and partner support on rape trauma. *American Journal of Orthopsychiatry, 60,* 379-391. doi:10.1037/h0079179

Nadelson, C., Notman, M., & Zackson, H. (1982). A follow-up study of rape victims. *American Journal of Psychiatry, 139*(10), 1266-1270. doi:10.1176/ajp.139.10.1266

Najdowski, C. J., & Ullman, S. E. (2011). The effects of revictimization on coping and depression in female sexual assault victims. *Journal of Traumatic Stress*, *24*(2), 218–221. doi:10.1002/jts.

Newcomb, M., & Carmona, J. (2004). Adult trauma and HIV status among Latinas: Effects upon psychological adjustment and substance use. *AIDS and Behavior, 8*(4), 417-428. doi:10.1007/s10461-004-7326-1

Nishith, H. A., Mechanic, M. B. & Resick, P. A. (2000). Prior interpersonal trauma: The contributon to current PTSD symptoms in female rape victims. *Journal of Abnormal Psychology, 109,* 20-25. doi:10.1037/0021-843X.109.1.20

Noll, J. G., Horowitz, L. A., Bonanno, G. A., Trickett, P. K., & Putnam, F. W. (2003). Revictimization and self-harm in females who experienced childhood sexual abuse: Results from a prospective study. *Journal of Interpersonal Violence, 18*(12), 1452–1471. doi:10.1177/0886260503258035

Olive, V. C. (2012). Sexual assault against women of color. *Journal of Student Research, 1*, 1-9. Retrieved from www.jofsr.com/index.php/path/article/download/27/19

Ortega, A. N., & Rosenheck, R. (2000). Posttraumatic stress disorder among Hispanic Vietnam veterans. *American Journal of Psychiatry, 157,* 615–619. doi:10.1176/appi.ajp.157.4.615

Ortega, A. N., Rosenheck, R., Alegria, M., & Desai, R. A. (2000). Acculturation and the lifetime risk of psychiatric and substance use disorders among Hispanics. *Journal of Nervous and Mental Disease, 188*, 728-735. doi:10.1097/00005053-200011000-00002

Ouimette, P. C., Moos, R. H., & Finney, J. W. (1998). Influence of outpatient treatment and 12-step group involvement on one-year substance abuse treatment outcomes. *Journal Of Studies On Alcohol*, *59*(5), 513-522. doi:10.15288/jsa.1998.59.513

Ozer, E., Best, S., Lipsey, T., & Weiss, D. (2003). Predictors of posttraumatic stress disorder and symptoms in adults: A meta-analysis. *Psychological Bulletin, 129*(1)*,* 52-73. doi:10.1037//0033-2909.129.1.52

Peterlin, B. L., Rosso, A. L., Sheftell, F. D., Libon, D. J., Mossey, J. M., & Merikangas, K. R. (2011). Post-traumatic stress disorder, drug abuse and migraine: New findings from the national comorbidity survey replication (NCS-R). *International Headache Society, 31*(2), 235-244. doi:10.1177/0333102410378051.

Pew Research Center. (2010). *Hispanics: Targets of Discrimination.* Retrieved from http://www.pewresearch.org/daily-number/hispanics-targets-of-discrimination/

Pew Research Center: Social & Demographic Trends. (2012). *The Rise of Asian Americans.* Retrieved from http://www.pewsocialtrends.org/2012/06/19/the-riseof-asian-americans/4/#chapter-3-intergroup-relations

Pew Research Center: Religion & Public Life (2014). *The Shifting Religious Identity of Latinos in the United States.* Retrieved from http://www.pewforum.org/2014/05/07/the-shifting-religious-identity-of-latinosin-the-united-states/

Phillips-Sanders, K., Moisan, P. A., Wadlington, S., Morgan, S., & English, K. (1995). Ethnic differences in psychological functioning among Black and Latino sexually abused girls. *Child Abuse Neglect, 19*(6), 691-706. doi:10.1016/0145-2134(95)00027-6

Pillay, A. L., & Schoubben-Hesk, S. (2001). Depression, anxiety, and hopelessness in sexually abused adolescent girls. *Psychological Reports*, *88*(3), 727-733.

doi:10.2466/pr0.2001.88.3.727

Pole, N., Best, S. R., Metzler, T., & Marmar, C. R. (2005). Why are Hispanics at greater risk for PTSD? *Cultural Diversity & Ethnic Minority Psychology, 11*(2)*,* 144–161. doi:10.1037/1099-9809.11.2.144

Resick, P. A., Calhoun, K. S., Atkeson, B. M., & Ellis, E. M. (1981). Social adjustment in victims of sexual assault. *Journal of Consulting and Clinical Psychology, 49*(5)*,* 705-712. doi:10.1037/0022-006X.49.5.705

Rich, C. L., Combs-Lane, A. M., Resnick, H. S., & Kilpatrick, D. G. (2004). Child sexual abuse and adult sexual revictimization. In L. J. Koenig, L. S. Doll, & A. O'Leary (Eds), *From child sexual abuse to adult sexual risk: Trauma, revictimization, and intervention* (pp. 49-68). Washington, DC: American Psychological Association. doi:10.1037/10785-003

Roberts, A. C., Nishimoto, R. H., & Kirk, R. S. (2003) Cocaine Abusing Women Who Report Sexual Abuse: Implications for Treatment. *Journal of Social Work Practice in the Addictions, 3*(1), 5-24. doi:10.1300/J160v03n01_02

Rosenheck, R. A., & Fontana, A. (1994). Utilization of mental health services by minority veterans of the Vietnam era. *Journal of Nervous and Mental Disease, 182*(12)*,* 685–691. doi:10.1097/00005053-199412000-00002

Ruch, L. O., & Chandler, S. M. (1983). Sexual assault trauma during the acute phase: An exploratory model and multivariate analysis. *Journal of Health and Social Behavior, 24*(2), 174-185. doi:10.2307/2136643

Ruch, L. O., & Leon, J. J. (1983). Sexual assault trauma and trauma change. *Women & Health, 8*(4), 5-21. doi:10.1300/J013v08n04_02

Ruef, A. M., Litz, B. T., & Schlenger, W. E. (2000). Hispanic ethnicity and risk for combat-related posttraumatic stress disorder. *Cultural Diversity and Ethnic Minority Psychology*, *6*(3), 235 –251. doi:10.1037/1099-9809.6.3.235

Sabina, C., Cuevas, C. A., & Schally, J. L. (2013). The effect of immigration and acculturation on victimization among a national sample of Latino women. *Cultural Diversity and Ethnic Minority Psychology*, *19*, 13–26. doi:10.1037/a0030500

Saladin, M. E., Drobes, D. J., Coffey, S. F., Dansky, B. S., Brady, K. T., & Kilpatrick, D. G. (2003). PTSD symptom severity as a predictor of cue-elicited drug craving in victims of violent crime. *Addictive Behaviors*, *28*(9), 1611-1629. doi:10.1016/j.addbeh.2003.08.037

Santello, M. D., & Leitenberg, H. (1993). Sexual aggression by an acquaintance: Methods of coping and later psychological adjustment. *Violence and Victims, 8,* 91-104. Retrieved from http://www.ingentaconnect.com.lib.pepperdine.edu/content/springer/vav/1993/00000008/00000002/art00001

Santiago, J. M., McCall-Perez, F., Gorcey, M., & Beigel, A. (1985). Long-term psychological effects of rape in 35 rape victims. *American Journal of Psychiatry, 142*(11)*,* 1338-1340. doi:10.1176/ajp.142.11.1338

Santos-Iglesias, P., & Sierra, J. C. (2012). Sexual victimization among Spanish college women and risk factors for sexual revictimization. *Journal of Interpersonal Violence, 27*(17), 3468-3485. doi:10.1177/0886260512445383

Schechter, D. S., Marshall, R., Salman, E., Goetz, D., Davies, S., & Liebowitz, M. R. (2000). Ataque de nervios and history of childhood trauma. *Journal of Traumatic Stress, 13*(3), 529-534. doi:10.1023/A:1007797611148

Schnitt J. M., & Nocks J. J. (1984). Alcoholism treatment of Vietnam veterans with post-traumatic stress disorder. *Journal of Substance Abuse Treatment, 1*(3), 179–189. doi:10.1016/0740-5472(84)90021-7

Sciolla, A., Glover, D. A., Loeb, T. B., Zhang, M., Myers, H. F., & Wyatt, G. E. (2011). Childhood sexual abuse severity and disclosure as predictors of depression among adult African-American and Latina women. *Journal of Nervous and Mental Disease*, *199*(7), 471–477. doi:10.1097/NMD.0b013e31822142ac

Scott, C. S., Lefley, H. P., Hicks, D. (1993). Potential risk factors for rape in three ethnic groups. *Community Mental Health Journal, 29*(2), 133-141. doi:10.1007/BF00756339

Shalev, A. Y., & Sahar, T. (1998). Neurobiology of the posttraumatic stress disorder. In A. Levy, E. Grauer, D. Ben-Nathan, & E. R. de Kloet (Eds.), *New frontiers in stress research: Modulation of brain function* (pp.235-248). Newark, NJ: Harwood Academic. Retrieved from https://www.researchgate.net/publication/235170842_New_Frontiers_in_Stress_Research_Modulation_of_Brain_Function

Shim, R. S., Compon, M. T., Rust, G., Druss, B. G., & Kaslow, N. J. (2009). Race ethnicity as a predictor of attitudes toward mental health treatment seeking. *Journal of Psychiatric Services, 60*(10), 1336-1341. doi:10.1176/ps.2009.60.10.1336

Smith, S. G., & Breiding, M. J. (2011). Chronic disease and health behaviors linked to experiences of nonconsensual sex among women and men. *Public Health*, *125*(9), 653–659. doi:10.1016/j.puhe.2011.06.006

Snowden, L. R., & Cheung, F. K. (1990). Use of inpatient mental health services by members of ethnic minority groups. *American Psychologist*, *45*, 347–355.

doi:10.1037/0003-066X.45.3.347

Spaccarelli, S., & Fusch, C. (1997). Variability in symptom expression among sexually abused girls: Developing multivariate models. *Journal of Clinical Child Psychology, 26,* 24-35. doi:10.1207/s15374424jccp2601_3

Stewart, S. H., & Israeli, A. L. (2002). Substance abuse and co-occurring psychiatric disorders in victims of intimate violence. In C. Wekerle & A. Walls (Eds.), *The violence and addiction equation: Theoretical and clinical issues in substance abuse and relationship violence* (pp. 98–122). New York, NY: Brunner-Routledge. doi:10.1176/appi.ps.53.12.1642

Sue, D. W., & Sue, D. (1987). Asian Americans and Pacific Islanders. In P. Pedersen (Ed.), *Handbook of cross-cultural counseling and therapy* (pp. 141–146). Westport, CT: Greenwood Press/New York: Praeger. Retrieved from https://books.google.com/books/about/Handbook_of_Cross_cultural_Counseling_an.html?id=qqONarg8KFoC

Temple, J. R., Weston, R., Rodriguez, B. F., & Marshall, L. L. (2007). Differing effects of partner and nonpartner sexual assault on women's mental health. *Violence Against Women*, *13*(3), 285–297. doi:10.1177/1077801206297437

Thoits, P. A. (1986). Social support as coping assistance. *Journal of Consulting Clinical Psychology, 54*(4), 416-423. doi:10.1037/0022-006X.54.4.416

Thompson, N., & Gurney, A. (2003). "He is everything": Religion's role in the lives of immigrant youth. *New directions for youth development: Understanding the social worlds of immigrant youth, 100*, 75-90. doi:10.1002/(issn)1537-5781

Tjaden, P., & Thoennes, N. (1998). *Prevalence, incidence, and consequences of violence against*

women: Findings from the National Violence Against Women Survey. Washington, DC: U.S. Department of Justice. Retrieved from https://www.ncjrs.gov/pdffiles/172837.pdf

Turner, H. A., & Muller, P. A. (2004). Long-term effects of child corporal punishment on depressive symptoms in young adults: Potential moderators and mediators. *Journal of Family Issues, 25,* 761-782. doi:10.1177/0092513X03258313

Ulibarri, M. D., Strathdee, S. A., Lozada, R., Magis-Rodriguez, C., Amaro, H., O'Campo, P., & Patterson, T. L. (2010). Intimate partner violence among female sex workers in two Mexico–U.S. border cities: Partner characteristics and HIV risk behaviors as correlates of abuse. *Psychological Trauma: Theory, Research, Practice, and Policy*, *2*(4), 318–325. doi:10.1037/a0017500

Ulibarri, M. D., Ulloa, E. C., & Salazar, M. (2015). Associations between mental health, substance use, and sexual abuse experiences among Latinas. *Journal Of Child Sexual Abuse: Research, Treatment, & Program Innovations For Victims, Survivors, & Offenders*, *24*(1), 35-54. doi:10.1080/10538712.2015.976303

Ullman, S. E. (1996a). Correlates and consequences of adult sexual assault disclosure. *Journal of Interpersonal Violence, 11*(4), 554–571. doi:10.1177/088626096011004007

Ullman, S. E. (1996b). Do social reactions to sexual assault victims vary by support provider? *Violence and Victims, 11,* 143–157. Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/8933710

Ullman, S. E. (2000). Psychometric characteristics of the Social Reactions Questionnaire. *Psychology of Women Quarterly, 24*(3)*,* 257–271. doi:10.1111/j.1471-6402.2000.tb00208.x

Ullman, S. E. (2003). A critical review of field studies on the link of alcohol and

adult sexual assault in women. *Aggression and Violent Behavior, 8*(5), 471–486. doi:10.1016/S1359-1789(03)00032-6

Ullman, S. E. (2007). A 10-year update on "review and critique of empirical studies of rape avoidance." *Criminal Justice and Behavior, 34,* 411-429. doi:10.1177/0093854806297117

Ullman, S. E., & Brecklin, L. R. (2002). Sexual assault history, PTSD, and mental health service seeking in a national sample of women. *Journal of Community Psychology, 30,* 261–279. doi:10.1002/jcop.10008

Ullman, S. E., & Brecklin, L. R. (2003). Sexual assault history and health-related outcomes in a national sample of women. *Psychology of Women Quarterly*, *27*(1), 46–57. doi:10.1111/1471-6402.t01-2-00006

Ullman, S. E., & Filipas, H. H. (2001). Predictors of PTSD symptom severity and social reactions in sexual assault victims. *Journal of Traumatic Stress, 14*(2)*,* 369-389. doi:10.1023/A:101112522052

Ullman, S. E., & Filipas, H. H. (2005). Ethnicity and child sexual abuse experiences of female college students. *Journal of Child Sexual Abuse*, *14*(3), 67–89. doi:10.1300/J070v14n03_04

Ullman, S. E., Filipas, H. H., Townsend, S. M., & Starzynski, L. L. (2005). Trauma exposure, posttraumatic stress disorder and problem drinking in sexual assault survivors. *Journal of Studies on Alcohol*, *66*(5), 610–619. doi:10.15288/jsa.2005.66.610

Ullman S. E., Najdowski C. J., & Filipas H. H. (2009). Child sexual abuse, post-traumatic stress disorder, and substance use: Predictors of revictimization in adult sexual assault survivors. *Journal of Child Sexual Abuse, 18,* 367–385.

doi:10.1080/10538710903035263

Ullman, S. E., Relyea, M., Peter-Hagene, L., & Vasquez, A. L. (2013). Trauma histories, substance use coping, PTSD, and problem substance use among sexual assault victims. *Addictive Behaviors*, *38*(6), 2219–2223. doi:10.1016/j.addbeh.2013.01.027

Ullman, S. E., & Siegel, J. M. (1995). Sexual assault, social reactions, and physical health. *Women's Health: Research on Gender, Behavior, and Policy, 1*, 289–308. Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/9373385

Ullman, S. E., Townsend, S. M., Filipas, H. H., & Starzynski, L. L. (2007). Structural models of the relations of assault severity, social support, avoidance coping, self-blame, and PTSD among sexual assault survivors. *Psychology Of Women Quarterly*, *31*(1), 23-37. doi:10.1111/j.1471-6402.2007.00328.x

Urquiza, A. J., & Goodlin-Jones, B. L. (1994). Child sexual abuse and adult revictimization with women of color. *Violence and Victims, 9,* 223-232. Retrieved from http://crawl.prod.proquest.com.s3.amazonaws.com/fpcache/cf5353b086d3ded1f2758cd0fdebe39e.pdf?AWSAccessKeyId=AKIAJF7V7KNV2KKY2NUQ&Expires=1476667358&Signature=XDxC25iqTGO55tM31Vl9tTJrqzo%3D

U.S. Census Bureau. (1997). Results of the 1996 race and ethnic targeted test. Washington, DC: US Bureau of the Census. Retrieved from https://www.census.gov/population/www/documentation/twps0018/twps0018.html

U.S. Department of Justice, Office of Justice Programs, National Institute of Justice. (2000), *Extent, Nature, and Consequences of Intimate Partner Violence: Findings From the National Violence Against Women Survey*. Retrieved from https://www.ncjrs.gov/pdffiles1/nij/181867.pdf

Valentiner, D. P., Riggs, D., Foa, E. B., & Gershuny, B. S. (1996). Coping strategies and PTSD in female victims of sexual assault and nonsexual assault. *Journal of Abnormal Psychology, 105,* 455–458. doi:10.1037//0021-843x.105.3.455

Vera, M., Alegria, M., Pattatucci-Aragon, A. M., & Peña, M. (2005). *Childhood sexual abuse and drug use among low-income urban Puerto Rican women*. Binghamton, NY: Haworth. doi:10.1300/j160v5n01_03

Warner, L. A., Alegria, M., & Canino, G. (2012). Childhood maltreatment among Hispanic women in the United States: An examination of subgroup differences and impact on psychiatric disorder. *Child Maltreatreatment*, *17*(2), 119–131. doi:10.1177/1077559512444593

Walsh, K., Resnick, H. S., Danielson, C. K., McCauley, J. L., Saunders, B. E., & Kilpatrick, D. G. (2014). Patterns of drug and alcohol use associated with lifetime sexual revictimization and current posttraumatic stress disorder among three national samples of adolescent, college, and household-residing women. *Addictive Behaviors*, *39*(3), 684-689. doi:10.1016/j.addbeh.2013.12.006

Weller, S., Baer, R., de Alba Garcia, J., & Rocha, A. (2008). Susto and nervios: Expressions for stress and depression. *Culture, Medicine and Psychiatry, 32*(3)*,* 406-420. doi:10.1007/s11013-008-9101-7

West, C. M., Kaufman Kantor, G., & Jasinski, J. L. (1998). Sociodemographic predictors and cultural barriers to help-seeking behavior by Latina and Anglo American battered women. *Violence and Victims, 13*, 361-375. Retrieved from http://www.drcarolynwest.com/media/sites/162/files/article_sociodemographic-predictors.pdf

Wilsnack, S. C., Wilsnack, R. W., Kristjanson, A. F., Vogeltanz-Holm, N. D., & Harris, T. R. (2004). Child sexual abuse and alcohol use among women: Setting the stage for risky sexual behavior. In L. J. Koenig, L. S. Doll, A. O'Leary, & W. Pequegnat (Eds.), *From child sexual abuse to adult sexual risk: Trauma, revictimization, and intervention* (pp. 181–200). Washington, DC: APA. doi:10.1037/10785-009

Wilson, A. E., Calhoun, K. S., & Bernat, J. A. (1999). Risk recognition and trauma related symptoms among sexually revictimized women. *Journal of Consulting and Clinical Psychology , 67*(5), 705–710. doi:10.1037/0022-006X.67.5.705

Wilson, L. C., & Scarpa, A. (2013). Childhood abuse, perceived social support, and posttraumatic stress symptoms: A moderation model. *Psychological Trauma: Theory, Research, Practice, and Policy, 6*(5), 512-518. doi:10.1037/a0032635

Xu, X., Campbell, J., & Zhu, F. (2001). Intimate partner violence against Chinese women: The past, present, and future. *Trauma, Violence, & Abuse, 2*(4), 296-315. doi:10.1177/1524838001002004002

Xu, Y., Sun, J., Zhang, J., & Xu, Z. (2001). Health-seeking behaviors and barriers to health care of Southeast Asian immigrants: Implications for the home health nurse. *Home Health Care Management & Practice, 14*, 22-30. doi:10.1177/108482230101400104

Yeh, C. J. (2003). Age, acculturation, cultural adjustment, and mental health symptoms of Chinese, Korean, and Japanese immigrant youth. *Cultural Diversity and Ethnic Minority Psychology Journal, 9*(1), 34-48. doi:10.1037/1099-9809.9.1.34

Zhang, A. Y., Snowden, L. R., & Sue, S. (1998). Differences between Asian and White Americans' help seeking and utilization patterns in the Los Angeles area. *Journal of Community Psychology*, *26*, 317–326. doi:10.1002/(sici)1520-6629(199807)26:4<317::aid-jcop>3.0.co:2-q

APPENDIX A

Demographics I

ADULT DEMOGRAPHICS (DA)

*DA1. Are you of Hispanic or Latino descent -- that is, Mexican, Mexican American, Chicano, Puerto Rican, Cuban, South or Central American or other Spanish culture or origin?

RECORD ALL MENTIONS

(IF NEC: Which one?)

NOT SPANISH/HISPANIC 0
MEXICAN 1
MEXICAN AMERICAN 2
CHICANO 3
PUERTO RICAN 4
CUBAN 5
SOUTH/CENTRAL AMERICAN 6
OTHER SPANISH (SPECIFY) 7

____

DON'T KNOW 8
REFUSED 9

APPENDIX B

Demographics II

*DA4. Which of the following best describes your race: American Indian, Alaska Native, Asian, black or African American, Native Hawaiian, Pacific Islander, or white?

RECORD ALL MENTIONS

PROBE BEFORE ACCEPTING REFUSAL

WHITE/ CAUCASIAN	1	
BLACK/AFRICAN AMERICAN	2	
AMERICAN INDIAN	3	
ALASKA NATIVE	4	
ASIAN	5	
NATIVE HAWAIIAN	6	
PACIFIC ISLANDER	7	
DON'T KNOW	8	**GO TO *DA27**
REFUSED	9	**GO TO *DA27**

APPENDIX C

Sexual Assault I

	YES (1)	NO (5)	DK (8)	RF (9)
*PT17. The next two questions are about sexual assault. The first is about rape. We define this as someone either having sexual intercourse with you or penetrating your body with a finger or object when you did not want them to, either by threatening you or using force, or when you were so young that you didn't know what was happening. Did this ever happen to you?	1 **GO TO *PT45** AND CODE "1"	5	8	9

APPENDIX D

Sexual Assault II

INTERVIEWER: FOR EACH ENDORSED EVENT, ASK THE FOLLOW-UP QUESTIONS AT RIGHT.

			AGE	# TIMES
			How old were you the first time?	How many times (did that happen in your life)?
	YES (1)	**NO (5)**		IF "ONGOING" FOR A PERIOD IN R'S LIFE, CODE 995.
***PT46.** (KEY PHRASE: sexually assaulted) Other than rape, were you ever sexually assaulted, where someone touched you inappropriately, or when you did not want them to? **DK** **8** GO TO *PT47 **RF** **9** GO TO *PT47	1 **CHECK OFF EVENT ON REF. CARD**	5 **GO TO *PT 47**	*PT46a. YEARS DK 998 RF 999	*PT46b. TIMES DK 998 RF 999

APPENDIX E

Sexual Assault III

***PT171**. Was it a one-time occurrence, or did it happen repeatedly over a period of days, weeks, months, or even years?

ONE-TIME	1	**GO TO *PT172**
REPEATEDLY	5	
DON'T KNOW	8	**GO TO *PT172**
REFUSED	9	**GO TO *PT172**

***PT171a**. (IF NEC: How long did this continue?)

_________ DURATION NUMBER

CIRCLE UNIT
OF TIME: DAYS 1 WEEKS 2 MONTHS 3 YEARS 4

DON'T KNOW 98
REFUSED 99

APPENDIX F

PTSD I

*PT265. What were the traumatic events that caused these recent reactions?

(PROBE UNTIL NO MORE MENTIONS: Any other traumatic events that caused these reactions during the past 12 months?)

INTERVIEWER: CIRCLE ALL THAT APPLY.

COMBAT EXPERIENCE	1
RELIEF WORKER IN WAR ZONE	2
CIVILIAN IN WAR ZONE	3
CIVILIAN IN REGION OF TERROR	4
REFUGEE	5
KIDNAPPED	6
TOXIC CHEMICAL EXPOSURE	7
AUTOMOBILE ACCIDENT	8
OTHER LIFE THREATENING ACCIDENT	9
NATURAL DISASTER	10
MAN-MADE DISASTER	11
LIFE-THREATENING ILLNESS	12
BEATEN UP BY CAREGIVER	13
BEATEN UP BY SPOUSE OR ROMANTIC PARTNER	14
BEATEN UP BY SOMEONE ELSE	15
MUGGED OR THREATENED WITH A WEAPON	16
RAPED	17
SEXUALLY ASSAULTED	18
STALKED	19
UNEXPECTED DEATH OF LOVED ONE	20
CHILD WITH SERIOUS ILLNESS	21
WITNESSED PHYSICAL FIGHT AT HOME	29
TRAUMATIC EVENT TO LOVED ONE	22
WITNESSED DEATH OR DEAD BODY, OR SAW SOMEONE SERIOUSLY HURT	23
ACCIDENTALLY CAUSED SERIOUS INJURY OR DEATH	24
PURPOSELY INJURED, TORTURED, OR KILLED SOMEONE	25
SAW ATROCITIES	26
SOME OTHER EVENT (SPECIFY)	27
DON'T KNOW	98
REFUSED	99

APPENDIX G

PTSD II

*****PT267. Of these events, was there one that caused you the <u>most</u> upsetting reactions during the past 12 months?

YES	1	
NO	5	**GO TO *PT269**
DON'T KNOW	8	**GO TO *PT269**
REFUSED	9	**GO TO *PT269**

*****PT268**.** (IF NEC: Which one?)

INTERVIEWER: RECORD NUMBER OF MOST UPSETTING EVENT REPORTED IN ***PT265**.

___________ NUMBER

INTERVIEWER: THIS EVENT WILL NOW BE REFERRED TO AS "WORST 12-MONTH EVENT."

DON'T KNOW	8
REFUSED	

APPENDIX H

PTSD III

	YES (1)	NO (5)	DK (8)	RF (9)
***PT269.** Please think of the 30-day period in the past 12 months when your reactions to [(WORST 12-MONTH EVENT)/ these events/ these experiences] were most frequent and intense. During that month, did you lose interest in doing things you used to enjoy?	1	5	8	9
*PT270. Did you feel emotionally distant or cut off from other people during that month?	1	5	8	9
*PT271. Did you have trouble feeling normal feelings like love, happiness, or warmth toward other people?	1	5	8	9
*PT272. Did you feel you had no reason to plan for the future because you thought it would be cut short?	1	5	8	9
*PT273. Did you have any trouble falling or staying asleep during that month?	1	5	8	9
*PT274. Were you more jumpy or more easily startled by ordinary noises?	1	5	8	9
*PT275. Did you purposely stay away from places, people or activities that reminded you of [(WORST 12-MONTH EVENT)]/ these events]?	1	5	8	9

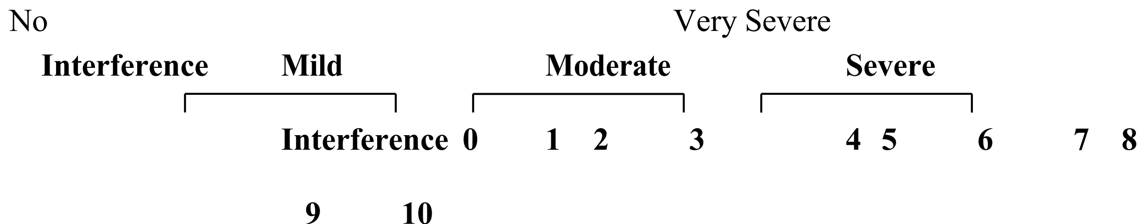
*PT277. INTERVIEWER CHECKPOINT: (SEE ***PT269-*PT275**)

ZERO "YES" REPONSES IN ***PT269-*PT275** 1 ~~**GO TO *TB1, NEXT SECTION**~~ **(GO TO *CC1, NEXT SECTION)** **

ALL OTHERS 2

APPENDIX I

PTSD IV



***PT278.** (RB, PG 64) Think about the month or longer in the past 12 when your reactions to (WORST 12-MONTH EVENT/ these events) were most severe. Using a 0 to 10 scale on page 64 of your booklet, where 0 means no interference and 10 means very severe interference, what number describes how much your reactions to (WORST 12-MONTH EVENT/ these events) interfered with each of the following activities during that time?

(IF NEC: How much did your reactions interfere with (ACTIVITY) during that time?)
(IF NEC: You can use any number between 0 and 10 to answer.)

NUMBER (0-10)

*PT278a. Your home management, like cleaning, Shopping, and taking care of the (house/ apartment)?

DOES NOT APPLY	97
DON'T KNOW	98
REFUSED	99

*PT278b. Your ability to work?

DOES NOT APPLY	97
DON'T KNOW	98
REFUSED	99

*PT278c. Your ability to form and maintain close relationships with other people?

DOES NOT APPLY	97
DON'T KNOW	98
REFUSED	99

*PT278d. Your social life?

DOES NOT APPLY	97
DON'T KNOW	98
REFUSED	99

*PT280. About how many days out of 365 in the past 12 months were you totally unable to work or carry out your normal activities because of your reactions [to (WORST 12- MONTH EVENT/ these events)]?

(IF NEC: You can use any number between 0 and 365 to answer.)

__________ NUMBER OF DAYS

DON'T KNOW 998
REFUSED 99

APPENDIX J

MDD I

*D9. Earlier in the interview, you mentioned having periods that lasted several days or longer when you lost interest in most things like work, hobbies, and other things you usually enjoy. Did you ever have a period of this sort that lasted most of the day nearly every day for two weeks or longer?

YES...1 **GO TO *D11**
NO 5
DON'T KNOW...................................8
REFUSED...9

*D9a. What is the longest period of days you ever had when you lost interest in most things you usually enjoy?

INTERVIEWER: "LESS THAN ONE DAY" CODE 0

__________ NUMBER

CIRCLE UNIT
OF TIME: DAYS ...1 WEEKS ....2 MONTHS....3 YEARS 4

PROBE DK: Was it three days or longer?

DON'T KNOW 998
REFUSED 999

USE THE KEY PHRASE "UNINTERESTED" THROUGHOUT THE SECTION **GO TO *D10**

APPENDIX K

MDD II

*D12. Did you ever have a period of being (sad/or/discouraged/or/uninterested in things) that lasted most of the day, nearly every day, for two weeks or longer?

YES ....1 **GO TO *D16**
NO 5
DON'T KNOW 8
REFUSED 9

*D12a. How long was the longest period of days you ever had when you were (sad/or/discouraged/or/uninterested) most of the day?
INTERVIEWER: "LESS THAN ONE DAY" CODE 0

_____________ DAYS

DON'T KNOW.................998
REFUSED.........................999

APPENDIX L

MDD III

		(1)	(5)	(8)	(9)
*D24a.	Did you feel sad, empty, or depressed most of the day nearly every day during that period of (several days/ two weeks)?	1	5 **GO TO *D24c**	8 **GO TO *D24c**	9 **GO TO *D24c**
*D24b.	Did you feel so sad that nothing could cheer you up nearly every day?	1	5	8	9
*D24c.	During that period of (several days/ two weeks), did you feel discouraged about how things were going in your life most of the day nearly every day?	1	5 **GO TO *D24e**	8 **GO TO *D24e**	9 **GO TO *D24e**
*D24d.	Did you feel hopeless about the future nearly every day?	1	5	8	9
***D24e.**	During that period of (several days/ two weeks), did you lose interest in almost all things like work and hobbies and things you like to do for fun?	1	5	8	9
*D24f.	Did you feel like nothing was fun even when good things were happening?	1	5	8	9

APPENDIX M

ID I

07/25/01

IRRITABLE DEPRESSION (IR)

*IR1 INTRO 1.	*IR1 INTRO 2.
Other problems that often occur during periods of feeling irritable or grouchy include things like changes in sleep, appetite, energy, the ability to concentrate and remember, and feelings of low self-worth. Did you ever have any of these problems during one of your episodes of being very irritable?	Earlier in the interview, you mentioned having periods that lasted several days or longer when most of the day you were very irritable, grouchy, or in a bad mood. People with episodes of this sort often have other problems at the same time. These include things like changes in sleep, appetite, energy, the ability to concentrate and remember, and feelings of low self-worth. Did you ever have any of these problems during one of your episodes of being very irritable?
YES....1 NO....5 **GO TO *IR72** DON'T KNOW....8 **GO TO *IR72** REFUSED....9 **GO TO *IR72**	YES....1 NO....5 **GO TO *IR72** DON'T KNOW....8 **GO TO *IR72** REFUSED....9 **GO TO *IR72**

*IR2. Did you ever have a period of being very irritable or grouchy and some of these other problems that lasted most of the day, nearly every day for a period of two weeks or longer?

YES....1 **GO TO *IR7**
NO....5
DON'T KNOW....8
REFUSED....9

*IR2a. What is the longest number of days in a row you ever had when you were very irritable and had some of these other problems most of the day?

IF VOL "LESS THAN ONE DAY," CODE 0

______________ NUMBER OF DAYS

DON'T KNOW....998
REFUSED....999

---

*IR3. INTERVIEWER CHECKPOINT: (SEE ***IR2a**)

DURATION OF 3 DAYS OR LONGER....1
ALL OTHERS....2 **GO TO *IR72**

---

*IR4. Did you ever have a year or more in your life when just about every month you were very irritable or grouchy and had some of these other problems for several days or more in a row?

YES....1
NO....5 **GO TO *IR72**
DON'T KNOW....8 **GO TO *IR72**
REFUSED....9 **GO TO *IR72**

*IR7. Please think of an episode of being very irritable or grouchy that lasted (*IR4 EQUALS '1': several days/ ALL OTHERS: two weeks) or longer and you also had the largest number of other problems at the same time. Is there one particular episode of this sort that stands out in your mind as the worst you ever had?

YES 1
NO ....5 **GO TO *IR7c**
DON'T KNOW ....8 **GO TO *IR7c**
REFUSED ....9 **GO TO *IR7c**

*IR7a. How old were you when that worst episode occurred?

_____________ YEARS OLD

DON'T KNOW 998
REFUSED 999

*IR7b. How long did that episode last?

_____________ NUMBER **GO TO *IR8**

CIRCLE UNIT OF TIME: DAYS......1 WEEKS......2 MONTHS......3 YEARS......4

DON'T KNOW .... 998 **GO TO *IR8**
REFUSED .... 999 **GO TO *IR8**

*IR7c. Then think of the last time you were very irritable or grouchy for (*IR4 EQUALS '1': several days/ ALL OTHERS: two weeks) or longer and also had other problems. During that time which of the following experiences did you have most of the day nearly every day? **GO TO *IR8a**

94

APPENDIX N

ID II

*IR8. In answering the next questions, think about the period of (*IR4 EQUALS '1': several days/ ALL OTHERS: two weeks) or longer during that episode when your irritability or grouchiness and other problems were most frequent and severe. During that period, which of the following problems did you have most of the day nearly every day.	YES (1)	NO (5)	DK (8)	RF (9)
*IR8a. Did you feel discouraged about how things were going in your life most of the day, nearly every day?	1	5	8	9
*IR8b. Did you lose the ability to take pleasure in having good things happen to you, like winning something or being praised or complimented?	1	5	8	9
*IR8c. During that (two-week) period, did you have a much larger appetite than usual nearly every day?	1 GO TO *IR8e	5	8	9
*IR8d. Did you have a much smaller appetite than usual nearly every day?	1	5	8	9
*IR8e. Did you have a lot more trouble either falling asleep, staying asleep, or waking up too early nearly every night during that (two week) period?	1 GO TO *IR8g	5	8	9
*IR8f. Did you sleep too much nearly every night during that period?	1	5	8	9
*IR8g. Did you have a lot more energy than usual nearly every day during that period?	1 GO TO *IR8i	5	8	9
*IR8h. Did you have a lot less energy than usual nearly every day during that period?	1	5	8	9
*IR8i. Were you so nervous or jittery nearly every day during that period that you paced up and down and couldn't sit still?	1	5	8	9
*IR8j. Did you have a lot more trouble concentrating than is normal for you nearly every day?	1	5	8	9
*IR8k. Did you lose your self-confidence?	1	5	8	9
*IR8*l*. Did you think about committing suicide?	1	5	8	9
*IR8m. Did you think about harming someone else?	1	5	8	9

*IR9. INTERVIEWER CHECKPOINT: (SEE ***IR8a-m**)

TWO OR MORE "YES" RESPONSES IN ***IR8a-m** 1
ALL OTHERS.. 2 **GO TO *IR72**

APPENDIX O

Substance Abuse

*SU65. First, was there ever a time in your life when your use of (IF ONLY ***SU41**EQUALS '1': marijuana or hashish/ IF ONLY ***SU42** EQUALS '1': cocaine/ IF ONLY ***SU41** EQUALS '1' AND ***SU42** EQUALS '1': either marijuana or hashish or cocaine / ALL OTHERS: drugs) frequently interfered with your work or responsibilities at school, on a job, or at home? (KEY PHRASE: interfered with your work)	1	5	8	9
*SU65a. Was there ever a time in your life when your use of (IF ONLY ***SU41**EQUALS '1': marijuana or hashish/ IF ONLY ***SU42** EQUALS '1': cocaine/ IF ONLY ***SU41** EQUALS '1' AND ***SU42** EQUALS '1': either marijuana or hashish or cocaine / ALL OTHERS: drugs) caused arguments or other serious or repeated problems with your family, friends, neighbors, or co-workers? (KEY PHRASE: caused problems with family, friends or others)	1	5 **GO TO *SU 65c**	8 **GO TO *SU 65c**	9 **GO TO *SU 65c**
*SU65b. Did you continue to use (it/ them) even though (it/ they) caused problems with these people? (NO KEY PHRASE)	1	5	8	9
***SU65c**. Were there times in your life when you were often under the influence of (IF ONLY ***SU41**EQUALS '1': marijuana or hashish/ IF ONLY ***SU42** EQUALS '1': cocaine/ IF ONLY ***SU41** EQUALS '1' AND ***SU42** EQUALS '1': either marijuana or hashish or cocaine ALL OTHERS: drugs) in situations where you could get hurt, for example when riding a bicycle, driving, operating a machine, or any thing else? (KEY PHRASE: jeopardized your safety because you sometimes used in situations where you could get hurt)	1	5	8	9

APPENDIX P

Substance Dependence

INTERVIEWER INSTRUCTION: IF R PROTESTS OR REFUSES TWO QUESTIONS, CODE ALL UNANSWERED ***SU72 SERIES** QUESTIONS '9' AND **GO TO *SU73**.	**YES (1)**	**NO (5)**	**D K (8)**	**R F (9)**
*SU72a. Did you ever need to use more than you used to in order to get high, or did you ever find that you could no longer get high on the amount you used to use?	1	5	8	9
*SU72b. People who cut down their substance use or stop using altogether may not feel well if they have been using steadily for some time. These feelings are more intense and can last longer than the usual hangover. Did you ever have times when you stopped, cut down, or went without (IF ONLY ***SU41**EQUALS '1': marijuana or hashish/ IF ONLY ***SU42** EQUALS '1': cocaine/ IF ONLY ***SU41** EQUALS '1' AND ***SU42** EQUALS '1': either marijuana or hashish or cocaine / ALL OTHERS: drugs) and then	1 **GO TO *SU 72d**	5	8	9
*SU72c. Did you ever have times when you used (IF ONLY ***SU41**EQUALS '1': marijuana or hashish/ IF ONLY ***SU42** EQUALS '1': cocaine/ IF ONLY ***SU41** EQUALS '1' AND ***SU42** EQUALS '1': either marijuana or	1	5	8	9
***SU72d**. Did you have times when you used drugs even though you promised yourself you wouldn't, or when you used a lot more than you intended?	1 **GO TO *SU 72g**	5	8	9
*SU72f. Were there times when you tried to stop or cut down on your use of (IF ONLY *SU41 EQUALS '1': marijuana or hashish/ IF ONLY *SU42 EQUALS '1' cocaine/IF ONLY SU41 EQUALS '1' and *SU42 EQUALS '1': either marijuana or hashish or cocaine/	1	5	8	9

*SU65d. Were you more than once arrested or stopped by the police because of driving under the influence of (IF ONLY ***SU41**EQUALS '1': marijuana or hashish/ IF ONLY ***SU42** EQUALS '1': cocaine/ IF ONLY ***SU41** EQUALS '1' AND ***SU42** EQUALS '1': either marijuana or hashish or cocaine / ALL OTHERS: drugs)or because of your behavior while you were high? (KEY PHRASE: resulted in problems with the police)	1	5	8	9
*SU72g. Did you ever have times of several days or more when you spent so much time using (IF ONLY *SU41EQUALS '1': marijuana or hashish/IF ONLY *SU42 EQUALS '1': cocaine/ IF ONLY *SU41 EQUALS '1' AND *SU42 EQUALS '1': either marijuana or hashish or cocaine / ALL OTHERS: drugs) or recovering from the effects of using that you had little time for anything else?	1	5	8	9
*SU72h. Did you ever have times lasting of a month or longer when you gave up or greatly reduced important activities because of your use – like sports, work, or seeing friends and family?	1	5	8	9
*SU72i. Did you ever continue to use (IF ONLY *SU41EQUALS '1': marijuana or hashish/ IF ONLY *SU42 EQUALS '1': cocaine/ IF ONLY *SU41 EQUALS '1' AND *SU42 EQUALS '1': either marijuana or hashish or cocaine / ALL OTHERS: drugs) when you knew you had a serious physical or emotional problem that might have been caused by or made worse by your use?	1	5	8	9

***SU79.** You reported having a number of problems related to drug use. How recently did you have any of these problems – in the past month, 2 to 6 months ago, 7 to 12 months ago, or more than 12 months ago?

PAST MONTH..1
2 TO 6 MONTHS AGO............................. 2
7 TO 12 MONTHS AGO........................... 3
MORE THAN 12 MONTHS AGO 4
DON'T KNOW 8
REFUSED 9

---

*SU82. Did you ever have three or more of these problems in the same year?

YES 1
NO .... 2 **GO TO *SU87**
DON'T KNOW... 8 **GO TO *SU87**
REFUSED .... 9 **GO TO *SU**

	ALO T (1)	**SOME (2)**	**A LITTLE (3)**	**NOT AT ALL (4)**	**D K (8)**	**RF (9)**
*SU86a. How much has your physical health been harmed by your use of [DRUG/ (either/ any) of these substances]) – a lot, some, a little, or not at all?	1	2	3	4	8	9

APPENDIX Q

Social Support

*SN1. The next few questions are about your social life [Not including your (IF ***SC3** EQUALS '1': husband/wife, IF ***SC3a** EQUALS '1': partner)]. How often do you talk on the phone or get together with relatives who do not live with you – most every day, a few times a week, a few times a month, about once a month, or less than once a month?

MOST EVERY DAY 1
A FEW TIMES A WEEK.............................. 2
A FEW TIMES A MONTH........................... 3
ONCE A MONTH 4
LESS THAN ONCE A MONTH 5
DON'T KNOW 8
REFUSED.. 9

*SN2. [Not including your (IF ***SC3** EQUALS '1': husband/wife, IF ***SC3a** EQUALS '1': partner)] how much can you rely on relatives who do not live with you for help if you have a serious problem – a lot, some, a little, or not at all?

A LOT 1
SOME.. 2
A LITTLE.. 3
NOT AT ALL... 4
DON'T KNOW 8
REFUSED.. 9

*SN3. Not including your (IF ***SC3** EQUALS '1': husband/wife, IF ***SC3a** EQUALS '1': partner)] how much can you open up to relatives who do not live with you if you need to talk about your worries – (a lot, some, a little, or not at all)?

A LOT 1
SOME.. 2
A LITTLE.. 3
NOT AT ALL... 4
DON'T KNOW 8
REFUSED.. 9

*SN4. Not including your (IF ***SC3** EQUALS '1': husband/wife, IF ***SC3a** EQUALS '1': partner)] how often do your relatives make too many demands on you – often, sometimes, rarely, or never?

OFTEN 1
SOMETIMES.. 2
RARELY.. 3
NEVER 4
DON'T KNOW.. 8
REFUSED.. 9

*SN5 Not including your (IF ***SC3** EQUALS '1': husband/wife, IF ***SC3a** EQUALS '1': partner)] how often do your relatives argue with you – (often, sometimes, rarely, or never)?

OFTEN 1
SOMETIMES.. 2
RARELY.. 3
NEVER 4
DON'T KNOW 8
REFUSED.. 9

*SN6. How often do you talk on the phone or get together with friends– most every day, a few times a week, a few times a month, about once a month, or less than once a month?

MOST EVERY DAY 1
A FEW TIMES A WEEK............................2
A FEW TIMES A MONTH.........................3
ONCE A MONTH 4
LESS THAN ONCE A MONTH.................5
DON'T KNOW..8
REFUSED... 9

*SN7. How much can you rely on your friends for help if you have a serious problem – a lot, some, a little, or not at all?

A LOT.. 1
SOME..2
A LITTLE...3
NOT AT ALL...4
DON'T KNOW..8
REFUSED... 9

*SN8. How much can you open up to your friends if you need to talk about your worries – (a lot, some, a little, or not at all)?

A LOT.. 1
SOME..2
A LITTLE...3
NOT AT ALL...4
DON'T KNOW..8
REFUSED... 9

*SN9. How often do your friends make too many demands on you – often, sometimes, rarely, or never?

OFTEN 1
SOMETIMES.. 2
RARELY..3
NEVER 4
DON'T KNOW..8
REFUSED... 9

*SN10. How often do your friends argue with you – (often, sometimes, rarely, or never)?

OFTEN 1
SOMETIMES.. 2
RARELY..3
NEVER 4
DON'T KNOW..8
REFUSED... 9

*SN11. INTERVIEWER CHECKPOINT: (SEE ***SC3** and ***SC3a**)

***SC3** EQUALS '1' OR ***SC3a** EQUALS '1' 1
ALL OTHERS..2 **GO TO *SN13**

*SN12. When you have a problem or worry, how often do you let your (husband/wife/partner) know about it – always, most of the time, sometimes, rarely, or never?

ALWAYS 1
MSOT OF THE TIME.....................................2
SOMETIMES.. 3
RARELY..4
NEVER 5
DON'T KNOW..8
REFUSED..9

*SN13. When you have a problem or worry, how often do you let someone (else) know about it – always, most of the time, sometimes, rarely, or never?

ALWAYS 1
MSOT OF THE TIME.....................................2
SOMETIMES.. 3
RARELY..4
NEVER 5
DON'T KNOW..8
REFUSED..9

*SN14. Next, I will read three statements and ask how much each one sounds like you. First, "I find it relatively easy to get close to other people. I am comfortable depending on others and having them depend on me. I don't worry about being abandoned or about someone getting too close to me." How much does this sound like you – a lot, some, a little, or not at all?

A LOT.. 1
SOME...2
A LITTLE...3
NOT AT ALL..4
DON'T KNOW..8
REFUSED... 9

*SN15. Here is the next statement. "I am somewhat uncomfortable being close to others; I find it difficult to trust them completely and difficult to depend on them. I am nervous when anyone get too close to me." How much does this sound like you – a lot, some, a little, or not at all?

A LOT.. 1
SOME...2
A LITTLE...3
NOT AT ALL..4
DON'T KNOW..8
REFUSED... 9

*SN16. Now the third statement. "I find that others are reluctant to get as close as I would like. I often worry that people who I care about do not love me or won't want to stay with me. I want to merge completely with another person, and this desire sometimes scares people away." How much does this sound like you – a lot, some, a little, or not at all?

A LOT.. 1
SOME...2
A LITTLE...3
NOT AT ALL..4
DON'T KNOW..8

APPENDIX R

Certificate of Completion

Certificate of Completion

The National Institutes of Health (NIH) Office of Extramural Research certifies that **Carissa Gustafson** successfully completed the NIH Web-based training course “Protecting Human Research Participants”.

Date of completion: 02/14/2015

Certification Number: 1697891

APPENDIX S

IRB Letter I

PEPPERDINE UNIVERSITY

Graduate & Professional Schools Institutional Review Board

February 26, 2015

Carissa Gustafson

Protocol #: P0215D04
Project Title: Understanding the Buffers and Risk Factors Among Ethnically Diverse Female Survivors of Sexual Victimization

Dear Ms. Gustafson:

Thank you for submitting your application, *Understanding the Buffers and Risk Factors Among Ethnically Diverse Female Survivors of Sexual Victimization*, for exempt review to Pepperdine University's Graduate and Professional Schools Institutional Review Board (GPS IRB). The IRB appreciates the work you and your faculty advisor, Dr. Bryant-Davis, have done on the proposal. The IRB has reviewed your submitted IRB application and all ancillary materials. I am pleased to inform you that your application has been granted **Provisional Approval.**

You will be granted official IRB approval once you have provided the GPS IRB a **"site approval letter"** stating that you have been given permission to conduct research at the aforementioned site(s) referenced in your application.

Please note, you cannot begin to recruit participants for your study until you address these issues and receive final exemption for your study.

Once you have obtained site approval, please revise your application and resubmit it to the following email address: gpsirb@pepperdine.edu. Furthermore, please refer to the protocol number denoted above in all further communication or correspondence related to this letter. Should you have additional questions, please contact the GPS IRB office at gpsirb@pepperdine.edu or 310-568-5753.

Sincerely,

Thema Bryant-Davis, Ph.D.
Chair, Graduate and Professional Schools
Pepperdine University

cc: Dr. Lee Kats, Vice Provost for Research and Strategic Initiatives
Mr. Brett Leach, Compliance Attorney
Dr. Thema Bryant-Davis, Faculty Advisor

6100 Center Drive, Los Angeles, California 90045 ▪ 310-568-5600

APPENDIX T

IRB Letter II

PEPPERDINE UNIVERSITY

Graduate & Professional Schools Institutional Review Board

April 17, 2015

Carissa Gustafson

Protocol #: P0215D04
Project Title: Understanding the Buffers and Risk Factors Among Ethnically Diverse Female Survivors of Sexual Victimization

Dear Ms. Gustafson:

Thank you for submitting your application, *Understanding the Buffers and Risk Factors Among Ethnically Diverse Female Survivors of Sexual Victimization*, for exempt review to Pepperdine University's Graduate and Professional Schools Institutional Review Board (GPS IRB). The IRB appreciates the work you and your faculty advisor, Dr. Bryant-Davis, have done on the proposal. The IRB has reviewed your submitted IRB application and all ancillary materials. Upon review, the IRB has determined that the above entitled project meets the requirements for exemption under the federal regulations (45 CFR 46 - http://www.hhs.gov/ohrp/humansubjects/guidance/45cfr46.html) that govern the protections of human subjects. Specifically, section 45 CFR 46.101(b)(4) states:

> (b) Unless otherwise required by Department or Agency heads, research activities in which the only involvement of human subjects will be in one or more of the following categories are exempt from this policy:
>
> **Category 4:** Research involving the collection or study of existing data, documents, records, pathological specimens, or diagnostic specimens, if these sources are publicly available or if the information is recorded by the investigator in such a manner that subjects cannot be identified, directly or through identifiers linked to the subjects.

Your research must be conducted according to the proposal that was submitted to the IRB. If changes to the approved protocol occur, a revised protocol must be reviewed and approved by the IRB before implementation. For any proposed changes in your research protocol, please submit a **Request for Modification Form** to the GPS IRB. Because your study falls under exemption, there is no requirement for continuing IRB review of your project. Please be aware that changes to your protocol may prevent the research from qualifying for exemption from 45 CFR 46.101 and require submission of a new IRB application or other materials to the GPS IRB.

A goal of the IRB is to prevent negative occurrences during any research study. However, despite our best intent, unforeseen circumstances or events may arise during the research. If an unexpected situation or adverse event happens during your investigation, please notify the GPS IRB as soon as possible. We will ask for a complete explanation of the event and your response. Other actions also may be required depending on the nature of the event. Details regarding the timeframe in which adverse events must be reported to the GPS IRB and the appropriate form to be used to report this information can be found in the *Pepperdine University Protection of Human Participants in Research: Policies and Procedures Manual* (see link to "policy material" at http://www.pepperdine.edu/irb/graduate/).

Please refer to the protocol number denoted above in all further communication or correspondence related to this approval. Should you have additional questions, please contact Kevin Collins, Manager of the Institutional Review Board (IRB) at gpsirb@peppderdine.edu. On behalf of the GPS IRB, I wish you success in this scholarly pursuit.

6100 Center Drive, Los Angeles, California 90045 ▪ 310-568-5600

APPENDIX U

IRB Letter III

PEPPERDINE UNIVERSITY

Graduate & Professional Schools Institutional Review Board

June 3, 2015

Carissa Gustafson

Protocol #: P0215D04-AM1
Project Title: Understanding the Buffers and Risk Factors Among Ethnically Diverse Female Survivors of Sexual Victimization

Dear Ms. Gustafson:

Thank you for submitting your amended exempt application, *Understanding the Buffers and Risk Factors Among Ethnically Diverse Female Survivors of Sexual Victimization* to Pepperdine University's Graduate and Professional Schools Institutional Review Board (GPS IRB). The IRB appreciates the work you and your faculty advisor, Dr. Bryant-Davis, have done on the proposal. The IRB has reviewed your submitted IRB application and all ancillary materials. Upon review, the IRB has determined that the above entitled project meets the requirements for exemption under the federal regulations (45 CFR 46 - http://www.hhs.gov/ohrp/humansubjects/guidance/45cfr46.html) that govern the protections of human subjects. Specifically, section 45 CFR 46.101(b)(4) states:

> (b) Unless otherwise required by Department or Agency heads, research activities in which the only involvement of human subjects will be in one or more of the following categories are exempt from this policy:
>
> **Category 4:** Research involving the collection or study of existing data, documents, records, pathological specimens, or diagnostic specimens, if these sources are publicly available or if the information is recorded by the investigator in such a manner that subjects cannot be identified, directly or through identifiers linked to the subjects.

Your research must be conducted according to the proposal that was submitted to the IRB. If changes to the approved protocol occur, a revised protocol must be reviewed and approved by the IRB before implementation. For any proposed changes in your research protocol, please submit a **Request for Modification Form** to the GPS IRB. Because your study falls under exemption, there is no requirement for continuing IRB review of your project. Please be aware that changes to your protocol may prevent the research from qualifying for exemption from 45 CFR 46.101 and require submission of a new IRB application or other materials to the GPS IRB.

A goal of the IRB is to prevent negative occurrences during any research study. However, despite our best intent, unforeseen circumstances or events may arise during the research. If an unexpected situation or adverse event happens during your investigation, please notify the GPS IRB as soon as possible. We will ask for a complete explanation of the event and your response. Other actions also may be required depending on the nature of the event. Details regarding the timeframe in which adverse events must be reported to the GPS IRB and the appropriate form to be used to report this information can be found in the *Pepperdine University Protection of Human Participants in Research: Policies and Procedures Manual* (see link to "policy material" at http://www.pepperdine.edu/irb/graduate/).

Please refer to the protocol number denoted above in all further communication or correspondence related to this approval. Should you have additional questions, please contact Kevin Collins, Manager of the Institutional Review Board (IRB) at gpsirb@peppderdine.edu. On behalf of the GPS IRB, I wish you success in this scholarly pursuit.

6100 Center Drive, Los Angeles, California 90045 ▪ 310-568-5600

APPENDIX V

Review of the Literature

Study Authors & Year	Title	Major Findings
Abbey, A., Zawacki, T., Buck, P.O., Clinton, A. M., & McAuslan, P. (2003).	Sexual assault and alcohol consumption: What do we know about their relationship and what types of research are still needed?	Approximately half of all sexual assaults are associated with either the perpetrator's alcohol consumption, the victim's alcohol consumption, or both. Although the emphasis of this review is on alcohol-involved sexual assaults, their unique aspects can only be evaluated by comparing them to other types of sexual assault. Theoretical perspectives on sexual assault that focus on characteristics of the perpetrator, the victim, and the situation are described. A number of personality traits, attitudes, and past experiences have been systematically linked to sexual assault perpetration, including beliefs about alcohol and heavy drinking. In contrast, only a few experiences have been significantly related to sexual assault victimization, including childhood sexual abuse and heavy drinking. There is support for both psychological and pharmacological mechanisms linking alcohol and sexual assault. Beliefs about alcohol's effects reinforce stereotypes about gender roles and can exacerbate their influence on perpetrators' actions. Alcohol's effects on cognitive and motor skills also contribute to sexual assault through their effects on perpetrators' and victims' ability to process and react to each other's verbal and nonverbal behavior.
Acierno, R., Resnick, H., Kilpatrick, D. G., Saunders, B., & Best, C. L. (1999).	Risk factors for rape, physical assault, and posttraumatic stress disorder in women: Examination of differential multivariate relationships.	Overall, past victimization, young age, and a diagnosis of active PTSD increased women's risk of being raped. By contrast, past victimization, minority ethnic status, active depression, and drug use were associated with increased risk of being physically assaulted. Risk factors for PTSD following rape included a history of depression, alcohol abuse, or experienced injury during the rape. However, risk factors for PTSD following physical assault included only a history of depression and lower education.

Afful, S. E., Strickland, J. R., Cottler, L., & Bierut, L. (2010).	Exposure to trauma: A comparison of cocaine-dependent cases and a community-matched sample.	Compared to community-based individuals, cocaine dependent cases recruited from treatment experienced higher rates of assaultive events including rape or sexual assault in women. Cocaine dependence was strongly associated with an increased risk of exposure to traumatic events and PTSD. Experiencing multiple, violent traumas increases the risk of PTSD, regardless of cocaine dependence.
Ahrens, C., Campbell, R., Ternier-Thames, K., Wasco, S., & Sefl, T. (2007).	Deciding whom to tell: Expectations and outcomes of rape survivors' first disclosures.	Qualitative analysis revealed that nearly 75% of first disclosures were to informal support providers and over one third of the disclosures were not initiated by the survivors themselves. Over half of the survivors received positive reactions and less than one third felt the disclosure had a detrimental impact on their recovery. Loglinear analysis suggested that survivors who actively sought help from informal support providers were more likely to receive positive than negative reactions. In contrast, survivors who actively sought help from formal support providers were more likely to receive negative than positive reactions. When disclosure to formal support providers was initiated by the formal support providers themselves, however, survivors received exclusively positive reactions.
Alegria, M., Jackson, J. S., Kessler, R. C., & Takeuchi, D. (2007).	National comorbidity survey replication (NCS-R).	The National Comorbidity Survey Replication (NCS-R) is a probability sample of the US carried out a decade after the original NCS (Kessler et al., 1994). The NCS-R repeats many of the questions from the NCS and also expands the questioning to include assessments based on the more recent DSM-IV diagnostics system (American Psychiatric Association, 1994). The two major aims of the NCS-R were: (1) to investigate time trends and their correlates over the decade of the 1990s; and (2) to expand the assessment of the prevalence and correlates of mental disorders beyond the assessment in the baseline NCS in order to address a number of important substantive

		and methodological issues that were raised by the NCS.
Andrews, G. & Peters, L. (1998).	The psychometric properties of the Composite International Diagnostic Interview.	The Composite International Diagnostic Interview, or CIDI, is a fully structured interview that maps the symptoms elicited during the interview onto DSM-IV and ICD-10 diagnostic criteria and reports whether the diagnostic criteria are satisfied.
Arata, C. M. (1999a).	Coping with rape: The roles of prior sexual abuse and attributions of blame.	Rape victims with a history of child sexual abuse were found to have higher levels of tram symptoms, made greater use of nervous and cognitive coping strategies, and were more likely to make attributions of blame towards themselves or society. Current symptoms were related to types of coping and attributions of blame, with history of child sexual abuse having an indirect relationship to these variables. The results suggest the importance of attribution and coping variables, as well as child sexual abuse history, as mediators of postrape adjustment.
Arata, C. M. (1999b).	Repeated sexual victimization and mental disorders in women.	PTSD was the only mental disorder which was found to differentiate between women with repeated victimization versus child-only or adult-only sexual assault.
Arata, C. M. (2000).	From child victim to adult victim: A model for predicting sexual revictimization.	Repeated victimization was associated with having experienced child sexual abuse involving physical contact, including intercourse and/or penetration. Women with repeated victimization engaged in more self-blame, reported higher levels of post-traumatic symptoms, and reported more high-risk sexual behavior. A path model was developed that indicated that the relationship between revictimization and child sexual abuse was mediated by self-blame, post-traumatic symptoms, and consensual sexual activity.
Arata, C. M. (2002).	Child sexual abuse and sexual revictimization.	Approximately one-third of child sexual abuse victims report experiencing repeated victimization. Child sexual abuse victims have a 2 to 3 times greater risk of adult revictimization than women without a history of child sexual abuse. Physical

		contact in abuse and revictimization in adolescence were found to lead to the greatest risk of revictimization. Repeated victims had more symptoms of Post Traumatic Stress Disorder (PTSD) and dissociation than women with a history of child sexual abuse alone.
Arau´jo, B. Y., & Borrell, L. N. (2006).	Understanding the link between discrimination, mental health outcomes, and life chances among Latinos.	This article reviews and critiques existing empirical evidence linking perceived discrimination to life chances and mental health outcomes among Latinos.
Atkeson, B. M., Calhoun, K. S., Resick, P. A., & Ellis, E. M. (1982).	Victims of rape: Repeated assessment of depressive symptoms.	115 rape victims (aged 15–71 years) were examined at 2 weeks and at 1, 2, 4, 8, and 12 months after the assault. Depressive symptoms were significantly higher in victims of rape than in non-victim controls following the assault. By 4 months post-rape, depressive symptoms in the victim group had diminished to the level shown by the non-victim control group.
Back, S., Dansky, B. S., Coffey, S. F., Saladin, M. E., Sonne, S., & Brady, K. T., (2000).	Cocaine dependence with and without post-traumatic stress disorder: a comparison of substance use, trauma history and psychiatric comorbidity.	Structured clinical interviews revealed that 42.9% of the sample met DSM-III-R criteria for lifetime PTSD. Comparisons between individuals with and without lifetime PTSD revealed that individuals with PTSD had significantly higher rates of exposure to traumatic events, earlier age of first assault, more severe symptomatology, and higher rates of Axis I and Axis II diagnoses. The results illustrate a high incidence of PTSD among cocaine dependent individuals.
Baer, R. D., Weller, S. C., de Alba Garcia, J. G., Glazer, M., Trotter, R., Pachter, L., & Klein, R. E. (2003).	A cross-cultural approach to the study of the folk illness nervios.	The focus of this paper is inter- and intracultural variations in descriptions in four Latino populations (i.e., Puerto Ricans, Mexicans, Mexican American, and Guatemalans) of the causes, symptoms, and treatments of nervios, as well as similarities and differences between nervios and susto in these same communities. They found agreement among all four samples on a core description of nervios, as well as some overlap in aspects of nervios and susto.

		However, they note that nervios is a much broader illness, related more to continual stresses. While susto seems to be related to a single stressful event.
Baker, F. M. (2001).	Diagnosing depression in African Americans.	This paper describes three alternative presentations of depressive illness among African Americans that differ from the DSM IV criteria for Major Depressive Disorder: “the stoic believer,” “the angry, ‘evil’ one” with a personality change, and “the John Henry doer.”
Banyard, V. L., Williams, L. M., & Siegel, J. A. (2001).	The long-term mental health consequences of child sexual abuse: An exploratory study of the impact of multiple traumas in a sample of women.	Child sexual abuse victims reported a lifetime history of more exposure to various traumas and higher levels of mental health symptoms. Exposure to traumas in both childhood and adulthood other than child sexual abuse mediated the relationship between child sexual abuse and psychological distress in adulthood. There were also some significant direct effects for child sexual abuse on some outcome measures.
Barnett, O. W., Miller-Perrin, C. L., & Perrin, R. D. (1997).	Family violence across the lifespan: An introduction.	Provides an introduction to the methodology, etiology, prevalence, treatment, and prevention of family violence. Chapters cover child physical, sexual, and emotional abuse; abused and abusive adolescents; courtship violence and date rape; spouse abuse, battered women, and batterers; and elder abuse.
Basile, K. C., Smith, S. G., Walters, M. L., Fowler, D. N., Hawk, K., & Hamburger, M. E. (2015).	Sexual violence victimization and associations with health in a community sample of Hispanic women.	This study sought to add to the limited information currently available on circumstances of sexual violence victimization and associated negative health experiences among Hispanic women. Data come from a community sample of mostly Mexican women in an urban southwestern city. Household interviews were completed with a sample of 142 women during 3 months in 2010. Findings indicate that 31.2% of women reported rape victimization and 22.7% reported being sexually coerced in their lifetime. Victims of rape and/or sexual coercion were significantly more likely to report symptoms of depression and post-traumatic stress disorder (PTSD) during their

		lifetime. Among victims whose first unwanted sexual experience resulted in rape and/or sexual coercion, perpetrators were almost always someone known to the victims, and were mostly family members or intimate partners, depending on the victim's age. About one-fifth of victims were injured and 17.1% needed medical services. These findings suggest the need for more attention to the physical and mental health needs of sexually victimized Hispanic women.
Bauer, H. M., Rodriguez, M. A., Quiroga, S. S., & Flores-Ortiz, Y. G. (2000).	Barriers to health care for abused Latina and Asian immigrant women.	This study identifies social, political, and cultural barriers to help seeking from health care organizations faced by abused Latina and Asian immigrant women. Qualitative data were collected through four semi-structured ethnic-specific focus group interviews with 28 abused Latina and Asian immigrant women. Sociopolitical barriers to help seeking and patient-provider communication included social isolation, language barriers, and, for some, discrimination and fears of deportation. Sociocultural barriers included dedication to the children and family unity, shame related to the abuse, and the cultural stigma of divorce.
Becker, J. V., Skinner, L. J., Abel, G. G., Axelrod, R., & Treacy, E. C. (1984).	Depressive symptoms associated with sexual assault.	Sexual assault survivors reported significantly more depressive symptoms than control subjects. The use of a weapon by the assailant were most highly correlated with development of depressive symptoms.
Benotsch, E. G., Brailey, K., Vasterling, J. J., & Sutker, P. B. (2000).	War zone stress, personal and environmental resources, and PTSD symptoms in Gulf War veterans: A longitudinal perspective.	Interpersonal resources decreased and posttraumatic stress disorder (PTSD) symptoms increased over time.
Bolstad, B. R., & Zinbarg, R. E. (1997).	Sexual victimization, generalized perception of control, and posttraumatic stress disorder symptom	The results showed that child sexual abuse experienced on multiple occasions was associated with diminished generalized perception of control and that diminished generalized perception of control is associated with greater PTSD symptom

	severity.	severity following adult sexual victimization when experienced on a single occasion or involving force. These results provide partial support for the uncontrollability/unpredictability model of PTSD.
Boney-McCoy, S., & Finkelhor, D. (1995).	Prior victimization: A risk factor for child sexual abuse and for PTSD-related symptomatology among sexually abused youth.	The experience of prior victimization (sexual and nonsexual) was found to increase children's risk for experiencing later child sexual abuse (CSA) in a national random sample of 2,000 American children aged 10-16 years. Prior victimization predicted subsequent CSA even when background variables (child's gender, race, age, geographic location, quality of relationship with parents, and relative level of violence in the home community) were controlled for. In addition, the prior victimization of a family member also predicted later CSA. Among children who experienced CSA, prior victimization increased the level of post-traumatic stress symptomatology, even after demographic factors and characteristics of the CSA episode (e.g., severity of the assault, severity of injury, fear of death or serious injury) were included in the model.
Borja, S. E., Callahan, J. L., & Long, P. J. (2006).	Positive and negative adjustment and social support of sexual assault survivors.	Both forms of informal support were found to be associated with positive outcomes. Only negative informal support was associated with posttraumatic stress symptoms.
Botta, R. A., & Pingree, S. (1997).	Interpersonal communication and rape: Women acknowledge their assaults.	This article examines whether a convenience sample of 123 undergraduate women, living in dormitories and sororities at a large midwestern university, who experienced unwanted anal, oral, or vaginal intercourse through threat of force, force, drugs, or intoxication name those experiences as rape and whether those women who acknowledge their rapes have better psychosocial adjustment. Results indicate women who acknowledge their experiences as rape score better on examined psychosocial adjustment variables.
Breslau, N., Davis, G. C., Peterson, E. L., &	Psychiatric sequelae of posttraumatic	The lifetime prevalence of traumatic events was 40% and of PTSD, 13.8%. Posttraumatic

Schultz, L. (1997).	stress disorder in women.	stress disorder signaled increased risks for first-onset major depression (hazards ratio, 2.1) and alcohol use disorder (hazards ratio, 3.0). The risk for major depression following PTSD was of the same magnitude as the risk for major depression following other anxiety disorders. Women with preexisting anxiety and PTSD had significantly increased risk for first-onset major depression. Additional analysis showed that preexisting major depression increased women's vulnerability to the PTSD-inducing effects of traumatic events and risk for exposure to traumatic events. Posttraumatic stress disorder influences the risk for first-onset major depression and alcohol use disorder. The causal explanation of these temporally secondary disorders is unclear and might involve the effect of PTSD or underlying vulnerabilities exposed by the traumatic experience.
Bryant-Davis, T., Chung, H., & Tillman, S. (2009).	From the margins to the center: Ethnic minority women and the mental health effects of sexual assault.	The authors looked at the experiences of African American, Asian American, Latina, and Native American female survivors of sexual assault including prevalence, risk factors, mental health effects, and barriers to service.
Bryant-Davis, T., Ullman, S. E., Tsong, Y., Tillman, S., & Smith, K. (2010).	Struggling to survive: sexual assault, poverty, and mental health outcomes of African American women.	Results indicated that while CSA history significantly accounted for 5.8% of the variance in PTSD and depression symptoms, income still accounted for an additional 1.6% of the variance in PTSD and depression symptoms. Among African American sexual assault survivors, poverty was positively related to depression, PTSD, and illicit drug use, while no relationship with suicidality was found.
Burgess, A. W. (1983).	Rape trauma syndrome.	Rape trauma has been measured in diverse ways (i.e., nature of the stressor experienced by victim, severity of the response, length of recovery time, and adjustment problems). Three responses to rape include: crisis response, steady-state response, and delayed response. The use of rape trauma syndrome in civil litigation cases is being used to testify as to

		psychological injuries of the rape.
Burgess, A. W., & Holmstrom, L. L. (1979).	Rape: Sexual disruption and recovery.	The trends of the results included: assessing the value that the victim has placed on sexual activity in order to predict the magnitude of the sexuality issue following rape; helping monitor the victim's reactions to resuming sexual activity and increase/decrease in symptoms.
Burnam, M. A., Stein, J. A., Golding, J. M., Siegel, J. M., Sorenson, S. B., Forsythe, A. B., & Telles, C. A. (1988).	Sexual assault and mental disorders in a community population.	In a cross-sectional probability survey of 3,132 household adults representing two Los Angeles communities, lifetime diagnoses of nine major mental disorders were compared between those who reported that they had been sexually assaulted at some time in their lives and those who reported no sexual assault. Sexual assault predicted later onset of major depressive episodes, substance use disorders, and anxiety disorders. Those who were assaulted in childhood were more likely than those first assaulted in adulthood to report the subsequent development of a mental disorder.
Burt, M. (1980).	Cultural Myths and Supports for Rape	This article describes the "rape myth" and tests hypotheses derived from social psychological and feminist theory that acceptance of rape myths can be predicted from attitudes such as sex role stereotyping, adversarial sexual beliefs, sexual conservatism, and acceptance of interpersonal violence. Results from regression analysis of interview data indicate that the higher the sex role stereotyping, adversarial sexual beliefs, and acceptance of interpersonal violence, the greater a respondent's acceptance of rape myths.
Cabassa, L. J., Zayas, L. H., & Hansen, M. C. (2006).	Latino adults' access to mental health care: A review of epidemiological studies.	This paper reviews 16 articles based on seven epidemiological studies, examines studies methodologies, and summarizes findings about how Latino adults access mental health services. Studies consistently report that, compared to non-Latino Whites, Latinos underutilize mental health services, are less likely to receive guideline congruent care, and rely more often on primary care for services. The structural, economic, psychiatric, and cultural factors that

		influence Latinos' service access are discussed.
Caetano, R., & Cunradi, C. (2003).	Intimate partner violence and depression among Whites, Blacks, and Hispanics.	This study sought to examine the relationship between intimate partner violence and depression. Results suggests that among men, Black and Hispanic ethnicity were protective against depression. Factors of risk for men included victimization by female to male partner violence, unemployment, and living in a high-unemployment neighborhood. Among women, the predictors are perpetration of moderate or severe female to male partner violence, and impulsivity.
Campbell, J. C. (Ed.). (1998).	Empowering survivors of abuse: Health care for battered women and their children.	This comprehensive volume contains a compilation of original research along with clinical, policy, and educational applications to guide the reader toward an understanding of abuse.
Campbell, J., Jones, A. S., Dienemann, J., Kub, J., Schollenberger, J., O'Campo, P., . . . Wynne, C. (2002).	Intimate partner violence and physical health consequences.	This study compared selected physical health problems of abused and never abused women with similar access to health care. Results suggest that abused women have a 50% to 70% increase in gynecological, central nervous system, and stress-related problems, with women sexually and physically abused most likely to report problems.
Campbell, R., Ahrens, C., Sefl, T., Wasco, S. M., & Barnes, H. E. (2001).	Social reactions to rape victims: Healing and hurtful effects on psychological and physical health outcomes.	In this study, 102 rape survivors were interviewed about the social reactions they received from family and friends post-rape. Results supported the contribution of positive social reaction (e.g., providing support, listening, believing) on victims' recovery is negligible, but that negative social reactions (e.g., blaming) hinder recovery.
Campbell, J. C., & Soeken, K. L. (1999).	Forced sex and intimate partner violence: Effects on women's risk and women's health.	Almost half (45.9) of the sample had been sexually assaulted as well as physically abused. Except for ethnicity, there were no demographic differences between those who were forced into sex and those who were not, and there was no difference in history of child sexual abuse. However, those who were sexually assaulted had higher scores on negative health symptoms, gynecological symptoms, and risk factors for homicide

		even when controlling for physical abuse and demographic variables. The number of sexual assault (childhood, rape and intimate partner) was significantly correlated with depression and body image.
Campbell, R., Ahrens, C., Sefl, T., Wasco, S. M., & Barnes, H. E. (2001).	Social reactions to rape victims: Healing and hurtful effects on psychological and physical health outcomes.	Results supported Ullman's (1996b) conclusion that the overall contribution of positive social reaction (e.g., providing support, listening, believing) on victims' recovery is negligible, but that negative social reactions (e.g.,blaming) hinder recovery. In contrast to Ullman's (1996b) work, this research also examined whether rape victims have similar perceptions as to what constitutes a "positive" and "negative" social reaction. Results indicated that victims often agree as to what reactions are healing (positive), but that they do not agree as to what is hurtful (negative). By taking victims' perceptions into account, this study was able to compare the relative contributions of social reactions that were considered healing, social reactions that were considered hurtful, and the absence of social reactions. Results indicated that survivors who had someone believe their account of what happened or were allowed to talk about the assault—and considered these reactions to be healing—had fewer emotional and physical health problems than victims who considered these reactions hurtful, or victims who did not experience these reactions at all.
Castro, F. G., & Hernandez, N. T. (2004).	A cultural perspective on prevention interventions.	Offers perspective on prevention interventions in a comprehensive overview of the psychology of Chicano/as.
Classen, C. C., Palesh, G., & Aggarwal, R. (2005).	Sexual revictimization: A review of the empirical literature.	Research suggests that two of three individuals who are sexually victimized will be revictimized. The occurrence of childhood sexual abuse and its severity are the best documented and researched predictors of sexual revictimization. Multiple traumas, especially childhood physical abuse, and recency of sexual victimization are also associated with higher risk. There is preliminary evidence that membership in

		some ethnic groups or coming from a dysfunctional family places an individual at a greater risk. Revictimization is associated with higher distress and certain psychiatric disorders. People who were revictimized show difficulty in interpersonal relationships, coping, self-representations, and affect regulation and exhibit greater self-blame and shame.
Clear, P. J., Vincent, J. P., & Harris, G. E. (2006).	Ethnic differences in symptom presentation of sexually abused girls	This study investigated the relationship between ethnicity and symptom presentation among Hispanic, African American, and Caucasian sexually abused girls. The study examined the relationship between ethnicity and depression, ethnicity and post-trauma intrusive symptoms, and ethnicity and post-trauma avoidance symptoms. Results indicated that African American girls had significantly higher levels of post-trauma avoidance symptoms than Hispanic girls, but not Caucasian girls. No significant differences were found between ethnic groups for depression or intrusive symptoms.
Collins, M. E. (1998).	Factors influencing sexual victimization and revictimization in a sample of adolescent mothers	This study involved secondary analysis of an existing longitudinal data set of a survey of adolescent mothers (n = 315). Using multivariate logistic regression analysis, data from Time 1 were used to predict victimization reported in the year between Time 1 and Time 2. Three factors—any sexual victimization reported at Time 1, previous victimization involving rape using force, and ever having been hit by a partner—increased the likelihood of reported sexual victimization at Time 2. Three other factors were found to reduce the risk of victimization: having been victimized more than 1 year prior to the first survey; being pregnant at Time 1; and reporting satisfaction with social relationships. Additional analyses were used to investigate risk factors for revictimization.
Conrad, M. M., & Pacquiao, D. F. (2005).	Manifestation, attribution, and coping with depression among	This study explored cultural influences on depression and care outcomes among Asian Indians with depression. Findings revealed a major influence of social and cultural context

	Asian Indians from the perspectives of health care practi tioners.	in expression of symptoms, illness attribution, help-seeking behaviors, and communication patterns. Religious beliefs and social stigma attached to mental illness contributed to prolonged denial of condition, difficulty in sharing emotional problems with professional caregivers, and delayed professional intervention. The traditional family hierarchy rooted in age and gender inequality interfered with help-seeking behaviors and adherence to prescribed regimen as well as heightened some family conflicts and hindered family adaptation after migration to the United States.
Conyers, J. J. (2007).	The 2005 reauthorization of the Violence Against Women Act: Why Congress acted to expand protections to immigrant victims.	The author provides an overview of the history of congressional involvement with the Violence Against Women Act's provisions to protect immigrant victims of domestic violence and other forms of violence against women.
Cottler, L. B., Compton, W. M., Mager, D., Spitznagel, E. L. & Janca, A. (1992).	Posttraumatic stress disorder among substance users from the general population.	Findings indicate that cocaine/opiate users are over three times as likely as comparison subjects to report a traumatic event, report more symptoms and events and are more likely to meet diagnostic criteria for PTSD. Physical attack, but not combat-related events, was the most prevalent event reported among cocaine/opiate users. Onset of substance use preceded onset of posttraumatic symptoms, suggesting that substance use predisposes the individual to exposure to traumatic events. When other variables-including antisocial behavior-were controlled, female gender and use of cocaine/opiates predicted PTSD.
Coyne, J. C. (1976).	Toward an interactional description of depression.	This article attempts to demonstrate the interpersonal dynamics of depression, and examines existing descriptions of the interpersonal behavior of the depressed person. Depressive symptomatology was congruent with the developing interpersonal situation of the depressed person, and the symptoms had a mutually maintaining relationship with the response of the social environment.

Cuellar, J., & Curry, T. R. (2007).	The prevalence and comorbidity between delinquency, drug abuse, suicide attempts, physical and sexual abuse, and self- mutilation among delinquent Hispanic females.	The present research assesses the prevalence of drug abuse, delinquency, suicide attempts, physical and sexual abuse, and self-mutilation as well as the extent of comorbidity among these problems. Results show very high levels of violent delinquency, marijuana abuse, suicide attempts, and self-mutilation. Comorbidity was also extensive between suicide attempts, self-mutilation, physical and sexual abuse, and between these variables and drug abuse and certain forms of delinquency.
Cuevas, C. A., Sabina, C., & Bell, K. A. (2012).	The effect of acculturation and immigration on the victimization and psychological distress link in a national sample of Latino women.	This study evaluated the effect of victimization, immigrant status, and both Anglo and Latino orientation on psychological distress in a national sample of Latino women. Results indicated that along with the total count of victimization experiences, Anglo and/or Latino orientation were strong predictors of all forms of psychological distress. Anglo orientation also functioned as a moderator between victimization and psychological distress measures for anger, dissociation, and anxiety.
Dansky, B. S., Brady, K. T., Saladin, M. E., Killeen, T., Becker, S., & Roitzsch, J. (1996).	Victimization and PTSD in individuals with substance use disorders: Gender and racial differences.	Approximately 90% of the participants had a lifetime history of sexual and/or physical assault, and approximately 50% had CR-PTSD. With the exception of rape, no gender differences in assault or CR-PTSD prevalence rates were observed. Women were more likely than men to perceive their life as endangered during a rape. Men were younger than women when they experienced their first (or only) aggravated assault and were more likely to have been assaulted by a family member. No racial differences were detected for assault or PTSD, although African-American patients were significantly more likely to identify cocaine as their primary drug than Caucasian patients.
Dansky, B., Saladin, M., Brady, K., Kilpatrick, D., & Resnick H. (1995).	Prevalence of victimization and posttraumatic stress disorder among	More than 80% of women in both samples had a history of sexual and/or physical assault and approximately one-quarter had current PTSD.

	women with substance use disorders: a comparison of telephone and in-person assessment samples.	
Davis, R. C., Brickman, E. & Baker, T. (1991).	Supportive and unsupportive responses of others to rape victims: Effects on concurrent victim adjustment.	Unsupportive behavior, but not supportive behavior, was found to bear a significant association to victim adjustment.
Djernes, J. K., (2006).	Prevalence and predictors of depression in populations of elderly: a review.	The prevalence of major depression ranged from 0.9% to 9.4% in private households, from 14% to 42% in institutional living, and from 1% to 16% among elderly living in private households or in institutions; and clinically relevant depressive symptom 'cases' in similar settings vary between 7.2% and 49%. The main predictors of depressive disorders and depressive symptom cases were: female gender, somatic illness, cognitive impairment, functional impairment, lack or loss of close social contacts, and a history of depression.
Elliot, D., Mok, D., & Briere, J. (2004).	Adult sexual assault: Prevalence, symptomatology, and sex differences in the general population.	Among 941 participants, ASA was reported by 22% of women and 3.8% of men. Multivariate risk factors for ASA included a younger age, being female, having been divorced, sexual abuse in childhood, and physical assault in adulthood. Childhood sexual abuse was especially common among sexually assaulted men and women (61 and 59%, respectively). ASA victims were more symptomatic than their non-assaulted cohorts on all scales of the Trauma Symptom Inventory (TSI; J. Briere, 1995), despite an average of 14 years having passed since the assault. Assaulted men reported greater symptomatology than assaulted women, whereas non-assaulted men reported less symptomatology than non-assaulted women
Ellis, E. M. (1983).	A review of empirical rape research: Victim reactions and	The purpose of this paper was to review results of empirical studies on victim reactions following rape and response to

	response to treatment	treatment. Short-term reactions were defined as those occurring during the first 3 months post-assault. During this time, most symptoms return to normal levels in most victims. Intermediate reactions, 3 months to one year post-assault, were described in terms of depression, social adjustment, sexual functioning, and fear and anxiety. At the end of this interval, victims still scored significantly higher than non-victims on measures of fear and anxiety.
Ellis, E. M., Atkeson, B., & Calhoun, K. S. (1981).	An assessment of long-term reactions to rape.	Victims were significantly more depressed and reported less pleasure in daily activities than matched non-victim controls. Those with the most severe reactions were women who had been victims of sudden attacks by complete strangers. Outcomes included depression, fatigue, and fear.
Ellsworth, P. C. (1994).	Sense, culture, and sensibility.	According to appraisal theories of emotion, emotions consist of patterned processes of appraisal of one's relation to the environment along specified dimensions, such as novelty, valence, certainty, control, attribution of agency, and consistency with social norms, along with associated physiological responses and action tendencies.
Epstein, J. N., Saunders, B. E., Kilpatrick, D. G., & Resnick, H. S. (1998).	PTSD as a mediator between childhood rape and alcohol use in adult women.	A history of childhood rape doubled the number of alcohol abuse symptoms that women experienced in adulthood. Path analysis and cross-validation results demonstrated significant pathways connecting childhood rape to PTSD symptoms and PTSD symptoms to alcohol use.
Escobar, J. I., Rubio-Stipec, M., Canino, G., & Karno, M. (1989).	Somatic Symptom Index (SSI): A new and abridged somatization construct.	Data revealed that the construct had a high prevalence and was related to low socioeconomic status, female gender, older chronological age, and Hispanic ethnic background. The presence of this construct determined preferential use of medical services and predicted high indices of disability.
Fava, M., Hwang, I., Rush, A. J., Sampson, N., Walters, E. E., & Kessler, R. C. (2010).	The importance of irritability as a symptom of depressive disorder:	Of the 19.2% of NCS-R respondents who met lifetime criteria for MDE, about 13.4% were classified as having either threshold or sub-threshold BP disorder.

	Results from the national comorbidity survey replication.	
Feiring, C., Taska, L., & Chen, K. (2002).	Trying to understand why horrible things happen: Attribution shame and symptom development following sexual abuse.	Abuse-specific internal attributions were consistently related to higher levels of psychopathology and were particularly important for predicting PTSD symptoms and parent and teacher reports of internalizing behavior problems, even after controlling for age, gender, abuse events, and general attributional style. Shame also was an important predictor of symptom level and mediated the relation between abuse-specific internal attributions and PTSD symptoms.
Filipas, H. H., & Ullman, S. E. (2001).	Social reactions to sexual assault victims from various support sources.	This study examined positive and negative social reactions received by 323 victims disclosing sexual assaults to informal and formal support providers. Analyses of both quantitative and qualitative data indicated that both positive and negative reactions are commonly received by victims disclosing their assaults to others, but that victims seeking help from formal support sources are more commonly faced with negative reactions of victim blame, stigmatizing responses, and controlling reactions from others. Preliminary analyses of the effects of specific reactions on adjustment from different types of support providers suggested that reactions of friends are particularly important for recovery. Positive reactions from friends appear to be more helpful, whereas negative reactions appear to be harmful from both informal and formal support sources.
Follette, V. M., Polusny, M. A., Bechtle, A. E., & Naugle, A. E. (1996).	Cumulative trauma: The impact of child sexual abuse, adult sexual assault and spouse abuse.	The results of this study indicate not only that victimization and revictimization experiences are frequent, but also that the level of trauma specific symptoms are significantly related to the number of different types of reported victimization experiences.
Fowler, D. N., & Hill, H. M. (2004).	Social support and spirituality as culturally relevant factors in coping	Findings from hierarchical regression analysis indicated that PTSD symptoms remain significantly related to partner abuse after controlling for the effects of social

	among African American women survivors of partner abuse.	support and spirituality.
Fraga, E. D., Atkinson, D. R., & Wampold, B. E. (2004).	Ethnic group preferences for multicultural counseling competencies.	Asian American, European American, and Hispanic undergraduate students were surveyed using a paired-comparison format to determine preferences for the 9 attitudes/beliefs, 11 knowledges, and 11 skills identified by D. W. Sue, P. Arredondo, and R. J. McDavis (1992) as characteristics of the competent multicultural counselor. Results indicated that preferences for 5 of the 9 attitudes/beliefs, 5 of the 11 knowledges, and 7 of the 11 skills competencies varied as a function of race/ethnicity.
Frank, E., & Anderson, B. P. (1987).	Psychiatric disorders in rape victims: Past psychiatric history and current symptomatology.	Rape victims and controls did not differ in the number or kind of past diagnoses; however, victims were significantly more likely to meet criteria for major depression, GAD, and drug abuse during the month preceding assessment.
Frank, E., Turner, S., & Duffy, B. (1979).	Depressive symptoms in rape victims.	Fifteen subjects were found to be moderately or severely depressed when measured on the self-report questionnaire. A closer examination of these 15 subjects revealed that 8 were suffering from a major depressive disorder.
Frazier, P. (2003).	Perceived control and distress following sexual assault: A longitudinal test of a new model.	Both personal past (behavioral self-blame) and vicarious past (rapist blame) control were associated with higher distress levels. In addition, the belief that future assaults are less likely was more strongly associated with lower distress levels than was future control. Present control (i.e., control over the recovery process) was most adaptive.
Frazier, P. A., & Burnett, J. W. (1994).	Immediate coping strategies among rape victims.	Responses to 20 coping items suggested that taking precautions and thinking positively were among the most frequently endorsed coping strategies. Expressing feelings, seeking social support, counseling, and keeping busy were most often listed as helpful by victims on an open-ended question. Staying home and withdrawing were associated with higher symptom levels: keeping busy, thinking positively, and

		suppressing negative thoughts were associated with lower symptom levels.
Frazier, P. A., Mortensen, H., & Steward, J. (2005).	Coping strategies as mediators of the relations among perceived control and distress in sexual assault survivors.	In Study 1, Past control (behavioral self-blame) was associated with more distress partly because it was associated with greater social withdrawal. Present control (control over the recovery process) was associated with less distress partly because it was associated with less social withdrawal and more cognitive restructuring. In Study 2, Coping strategies again mediated the relations among the measures of past and present control and distress.
Freedman, S. A., Brandes, D., Peri, T., & Shalev, A. (1999).	Predictors of chronic post-traumatic stress disorder.	Depressive symptoms were the best predictors of PTSD at both time points. Intrusive symptoms and peritraumatic dissociation were better at predicting 4-month PTSD than 1-year PTSD. It is concluded that the occurrence of depression during the months that follow a traumatic event is an important mediator of chronicity in PTSD.
Gibson, L. E., & Leitenberg, H. (2001).	The impact of child sexual abuse and stigma on methods of coping with sexual assault among undergraduate women.	Sexually assaulted young women with a history of child sexual abuse used more disengagement methods of coping to deal with the adult sexual assault than women without this history. In addition, the relationship between prior sexual abuse and the use of disengagement coping strategies was mediated by feelings of stigma, but not by feelings of betrayal and powerlessness or beliefs in the meaningfulness and benevolence of the world.
Gidycz, C. A., Hanson, K., & Layman, M. B. (1995).	A prospective analysis of the relationships among sexual assault experiences: An extension of previous findings.	Log-linear analysis indicated that chances of being victimized in one time period increased with greater severity of victimization in the preceding time period. The path analysis assessing the mediating effects of these variables on victimization experiences was partially supported.
Gladstone, G. L., Parker, G. B., Mitchell, P. B., Malhi, G. S., Wilhelm, K., &	Implications of childhood trauma for depressed women: an analysis of pathways	Childhood sexual abuse is an important risk factor to identify in women with depression. Depressed women with a childhood sexual abuse history create a subgroup of patients

Austin, M.P. (2004).	from childhood sexual abuse to deliberate self-harm and revictimization.	who may need interventions to combat both depression recurrence and harmful coping strategies.
Gladstone, G., Parker, G., Wilhelm, K., Mitchell, P., & Austin, M. P. (1999).	Characteristics of depressed patients who report childhood sexual abuse	Patients with history of abuse did not differ from those without a history, but they did have higher self-report depression scores. They also showed more self-destructive behavior, personality dysfunction and overall adversity in their childhood environment. Childhood sexual abuse appears to be associated with greater chance of having experienced a broadly dysfunctional childhood home environment.
Goldenberg I. M., Mueller T., Fierman E. J., Gordon A., Pratt L., Cox K., . . . Keller M. B. (1995).	Specificity of substance use in anxiety-disordered subjects.	Subjects whose anxiety disorder had an onset before their substance use disorder (primary anxiety) were compared with those whose substance use preceded onset of an anxiety disorder (secondary anxiety) for differences in distribution of subjects among categories of substance of abuse. Primary and secondary anxiety groups do not have different ages of onset for substance use disorder, nor was there greater likelihood for choosing alcohol for any of the anxiety disorders. However, there is a decreased risk of alcohol use in the small group of generalized anxiety subjects and an increased risk of opioid use in the small group of posttraumatic stress disorder subjects. There was no indirect support for the self-medication hypothesis. Neither ahe of onset data, specific substance association, there was no indirect support for the the self-medication hypothesis. Neither age of onset data, specific substance association, or proximal association support a simple interaction. The strongest finding supported an “avoidance” of CNS stimulants.
Golding, J. M., Siegel, J. M. Sorenson, S. B. Burnam, M. A., & Stein, J. A. (1989).	Social Support Sources Following Sexual Assault.	This study used data from 3,132 randomly selected survey respondents to investigate the use and helpfulness of seven potential social support sources in coping with sexual assault. About two-thirds of the 447 respondents had told someone about the assault. Over half had talked to a friend or

		relative (59.3%). Fewer respondents consulted police (10.5%), mental health professionals (16.1%), physicians (9.3%), clergy (3.9%), rape crisis centers (1.9%), and legal professionals (1.6%). Most of those who told someone found at least one person helpful (73.8%). Rape crisis centers (94.2%) and legal professionals (82.7%) were most frequently described as helpful, followed by mental health professionals (70.1%), friends and relatives (66.6%), clergy (63.1%), physicians (55.6%), and police (38.2%).
Gonzalez-Guarda, R. M., Peragallo, N., Vasquez, E. P., Urrutia, M. T., & Mitrani, V. B. (2009).	Intimate partner violence, depression, and resource availability among a community sample of Hispanic women	This study investigated the relationships among resource availability, IPV, and depression among Hispanic community-dwelling women. Results suggest that although most of the relationships among resource availability, IPV, and depression supported the conceptual framework, the importance of incorporating additional cultural, relationship, and social factors are stressed.
Grauerholz, L. (2000).	An ecological approach to understanding sexual revictimization: Linking personal, interpersonal, and sociocultural factors and processes.	This ecological model explores how sexual revictimization is multiply determined by factors related to the victim's personal history (e.g., traumatic sexualization), the relationship in which revictimization occurs (e.g., decreased ability to resist unwanted sexual advances), the community (e.g., blaming the victim attitudes).
Grice, D. E., Brady, K. T., Dustan, L. R., Malcolm, M., & Kilpatrick, D. G. (1995).	Sexual and physical assault history and posttraumatic stress disorder in substance dependent individuals.	Sixty-six percent of individuals had a history of sexual or physical assault. Half of the assault victims met DSM-III-R criteria for PTSD. Type of assault and specific characteristics of victims were significantly associated with psychiatric disorders. Women had higher rates of sexual assault history, serial assault, and familial assault than men. Individuals who had experienced childhood assault had earlier age at onset of substance dependence than those who had not experienced childhood assault.
Gutner, C. A., Rizvi, S. L., Monson, C. M., & Resick, P. A. (2006).	Changes in coping strategies, relationship to perpetrator, and	Results indicate that changes in coping strategies over time are associated with the severity of the PTSD symptoms. Assault type was not a significant factor in the

	posttraumatic distress in female crime victims.	association between changes in coping and PTSD, but perpetrator status was. Victims with known perpetrators, who coped more by social withdrawal, had more severe PTSD symptoms over time.
Haro. J. M., Arbabzadeh-Bouchez, S., De Girolamo, G. Guyer, M. E., Jin, R., Lepine, J. P., . . . Kessler, R. C. (2006).	Concordance of the Composite International Diagnostic Interview Version 3.0 (CIDI 3.0) with standardized clinical assessments in the WHO World Mental Health Surveys	The DSM-IV diagnoses generated by the fully structured lay-administered Composite International Diagnostic Interview Version 3.0 (CIDI 3.0) in the WHO World Mental Health (WMH) surveys were compared to diagnoses based on follow-up interviews with the clinician-administered non-patient edition of the Structured Clinical Interview for DSM-IV (SCID) in probability subsamples of the WMH surveys in France, Italy, Spain, and the US.
Hill, T. D., Kaplan, L. M., French, M. T., & Johnson, R. J. (2010).	Victimization in early life and mental health in adulthood: An examination of the mediating and moderating influences of psychosocial resources.	Although no indirect effects of physical assault were observed, the effect of sexual coercion is partially mediated by instrumental support and self-esteem. The effects of physical assault and sexual coercion are moderated by emotional support and self-esteem.
Hill, P. C., & Pargament, K. I. (2003).	Advances in the conceptualization and measurement of religion and spirituality: Implications for physical and mental health research.	The authors highlight recent advances in the delineation of religion and spirituality concepts and measures theoretically and functionally connected to health. They also point to areas for areas for growth in religion and spirituality conceptualization and measurement.
Hinton, D. E., Chong, R., Pollack, M. H., Barlow, D. H., & McNally, R. J. (2008).	Ataque de nervios: Relationship to anxiety sensitivity and dissociation predisposition.	This study investigated the relative importance of "fear of arousal symptoms" (i.e., anxiety sensitivity) and "dissociation tendency" in generating ataque de nervios. Among the whole sample (n = 70), in a logistic regression analysis, the Anxiety Sensitivity Index significantly predicted (odds ratio = 2.6) the presence of ataque de nervios, but the Dissociation Experiences Scale did not.
Hobfoll, S. E. (1991).	Traumatic stress: A theory based on rapid loss of resources.	This article applied Hobfoll's (1988; 1989) Conservation of Resources (COR) stress theory to the instance of traumatic stress.

		COR theory posits that stress occurs when resources are threatened, when resources are lost, or when individuals invest resources without gaining adequate resources in return. The rapidness of resource loss is related to the fact that traumatic stressors (1) often attack people's basic values, (2) often occur unexpectedly, (3) make excessive demands, (4) are outside of the realm for which resource utilization strategies have been developed, and (5) leave a powerful mental image that is easily evoked by cues associated with the event.
Holmstrom, L. L., & Burgess, A. W. (1979).	Rape: Husbands and boyfriends initial reactions.	This study analyzed the reactions of husbands and boyfriends to the rape of a wife or girlfriend. Interviews with sixteen couples revealed that the man's reaction to the rape has two main components. The first is his own response to the rape-his perceptions of who is the victim, wanting to go after the assailant, and "if-only" feelings. The second component involves his interaction with the raped woman, and here the issues are whether the couple can discuss the rape, how they deal with the woman's new phobias, and the resumption of sexual relations.
House, J. (1981).	Work, stress, and social support.	Social support may reduce occupational stress, improve health, and buffer the impact of stress on health.
Hyman, S. M., Gold, S. N, Cott, M. A. (2003).	Forms of social support that moderate PTSD in childhood sexual abuse survivors.	Regression analysis indicated that social support significantly buffered PTSD development. The best model was one which contained self-esteem and appraisal support. Tangible and belonging support added little to prediction. Further, self-esteem support was identified as the most important variable in preventing PTSD development.
Ireland, T., & Widom, C. S. (1994).	Childhood victimization and risk for alcohol and drug arrests.	Analyses indicate that childhood maltreatment is a significant predictor of adult, but not juvenile, arrests for alcohol and/or drug related offenses.
Iwata, N., Turner, R. J., & Lloyd, D. A. (2002).	Race/ethnicity and depressive symptoms in community-dwelling young adults: A differential	DIF analyses indicated that: (1) about half of the CES-D items functioned differently among non-Hispanic whites compared to each of the other racial/ethnic groups; (2) the manifestation of symptoms

	item functioning analysis.	seemed to be similar for both Hispanic groups, except for low positive affect; (3) African-Americans tended to favor somatic symptoms over affective (depressive) symptoms; (4) Immigrant Hispanics appeared to inhibit the expression of positive affect, and thus more high scorers on the total CES-D were observed within this subgroup. In contrast, no differences were observed when only negative items were considered.
Jacques-Tiura, A. J., Tkatch, R., Abbey, A., & Wegner, R. (2010).	Disclosure of sexual assault: Characteristics and implications for posttraumatic stress symptoms among African American and Caucasian survivors.	This study examined the effects of disclosure in a community sample of Caucasian and African American sexual assault survivors who completed computer-assisted self-interviews. Among the 58.6% of survivors who had disclosed to someone (*n* = 136), 96% had disclosed to at least 1 informal and 24% at least 1 formal support provider. The experiences of African American and Caucasian survivors were similar in many ways. Participants received more positive than negative responses from others, although only negative responses were related to posttraumatic stress disorder symptoms, and particularly so for African American participants. Regretting disclosure and disclosure to formal providers were also related to posttraumatic stress disorder symptoms.
Kalaydjian, A., Swendsen, J., Chiu, W., Dierker, L., Degenhardt, L., Glantz, M., . . . Kessler, R. (2009).	Sociodemographic predictors of transition across stages of alcohol use, disorders, and remission in the national comorbidity survey replication.	The lifetime prevalence estimates include 91.7% lifetime alcohol use, 72.9% regular use, 13.2% for abuse, 5.4% for dependence with abuse. The transition from use to regular use to abuse was linked with the male sex, young age, non-Hispanic white race/ethnicity, low education, student status, and never being married.
Kaukinen, C., & DeMaris, A. (2005).	Age at first sexual assault and current substance use and depression.	This article explores how the association between sexual violence and substance use and mental health differs by race and life course stage. Although sexual violence did not heighten the risk of problem drinking for White women, minority women victimized in adulthood are significantly more likely to

		engage in problem drinking and use illicit drugs. Hispanic women were more likely to suffer depression as a consequence of child sexual assault.
Kessler, R. C., Berglund, P., Chiu, W. T., Demler, O., Heeringa, S., Hiripi, E., . . .Zheng, H. (2004).	The US national comorbidity survey replication (NCS-R): Design and field procedures.	Provides information about how surveys were completed with initial non-respondents.
Kessler, R. C., McGonagle, K. A., Zhao, S., Nelson, C. B., Hughes, M., Eshleman, S., . . . Kendler, K. S. (1994).	Lifetime and 12-month prevalence of DSM-III-R psychiatric disorders in the United States: Results from the national comorbidity survey	The lifetime prevalence estimates include 28.8% anxiety, 20.8% mood disorders, 24.8% impulse-control, and 14.6% substance use disorders. The median age of onset for substance use is 20 years old.
Kessler, R. C., & Merikangas, K. R. (2004).	The national comorbidity survey replication (NCS-R): Background and aims.	NCS-R was created to investigate time trends and their correlates over the decade of the 1990s and to expand the assessment of the prevalence and correlates of mental disorders beyond the assessment in the baseline NCS in order to address a number of important substantive and methodological issues that were raised by the NCS.
Kessler, R. C., Sonnega, A., Bromet, E., Huges, M., & Nelson, C. B. (1995).	Posttraumatic stress disorder in the national comorbidity survey.	Results showed that prevalence is elevated among women and the previously married. Traumas that were most commonly associated with PTSD were combat exposure and witness among men and rape and sexual molestation among women.
Kessler, R. C., & Ustun, T. B. (2004).	The World Mental Health (WMH) survey initiative version of the World Health Organization (WHO) Composite International Diagnostic Interview (CIDI).	This paper presents an overview of the World Mental Health Survey Initiative version of the World Health Organization Composite International Diagnostic Interview.
Kilpatrick, D. G., Acierno, R., Resnick, H. S., Saunders, B. E., & Best, C. L. (1997).	A 2-year longitudinal analysis of the relationship between violent assault and substance use in	Use of drugs, but not abuse of alcohol, increased odds of revictimization. Reciprocally, after revictimization, odds of both alcohol abuse and drug use were significantly increased. For illicit drug use,

	women.	findings support a vicious cycle relationship in which substance use increases risk of revictimization and revictimization increases risk of subsequent substance use.
Kilpatrick, D. G., Edmunds, C. N. & Seymour, A. K. (1992).	Rape in America: A Report to the Nation.	This report presents key statistics on rape in America.
Kilpatrick, D. G., Saunders, B. E., Veronen, L. J., Best, C. L., & Von, J. M. (1987).	Criminal victimization: Lifetime prevalence, reporting to police, and psychological impact.	In total, 75% of the sample (*n* = 295) had been victimized by crime, and 41.4% of all crimes were reported to the police. Reporting rates differed by crime type. Burglary had the highest reporting rate (82.4%) and sexual assault the lowest (7.1%). Of all crime victims, 27.8% subsequently developed posttraumatic stress disorder.
Kilpatrick, D. G., Veronen, L. J., & Best, C. L. (1985).	Factors predicting psychological distress among rape victims.	Initial distress was a better predictor of subsequent psychological functioning than other variables.
Kilpatrick, D. G., Veronen, L. J., & Resick, P. A. (1981).	Effects of a rape experience: A longitudinal study.	Findings were that victims were significantly more anxious, fearful, suspicious, and confused than non-victims for at least a year after their assaults. However, there was significant improvement on those as well as other measures of personality and mood state over time, particularly between 1 and 6 months.
King, D. W., King, L. A., Foy, D. W., Keane, T. M., & Fairbank, J. A. (1999).	Posttraumatic stress disorder in a national sample of female and male Vietnam veterans: Risk factors, war-zone stressors, and resilience-recovery variables.	Relationships among pre-trauma risk factors (e.g., family instability, childhood antisocial behavior), war-zone stressors (e.g., combat, perceived threat), post-trauma resilience-recovery variables (e.g., hardiness, social support), and PTSD symptom severity were examined. For both genders, direct links to PTSD from pre-trauma, war-zone, and post-trauma variable categories were found; several direct associations between pre-trauma and post-trauma variables were documented. Although war-zone stressors appeared preeminent for PTSD in men, post-trauma resilience-recovery variables were more salient for women.
Koss, M. P., Dinero, T. E., Seibel, C. A., & Cox, S. L. (1989).	Stranger and acquaintance rape: Are there differences	Rapes by acquaintances, compared with strangers, were more likely to involve a single offender and multiple episodes, were

	in the victim's experience?	less likely to be seen as rape or to be revealed to anyone, and were similar in terms of the victim's resistance. In general, acquaintance rapes were rated as less violent than stranger rapes. The exception was rapes by husbands or other family members, which were rated equally violent to stranger rapes but were much less likely to occur in a context of drinking or other drug use. In spite of these different crime characteristics, virtually no differences were found among any of the groups in their levels of psychological symptoms.
Koss, M. P., Figueredo, A. J., & Prince, R. J. (2002).	Cognitive mediation of rape's mental, physical, and social health impact: Test of four models in cross-sectional data.	Personological and rape characteristics influenced the level of self-blame experienced and the intensity of maladaptive beliefs about self and others. Self-blame and maladaptive beliefs predicted psychological distress, which strongly influenced all health outcomes. Self-ratings of rape memory characteristics contributed little to predicting post-rape distress.
Koverola, C., Proulx, J., Battle, P., & Hanna, C. (1996).	Family functioning as predictors of distress in revictimized sexual abuse survivors.	Findings indicated that the revictimized group reported the most severe forms of sexual assault relative to other victimized groups. The victimized groups were all significantly more distressed than the non-abused control group with the revictimized group reporting significantly more PTSD symptomatology than other victimization groups. The victimization groups differed significantly from the non-abused group on dimensions of family functioning, but they did not differ significantly from each other. Multiple stepwise regression analysis indicated that conflict and control were significant predictors of distress in the victimization group. Cohesion was a significant predictor of distress in the non-abused group.
Krahé, B., Scheinberger-Olwig, R., Waizenhöfer, E., & Kolpin, S. (1999).	Childhood sexual abuse and revictimization in adolescence.	The aim of this study was to examine the link between childhood experiences of sexual abuse and subsequent revictimization in adolescence. A sample of 281 female adolescents between 17–20 years of age, who participated in a

		prevalence survey of unwanted sexual contacts, completed the Sexual Experiences Survey as a measure of unwanted sexual contacts in adolescence and indicated whether or not they had experienced childhood sexual abuse. Childhood experiences of sexual abuse were reported by 8.9% of the respondents, a further 8.5% indicated they were not sure if they had been sexually abused as children. Both abused women and women uncertain about their victimization status were significantly more likely to report unwanted sexual contacts as adolescents than women who did not state abuse. The link between childhood abuse and subsequent victimization was mediated by a higher level of sexual activity among the abuse victims.
Lefley, H. P., Scott, C. S., Llabre, M. & Hicks, D. (1993).	Cultural beliefs about rape and victim's responses in three ethnic groups.	Cultural definitions of rape were assessed among 101 African-American, Hispanic, and non-Hispanic white female rape victims and 89 non-victims matched for ethnicity, age, marital status, and socioeconomic status. Hispanics scored highest and whites lowest both in perceived community victim-blaming and in victims' psychological distress.
Leong, F. T. L. (1994).	Asian Americans' differential patterns of utilization of inpatient and outpatient public mental health services in Hawaii.	The major purpose of the present study was to examine Asian Americans' differential patterns of utilization of mental health services in Hawaii. Using a dataset from the state of Hawaii's Department of Health, mental health service utilization rates for three Asian-American groups (Chinese, Japanese, and Filipino) were compared to each other and to those of White Americans. It was found that there were ethnic subgroups (e.g., Chinese versus Filipino) and intergroup differences (i.e., Asian versus White) in the utilization of inpatient and outpatient mental health services as well as in sources of referral into the mental health system.
Leong, F., Leach, M., Yeh, C., & Chou, E. (2007).	Suicide among Asian Americans: What do we know? What do we need to know?	In analyzing what is known and what still needs to be learned about suicide among Asian Americans, this article provides a critical review of significant factors such as

		age, gender, religious and spirituality issues, acculturation, social support, familial dynamics, social integration as well as gay/lesbian/bisexual orientations.
Levitan, R. D., Parikh, S. V., Lesage, A. D., Hegadoren, K. M., Adams, M., & Kennedy, S. H. (1998).	Major depression in individuals with a history of childhood physical or sexual abuse: Relationship to neurovegetative features, mania, and gender.	A history of physical or sexual abuse in childhood was associated with major depression with reversed neurovegative features, whether or not manic subjects were included in the analysis. A strong relationship between mania and childhood physical abuse was found. A significant main effect of female gender on risk of early sexual abuse, however, none of the group-by-gender interactions predicted early abuse. Both men and women having a childhood history of either physical or sexual abuse was associated with a higher risk of depressive episodes with reversed neurovegatative features whether or not individuals with mania were considered.
Lewis, M. (1992).	The exposed self.	Drawing theories and research this book offers an empirically account of the development of shame.
Lewis, M. J., West, B., Bautista, L., Greenberg, A. M., & Done-Perez, I. (2005).	Perceptions of service providers and community members on intimate partner violence within a Latino community.	This study examined perceptions regarding intimate partner abuse (IPV) in a largely Latino community in New Jersey through focus groups with Latino community members and key informant interviews with providers of services to this population. Questions examined definitions of partner abuse; perceptions of factors contributing to, or protecting against, IPV; and barriers to reporting IPV both for the victim and the community at large. Atlas.ti, a qualitative data package, was used to analyze transcripts for themes drawn from the literature and preliminary review of transcripts. Findings point to both similarities and some potentially important differences between the perspectives of community members and service providers in such areas as definitions of partner abuse, factors associated with abuse, and barriers to reporting.
Lewis-Fernandez, R., Garrido-Castillo, P.,	Dissociation, childhood trauma,	This study examined the relationships of dissociation and childhood trauma with

Bennasar, M. C., Parrilla, E. M., Laria, A. J., Ma, G., & Petkova, E. (2002).	and ataque de nervios among Puerto Rican psychiatric outpatients.	ataque de nervios. Forty Puerto Rican psychiatric outpatients were evaluated for frequency of ataque de nervios, dissociative symptoms, exposure to trauma, and mood and anxiety psychopath- ology. Among 29 patients, clinician-rated dissociative symptoms increased with frequency of ataque de nervios.
Lipsky, S., & Caetano, R. (2007).	The role of race/ethnicity in the relationship between emergency department use and intimate partner violence: Findings from the 2002 National Survey on Drug Use and Health.	The relationship between intimate partner violence among women in the general population and emergency department were examined. Women who reported intimate partner violence victimization were 1.5 times more likely than were non-victims to use the emergency department, after accounting for race/ethnicity and substance use. In race/ethnic–specific analyses, only Hispanic victims were more likely than their non-victim counterparts to use the emergency department, whereas substance use factors varied among groups.
Littleton, H. L., & Breitkopf, C. R. (2006).	Coping with the experience of rape.	Results suggested that sequelae of the assault such as feelings of self-blame and negative reactions received from others are potentially important predictors of avoidance coping.
Littleton, H. L., Grills-Taquechel, A. E., Buck, K. S., Rosman, L., & Dodd, J. C. (2013).	Health risk behavior and sexual assault among ethnically diverse women.	The current study examined sexual assault history and two health risk behaviors (hazardous drinking and engaging in sexual behavior to regulate negative affect) in a diverse sample of 1,620 college women. Depression and anxiety were examined as mediators of the relationship between sexual assault and health risk behaviors. There was evidence of moderated mediation, such that for European American women, but not for ethnic minority women, both forms of psychological distress were significant mediators of the sexual assault/hazardous drinking relationship. In contrast, among all ethnic groups, the relationship between sexual assault and both forms of psychological distress was mediated by the use of sexual behavior as an affect regulation strategy. Results support a need to evaluate the assault experiences of ethnically diverse women, as well as the impact of the assault

		on their post-assault experiences including health risk behaviors and psychological adjustment. Additionally, results suggest that practitioners should carefully assess health risk behaviors among victims of sexual assault and be aware that there may be differences in the risk factors and motives for these behaviors among women of various ethnic backgrounds.
MacGreene, D. M., & Navarro, R. L. (1998).	Situation-specific assertiveness in the epidemiology of sexual victimization among university women.	Assertiveness specific to situations with the opposite gender was protective at all three assessment times. Prior victimization, alcohol use, poor adjustment (as indicated by depression an anxiety), multiple sexual partners, and insecurity about relationships with the opposite gender were significant risk factors.
Macy, R., Nurius, P., & Norris, J. (2006).	Responding in their best interests: Contextualizing women's coping with acquaintance sexual aggression.	Using an investigation of 202 college women who completed a survey about coping with sexual aggression from a known male assailant, this study examined assailant behaviors, along with women's victimization history, alcohol use, positive relationship expectancies, and sexual assertiveness, to clarify how these factors shape women's responses to acquaintance sexual aggression. Multivariate regression analyses showed that these factors and assailant actions accounted uniquely and cumulatively for women's responding.
Marsella, A., Friedman, M., & Spain, E. H. (1996).	Ethnocultural aspects of PTSD: An overview of issues and research directions.	This is a systematic examination of ethnocultural aspects of PTSD. Leaders in the field of PTSD research and practice explore both universal and culture-specific reactions to trauma, and discusses implications for research, treatment, and prevention.
Marshall, G. N., Schell, T. L., & Miles, J. N. (2009).	Ethnic differences in posttraumatic distress: Hispanics' symptoms differ in kind and degree.	This longitudinal study of physical injury survivors examined the degree to which Hispanic and non-Hispanic Caucasians reported similar PTSD symptoms. Results replicated prior research indicating that Hispanics report greater overall PTSD symptom severity. Relative to non-Hispanic Caucasians, Hispanics tended to report higher levels of symptoms that could be

		regarded as exaggerated or intensified cognitive and sensory perceptions (e.g., hypervigilance, flashbacks). Findings suggest that the pattern of PTSD symptoms experienced most prominently by Hispanics differs in kind and not merely in degree.
Matsuoka, J. K., Breaux, C., & Ryujin, D. H. (1997).	National utilization of mental health services by Asian Americans/ Pacific Islanders.	In an effort to ascertain an overall national pattern for the utilization of mental health services by Asian Americans/Pacific Islanders (AA/PI), the researchers statistically analyzed 1986 survey data provided by the National Institute of Mental Health. All AA/PI utilization rates were contrasted with those for Euro Americans. Nationally, such contrasts indicate an extensive pattern of differential usage ($p's < .0001$) with Asian Americans/Pacific Islanders being three times less likely than their Euro American counterparts to use available mental health services.
McCall, G. J., & Resick, P. A. (2003).	A pilot study of PTSD symptoms among Kalahari bushmen.	This study assesses PTSD in a radically nonwestern culture, that of the Kalahari Bushmen, the Ju/'hoansi. Thirty-five percent of the sample met the criteria for PTSD for incidents occurring within the past year. All participants met the re-experiencing and arousal criteria but many otherwise distressed participants did not meet the avoidance criterion for PTSD. These results compare closely with PTSD assessments in other non-Western societies, while providing some empirical support of two new ideas about how the avoidance behaviors in such societies might be reconciled with information-processing theories of PTSD.
McDonald, P., Bryant, R. A., Silove, D., Creamer, M., O'Donnell, M., & McFarlane, A. C. (2013).	The expectancy of threat and peritraumatic dissocation.	This study investigated the extent to which peritraumatic dissociation is predicted by the amount of perceived warning that participants had of the impact of the trauma. Randomized eligible admissions to four major trauma hospitals ($n = 243$) were assessed during hospital admission with the Peritraumatic Dissociation Experiences Questionnaire (PDEQ) and the perceived warning that participants had before the trauma impact occurred. Whereas female

		gender predicted both Awareness and Derealization subscale scores on the PDEQ, perceived warning also predicted scores on the Derealization subscale. This finding suggests that the degree of anticipated threat may contribute to peritraumatic dissociation.
McFarlane, A. C. (1998).	Epidemiological evidence about the relationship between PTSD and alcohol abuse: The nature of the association.	A series of studies are presented which examine the relationship between PTSD and alcohol abuse. A cross-sectional study of 2,501 subjects in a community sample examined the relationship between at-risk drinking and 11 types of traumatic events. The traumatic events associated with at-risk drinking were involvement in life threatening accidents, witnessing severe injury, rape, being the victim of serious physical assault using the CIDI. In a longitudinal study of 469 firefighters exposed to a natural disaster, PTSD was associated with both an increase and decrease in alcohol consumption and PTSD rather than exposure accounted for the changes in drinking behavior. In three other populations, psychiatric inpatients, motor accident victims and female prisoners, the association between PTSD and alcohol abuse emphasized the clinical and public health importance of this relationship. The available evidence does nevertheless support the causal nature of this relationship. Other risk factors are necessary to predict alcohol abuse following exposure to traumatic events, although exposure to traumatic events can be caused by alcohol abuse.
McFarlane, J., Malecha, A., Watson, K., Gist, J., Batten, E., Hall, I., & Smith, S. (2005).	Intimate partner sexual assault against women: Frequency, health consequences, and treatment outcomes.	Sixty-eight percent of the physically abused women reported sexual assault. Fifteen percent of the women attributed 1 or more sexually-transmitted diseases to sexual assault, and 20% of the women experienced a rape-related pregnancy. Sexually assaulted women reported significantly (p = .02) more PTSD symptoms compared with nonsexually assaulted women. One significant (p = .003) difference occurred between ethnic groups and PTSD scores. Regardless of sexual assault or no assault, Hispanic women reported significantly higher mean PTSD

		scores compared with African-American women (p = .005) and White women (p = .012). The risk of sexual reassault was decreased by 59% and 70% for women who contacted the police, or applied for a protection order, after the first sexual assault. Receiving medical care decreased the woman's risk of further sexual assault by 32%.
Mennen, F. E. (1994).	Sexual abuse in Latina girls: Their functioning and a comparison with White and African American girls.	This study was designed to help address the lack of research on sexual abuse in Latinas. This study evaluated symptoms of depression, anxiety, and self-concept in a racially mixed sample of sexually abused girls. Latinas had elevated levels of depression and anxiety and lower levels of self-concept than children in standardization samples. Their symptom levels did not differ from the sexually abused White and African American girls in the study. They were also very similar to the other subjects in relationship to the identity of the perpetrator, the age when the abuse began, and the kind of abuse. The only racial/ethnic difference found in the study was in duration of the abuse, with White girls experiencing longer abuse than the Latina or African American subjects.
Messman-Moore, T. L., & Long, P. J. (2000).	Alcohol and substance use disorders as predictors of child to adult sexual revictimization in a sample of community women.	CSA survivors were more likely than non-victims to meet criteria for both substance use disorders and to report rape (e.g., unwanted intercourse due to threat or use of force, or due to the inability to consent due to the respondent’s alcohol or drug use) and coerced intercourse (e.g., unwanted intercourse due to verbal coercion or misuse of authority by the perpetrator) by acquaintances, strangers, and husbands. In general, both CSA and substance use disorders were predictive of adult sexual victimization, but there were no significant interactions between these factors. Overall, substance use disorders were related to rape for all women; this relationship was not unique to CSA survivors. Alcohol and substance related

		diagnoses predicted rape by all three types of perpetrators, but CSA was predictive of rape only by acquaintances and strangers and not husbands. In contrast, CSA predicted coerced intercourse by all three perpetrators, while alcohol- and substance-related diagnoses predicted coerced intercourse by acquaintances and strangers, but not husbands.
Messman-Moore, T. L., & Long, P. J. (2003).	The role of childhood sexual abuse sequelae in the sexual revictimization of women: An empirical review and theoretical reformulation.	There is now widespread empirical evidence that CSA survivors are at greater risk for sexual revictimization in adulthood, but less is known of the mechanisms underlying this relationship. Despite the lack of a conceptual framework to guide research, there has been a recent influx of studies examining explanatory variables, with most focusing on the psychological sequelae of CSA: alcohol and drug use, sexual behavior, dissociation, posttraumatic symptomatology, poor risk recognition, and interpersonal difficulties. With the exception of sexual behavior, the studies reviewed here provide limited or mixed support for the role of intrapersonal factors in revictimization.
Messman-Moore, T. L., Long, P. J., & Siegfried, N. J. (2000).	The revictimization of child sexual abuse survivors: An examination of the adjustment of college women with child sexual abuse, adult sexual assault, and adult physical abuse.	Results support the cumulative effect of trauma but do not indicate differential effects for child to adult revictimization. Women with revictimization and multiple adult assaults reported more difficulties compared to women with only one form of assault abuse or no victimization. Women with CSA only reported similar symptoms as revictimized women and women with multiple adult assaults reported higher levels of distress than non-abused women and appeared somewhat more likely to experience anxiety and PTSD related symptoms as compared to women with only adult abuse. Women with adult assault only and no abuse reported similar levels of distress.
Mesquite, B., & Frijda, N. H. (1992)	Cultural variations in emotions: A review.	The psychological and anthropological literature on cultural variations in emotions was reviewed. Cultural differences in emotions appear to be due to differences in

		event types or schemas, in culture-specific appraisal propensities, in behavior repertoires, or in regulation processes. Differences in taxonomies of emotion words sometimes reflect true emotion differences like those just mentioned, but they may also just result from differences in which emotion-process phase serves as the basis for categorization.
Meyer, C. B., & Taylor, S. E. (1986).	Adjustment to rape.	As in previous research, high levels of behavioral and characterological self-blame for rape were found. Contrary to prior hypotheses, behavioral self-blame was not associated with good adjustment. Rather, both behavioral and characterological self-blame were associated with poor adjustment. Societal blame was the only causal attribution for rape that was unassociated with adjustment. Remaining at home and withdrawing from others were both associated with poor adjustment, and the use of stress reduction techniques was associated with good adjustment.
Miller B., Downs W., & Testa M. (1993).	Interrelationships between victimization experiences and women's alcohol use.	The rates of childhood victimization were significantly greater for participants with alcohol problems in treatment as compared to participants without alcohol problems in treatment. Even when holding the treatment condition and family background variables constant, childhood victimization had a specific connection to the development of women's alcohol problems.
Miner, M. H., Flitter, J. M. K., & Robinson, B. E. (2006).	Association of sexual revictimization with sexuality and psychological function.	Data indicate that women who experience sexual revictimization are more at risk for emotional stress and psychological pathology than women with no history of abuse. In addition, women who are revictimized appear to be at greater risk for emotional problems than women sexually abused only as a child or sexually assaulted only as adults. Revictimization also appears to be associated with an increased probability of engaging in prostitution, even higher than women with childhood- or adult only victimization, who showed increased probability when compared to women never

		abused. Finally, women who are revictimized showed increased HIV risk, in that they were 4 times less likely than other women to consistently use condoms, but no more likely to be in monogamous relationships or less likely to have multiple partners.
Molnar, B. E., Buka, S. L., & Kessler, R. C. (2001).	Child sexual abuse and subsequent psychopathology: Results from the national comorbidity survey	CSA usually occurs as a part of the larger syndrome of childhood adversities. In a subsample of respondents, odds of depression and substance problems associated with CSA were higher. Among women, rape (vs. molestation), knowing the perpetrator (vs. strangers), and chronicity of CSA (vs. isolated incidents) were associated with higher odds of some disorders.
Moor, A. (2007).	When recounting the traumatic memories is not enough: Treating persistent self-devaluation associated with rape and victim-blaming myths.	This paper seeks to address a gap in the literature concerning the treatment of the combined impact of rape and related internalized rape myths on survivors' sense of self. Explicit guidelines for therapy are outlined in accordance. The authors suggest that to be most effective, treatment must provide a therapeutic environment free of all prejudicial attitudes toward rape survivors, wherein rape-specific injuries to the self are directly and empathically addressed.
Moss, M., Frank, E., & Anderson, B. (1990).	The effects of marital status and partner support on rape trauma.	Marital status did not significantly affect psychological symptoms following the assault. For married women, lack of support by the partner-particularly when it was unexpected-was significantly related to poor psychological functioning after the rape.
Nadelson, C., Notman, M., & Zackson, H. (1982).	A follow-up study of rape victims.	One hundred and thirty women were seen in a general hospital emergency room after being raped. Forty-one of the women were interviewed 1-2 1/2 years after the rape. Half of the women continued to fear being alone and three-quarters reported still being suspicious of others. Many also felt restricted in their daily lives and had self-reported episodes of depression and sexual problems, which they attributed to the rape; none had a history of mental or emotional disturbance.
Najdowski, C. J., &	The effects of	Women who were revictimized reported

Ullman, S. E. (2011).	revictimization on coping and depression in female sexual assault victims.	more depression. This effect was explained in part by revictimized women's increased maladaptive coping.
Newcomb, M., & Carmona, J. (2004).	Adult trauma and HIV status among Latinas: Effects upon psychological adjustment and substance use.	This study tests the differential contribution of adult trauma and other life stressors to psychological adjustment and substance use among Latinas who differ in their HIV status and level of acculturation. Findings indicated that both acculturation and HIV status were related to the outcome variables, but did not influence these over time, emphasizing the developmental stability of these processes. The primary predictors of change in the outcome variables were domestic and sexual trauma were exacerbated by HIV positive status.
Nishith, H. A., Mechanic, M. B. & Resick, P. A. (2000).	Prior interpersonal trauma: The contribution to current PTSD symptoms in female rape victims.	Results from path analyses showed that a history of child sexual abuse seems to increase vulnerability for adult sexual and physical victimization and appears to contribute to current PTSD symptoms within the cumulative context of other adult trauma.
Noll, J. G., Horowitz, L. A., Bonanno, G. A., Trickett, P. K., & Putnam, F. W. (2003).	Revictimization and self-harm in females who experienced childhood sexual abuse: Results from a prospective study.	Abused participants reported twice as many subsequent rapes or sexual assaults (p = .07), 1.6 times as many physical affronts including domestic violence (p = .01), almost four times as many incidences of self-inflicted harm (p = .002), and more than 20% more subsequent, significant lifetime traumas (p = .04) than did comparison participants. Sexual revictimization was positively correlated with PTSD, peritraumatic dissociation, and sexual preoccupation. Physical revictimization was positively correlated with PTSD symptoms, pathological dissociation, and sexually permissive attitudes. Self-harm was positively correlated with both peritraumatic and pathological dissociation
Olive, V. C. (2012).	Sexual assault against women of color.	This paper approaches the issue of sexual assault against women of color from an intersectional perspective. By analyzing the current body of research on the subject, it

		argues that women of color's experience of sexual assault are fundamentally different from that of white women for multiple reasons.
Ortega, A. N., & Rosenheck, R. (2000).	Posttraumatic stress disorder among Hispanic Vietnam veterans.	The purpose of this study was to examine PTSD among Hispanics who served in the Vietnam War. After adjustment for premilitary and military experiences, the authors found that Hispanic, particularly Puerto Rican, Vietnam veterans had significantly more severe PTSD symptoms and a higher probability of experiencing PTSD than nonminority veterans. However, they had no greater risk for other mental disorders, and their greater risk for PTSD was not explained by acculturation. Despite their more severe symptoms, Hispanic veterans, especially Puerto Rican veterans, showed no greater functional impairment than non-Hispanic white veterans.
Ortega, A. N., Rosenheck, R., Alegria, M., & Desai, R. A. (2000).	Acculturation and the lifetime risk of psychiatric and substance use disorders among Hispanics.	This study examined the lifetime risk of psychiatric and substance use disorders among U.S. Hispanic subgroups and the specific role of nativity, parental nativity, language preferences, and other sociodemographic characteristics as risk factors for these disorders. When compared with non-Hispanic whites, Mexican-Americans were less likely to have any psychiatric disorder. After multivariate adjustment, acculturation items predicted greater risk of having any DSM-III-R disorders for Mexican-Americans and "other" Hispanics and greater risk of having a substance abuse disorder for Puerto Ricans, among other significant relationships.
Ouimette, P. C., Moos, R. H., & Finney, J. W. (1998).	Influence of outpatient treatment and 12-step group involvement on one-year substance abuse treatment outcomes.	This study examined whether substance abuse patients self-selecting into one of three aftercare groups (outpatient treatment only, 12-step groups only, and outpatient treatment and 12-step groups) and patients who did not participate in aftercare differed on 1-year substance use and psychosocial outcomes. Patients who participated in both outpatient treatment and 12-step groups fared the best

		on 1-year outcomes. Patients who did not obtain aftercare had the poorest outcomes. In terms of the amount of intervention received, patients who had more outpatient mental health treatment, who more frequently attended 12-step groups or were more involved in 12-step activities had better 1-year outcomes. In addition, patients who kept regular outpatient appointments over a longer time period fared better than those who did not.
Ozer, E., Best, S., Lipsey, T., & Weiss, D. (2003).	Predictors of posttraumatic stress disorder and symptoms in adults: A meta-analysis.	A review of 2,647 studies of PTSD yielded 476 potential candidates for a meta-analysis of predictors of PTSD or of its symptoms. From these, 68 studies met criteria for inclusion in a meta-analysis of 7 predictors: (a) prior trauma, (b) prior psychological adjustment, (c) family history of psychopathology, (d) perceived life threat during the trauma, (e) post-trauma social support, (f) peritraumatic emotional responses, and (g) peritraumatic dissociation. All yielded significant effect sizes, with family history, prior trauma, and prior adjustment the smallest and peritraumatic dissociation the largest. The results suggest that peritraumatic psychological processes, not prior characteristics, are the strongest predictors of PTSD.
Peterlin, B. L., Rosso, A. L., Sheftell, F. D., Libon, D. J., Mossey, J. M., & Merikangas, K. R. (2011).	Post-traumatic stress disorder, drug abuse and migraine: New findings from the national comorbidity survey replication (NCS-R).	Lifetime prevalence rates of PTSD were greater in those with EM compared to those without headache.
Pew Research Center. (2010).	Hispanics: Targets of Discrimination.	A brief report on perceptions of racism among Hispanics.
Pew Research Center: Social & Demographic Trends. (2012).	The Rise of Asian Americans.	A report on Asian Americans including economic, educational, demographic characteristics, etc.
Pew Research Center: Religion & Public Life (2014).	The Shifting Religious Identity of Latinos in the United States.	A review of the results on a nationwide survey of more than 5,000 Hispanics regarding religious identity.
Phillips-Sanders, K.,	Ethnic differences in	Latino girls received significantly higher

Moisan, P. A., Wadlington, S., Morgan, S., & English, K. (1995).	psychological functioning among Black and Latino sexually abused girls.	scores for depression than Black girls. These differences in depression appeared to be related to ethnic differences in the circumstances of the abuse. Latino girls were abused at a younger age; more likely to be abused by a relative; and more likely to have had a sibling abused. Latino were also more likely to report high levels of family conflict and somewhat lower levels of maternal support. Ethnicity was also found to be related to psychological functioning independently of the impact of other factors such as the circumstances of the abuse.
Pillay, A. L., & Schoubben-Hesk, S. (2001).	Depression, anxiety, and hopelessness in sexually abused adolescent girls.	Those 31 participants who were repeatedly abused showed higher distress than the 19 abused ones. Depression is commonly manifested by adolescents who have been sexually abused. Those participants who had been repeatedly abused showed more severe depressive symptoms, anxiety, and hopelessness than those experiencing a single-episode abused. This may reflect constant fear and threat of further attack under which the repeatedly abused child lives.
Pole, N., Best, S. R., Metzler, T., & Marmar, C. R. (2005).	Why are Hispanics at greater risk for PTSD?	The authors found that greater peritraumatic dissociation, greater wishful thinking and self-blame coping, lower social support, and greater perceived racism were important variables in explaining the elevated PTSD symptoms among Hispanics.
Resick, P. A., Calhoun, K. S., Atkeson, B. M., & Ellis, E. M. (1981).	Social adjustment in victims of sexual assault.	Victims exhibited disruption in overall social adjustment and most of the subscale roles for the first few months following the assaults. At 4 months following the rape, most of the subscales had stabilized at levels similar to the non-victims'. Work adjustment continued to be affected at 8 months.
Rich, C. L., Combs-Lane, A. M., Resnick, H. S., & Kilpatrick, D. G. (2004).	Child sexual abuse and adult sexual revictimization.	Research indicates that a range of factors are associated with an increased risk for ASA among women, including alcohol use, illicit drug use, psychological distress related to past exposure to traumatic events, sexual behavior, and impaired risk recognition. However, a history of CSA, which has been associated with these potential mediating risk

		factors, has been identified as the strongest predictor of ASA.
Roberts, A. C., Nishimoto, R. H., & Kirk, R. S. (2003).	Cocaine Abusing Women Who Report Sexual Abuse: Implications for Treatment.	In this study, four hundred seventy-three substance-abusing women were assessed for histories of sexual abuse. The results of bivariate analysis indicated that Sexual Abuse Survivors (SAS) had higher levels of depression, anxiety, and psychological distress. A greater number of SAS reported histories of emotional and physical abuse. They also had greater severity on ASI scales of alcohol, drug, medical, and family/social difficulty. Logistic regression analysis indicated that women who were survivors of sexual abuse were more likely to have histories of emotional and physical abuse, higher levels of addiction severity, and more family members who used drugs.
Rosenheck, R. A., & Fontana, A. (1994).	Utilization of mental health services by minority veterans of the Vietnam era.	This study sought to identify differences in utilization of mental health services among members of five minority groups who served in the military during the Vietnam era. Black veterans and Mexican Hispanic veterans were significantly less likely than white veterans to have used non-VA mental health services or self-help groups, after adjusting for health status and other factors. There were no differences between ethnocultural groups in use of VA mental health services, or services provided by non-psychiatrist physicians or clergy, even after adjustment was made for health and economic factors.
Ruch, L. O., & Chandler, S. M. (1983).	Sexual assault trauma during the acute phase: An exploratory model and multivariate analysis.	An exploratory model of variables affecting sexual assault trauma during the acute phase was proposed and tested, using a multivariate statistical analysis. As predicted, trauma level was affected by variables related to the attack.
Ruch, L. O., & Leon, J. J. (1983).	Sexual assault trauma and trauma change.	An exploratory model of variables affecting level of sexual trauma at given times and change in trauma levels over time was developed and tested using a sample of female rape victims admitted to a treatment center over a two-year period. Based on a one-way analysis of variance and multiple classification analysis, the findings indicate

		that a previous rape best explains trauma change, while victim's demographics, social supports, and other prior life stress variables are important at specific time period during the rape trauma syndrome.
Ruef, A. M., Litz, B. T., & Schlenger, W. E. (2000).	Hispanic ethnicity and risk for combat-related posttraumatic stress disorder.	This article first summarized the findings of the NVVRS with regard to race/ethnicity and PTSD, and then it makes a careful assessment of both the external and the internal validity of these findings. Conceptual issues were addressed and, where possible, further analyses of the NVVRS data set are conducted to identify factors that account for ethnic differences in rates of the disorder. Possible mediators of the effects of Hispanic ethnicity on vulnerability to PTSD were identified, including psychosocial factors (racial/ethnic discrimination and alienation) and sociocultural influences (stoicism and normalization of stress, alexithymia, and fatalism).
Sabina, C., Cuevas, C. A., & Schally, J. L. (2013).	The effect of immigration and acculturation on victimization among a national sample of Latino women.	This study examined the effect of immigrant status, acculturation, and the interaction of acculturation and immigrant status on self-reported victimization in the United States among Latino women, including physical assault, sexual assault, stalking, and threatened violence. In addition, immigrant status, acculturation, gender role ideology, and religious intensity were examined as predictors of the count of victimization among the victimized subsample. Immigrant women reported significantly less victimization than U.S.-born Latino women in bivariate analyses. Anglo orientation was associated with greater odds of all forms of victimization, whereas both Latino orientation and being an immigrant were associated with lower odds of all forms of victimization. Latino orientation was more protective for immigrant women than for U.S.-born Latino women with regard to sexual victimization. Among the victimized subsample, being an immigrant, Anglo acculturation, and masculine gender role were associated with a higher victimization

		count, whereas Latino orientation and religious intensity were associated with a lower victimization count.
Saladin, M. E., Drobes, D. J., Coffey, S. F., Dansky, B. S., Brady, K. T., & Kilpatrick, D. G. (2003).	PTSD symptom severity as a predictor of cue-elicited drug craving in victims of violent crime.	This study examined PTSD symptom severity as a predictor of cue-elicited craving among alcohol- and cocaine-dependent individuals with a history of at least one physical and/or sexual assault. Results indicated a high degree of correlation between self-report craving and (a) PTSD symptom severity, (b) type of substance use disorder (SUD) [alcohol dependence (AD) vs. cocaine dependence (CD)], and (c) sex and race of participant. A series of stepwise multiple regressions indicated that PTSD severity was significantly predictive of trauma cue-elicited craving and drug cue-elicited craving.
Santello, M. D., & Leitenberg, H. (1993).	Sexual aggression by an acquaintance: Methods of coping and later psychological adjustment.	Two years on average after the assault, these women reported more psychological problems on the Brief Symptom Inventory (Derogatis & Spencer, 1982) than a comparison group who had not been assaulted since age 16. Respondents who had survived sexual aggression were asked to indicate on the Coping Strategies Inventory the methods they had used to cope with this experience and the methods they had used to cope with a separate nonsexual stressful event, which also had occurred since age 16. Multiple regression analyses indicated that disengagement methods of coping with sexual aggression per se accounted for unique variance in general psychological distress as measured by the Global Severity Index of the Brief Symptom Inventory and in posttraumatic stress disorder symptoms as measured by a DSM-III-R derived checklist.
Santiago, J. M., McCall-Perez, F., Gorcey, M., & Beigel, A. (1985)	Long-term psychological effects of rape in 35 rape victims.	Rape victims were found to be significantly more depressed, generally anxious, and fearful than control subjects. Only one rape situation variable, the survivor having been a prior victim of sexual assault, was found to be related to a higher degree of depression and anxiety.
Santos-Iglesias, P., &	Sexual victimization	Results showed that 30.4% of them engaged

Sierra, J. C. (2012).	among Spanish college women and risk factors for sexual revictimization.	in undesired sexual contact while almost 4% were victims of rape. The most frequent perpetrators were partners or ex-partners, acquaintances, or dating partners, but not strangers. Finally, the relationship between child sexual abuse and adolescent and adult sexual victimization was mediated by number of consensual sexual partners and sexual assertiveness.
Schechter, D. S., Marshall, R., Salman, E., Goetz, D., Davies, S., & Liebowitz, M. R. (2000).	Ataque de nervios and history of childhood trauma.	Psychiatric diagnoses, history of ataque, and childhood trauma in treatment-seeking Hispanic outpatients (n = 70) was assessed. Significantly more subjects with an anxiety or affective disorder plus ataque reported a history of physical abuse, sexual abuse, and/or or a substance-abusing caretaker than those with psychiatric disorder but no ataque.
Schnitt, J. M., & Nocks, J. J. (1984).	Alcoholism treatment of Vietnam veterans with post-traumatic stress disorder.	Vietnam veterans with alcoholism and PTSD are a clinically problematic population. Early self-medication of the PTSD with alcohol led for some to alcohol abuse and dependency. These may often be treated in an intensive alcoholism program. At evaluation both diagnoses are made, and patients are told that alcohol or drug use is not tolerated. The program first focuses on traditional alcoholism treatment issues. Early and constant support to enhance self-esteem and to reduce guilt helps the patient later to tolerate the gradual investigation of the anger and self-loathing associated with both disorders. Important forces include family and peer support, effective limit setting in a structured milieu, supportive confrontation of alcoholic denial through multidisciplinary treatment in the absence of alcohol. Outpatient follow-up treatment groups include other PTSD sufferers and focus on establishing trust, interweaving the issues of adjustment to sobriety with discussion of the combat experience in a safe, accepting environment, with careful modulation of anxiety by the clinician. Medication must be conservative; benzodiazepines are not used after the detoxification period.

Sciolla, A., Glover, D. A., Loeb, T. B., Zhang, M., Myers, H. F., & Wyatt, G. E. (2011).	Childhood sexual abuse severity and disclosure as predictors of depression among adult African-American and Latina women.	This study examined the peritrauma variable of abuse severity and the post-trauma variables of disclosure and self-blame as predictors of current depression symptoms in 94 low-income African American and Latina women with histories of CSA. After controlling for non-sexual childhood adversity and adult burden (i.e., chronic stress), severe CSA overall was associated with higher depression scores, especially among Latinas who disclosed their abuse. Depression symptoms among African American women were highest in those who disclosed and reported high levels of self-blame at the time of the incident.
Scott, C. S., Lefley, H. P., & Hicks, D. (1993).	Potential risk factors for rape in three ethnic groups.	This article describes the frequency of possible risk factors that emerged during a cross-cultural study of psychosocial response to sexual assault among African-American, Hispanic, and non-Hispanic white women presenting for treatment at a major urban rape treatment center. Of 881 victims screened, 51% had no observable risk factors while 49% fell into categories of variables that previous research has associated with increased vulnerability. Included were mental disability (psychiatric or developmental), a prior history of rape or incest, tourist or visitor status (site unfamiliarity), and homelessness. Ethnic groups differed significantly in these categories, suggesting socioeconomic and cultural variables that may affect rape statistics and that should be taken into account in rape prevention programs in the community.
Shalev, A. Y., & Sahar, T. (1998).	Neurobiology of the posttraumtic stress disorder.	Provides an overview of the research and theory of neurobiological unpinning of posttraumatic stress disorder.
Shim, R. S., Compon, M. T., Rust, G., Druss, B. G., & Kaslow, N. J. (2009).	Race-ethnicity as a predictor of attitudes toward mental health treatment seeking.	African-American race-ethnicity was a significant independent predictor of greater reported willingness to seek treatment and lesser reported embarrassment if others found out about being in treatment. Latino race-ethnicity was also associated with an increased likelihood of willingness to seek

		professional help and lesser embarrassment if others found out, but these differences did not persist after adjustment for the effects of socioeconomic variables.
Smith, S. G., & Breiding, M. J. (2011).	Chronic disease and health behaviors linked to experiences of nonconsensual sex among women and men.	The current study examined this relationship as part of a large public health survey that collected information on a range of health behaviors and health risks. Among both women and men, previous non-consensual sex was associated with health conditions such as high cholesterol, stroke and heart disease, and risk behaviors such as human immunodeficiency virus risk factors, smoking and excessive drinking. Sexually victimized women were more likely to report having had a heart attack or heart disease than non-victims.
Snowden, L. R., & Cheung, F. K. (1990).	Use of inpatient mental health services by members of ethnic minority groups.	This study examined national data on psychiatric hospitalization, which points to marked ethnic-related differences. Blacks and Native Americans were considerably more likely than Whites to be hospitalized; Blacks were more likely than Whites to be admitted as schizophrenic and less likely to be diagnosed as having an affective disorder; Asian Americans/Pacific Islanders are less likely than Whites to be admitted, but remain for a lengthier stay, at least in state and county mental hospitals.
Spaccarelli, S., & Fusch, C. (1997).	Variability in symptom expression among sexually abused girls: Developing multivariate models.	This study examined which of several apparent risk variables were predictors of internalizing and externalizing problems in 48 girls who were referred for therapy after disclosing sexual abuse. As hypothesized, results indicated that internalizing and externalizing problems were associated with different sets of predictor variables. Victims' self-reports of depression and anxiety were related to lower perceived support from nonoffending parents, more use of cognitive avoidance coping, and more negative appraisals of the abuse.
Stewart, S. H., & Israeli, A. L. (2002).	Substance abuse and co-occurring psychiatric disorders in victims	The authors first examine the mental health correlates of exposure to familial childhood physical and sexual abuse, including both psychiatric disorders and substance-related

	of intimate violence.	disorders. Included are studies with adults using long-term retrospective methodologies, studies with adolescents conducted closer in time to the childhood violence exposure, and a few prospective, longitudinal studies. Studies concerning the mental health correlates of partner-to-partner violence ("spousal battery"), including both psychiatric and chemical use disorders, are reviewed next. The authors explore specific mechanisms that may explain the higher rates of both certain psychiatric disorders and of substance-related disorders among victims of domestic violence, and review evidence regarding comorbidity and potential function relations. Finally, a methodological critique of studies is provided and suggestions are proposed for future research.
Sue, D. W., & Sue, D. (1987).	Asian Americans and Pacific Islanders.	This is a chapter in a comprehensive review of conceptual frameworks for counseling and therapy in cross-cultural problems, which is specific to Asian American and Pacific Islanders.
Temple, J. R., Weston, R., Rodriguez, B. F., & Marshall, L. L. (2007).	Differing effects of partner and nonpartner sexual assault on women's mental health.	This study contrasted the effects of intimate partner and non-partner sexual assault on women's mental health among a sample (n = 835) of low-income, ethnically diverse community women. Compared to sexual assault by a previous partner or by a non-intimate partner, sexual assault by a current partner was the strongest predictor of PTSD, stress, and dissociation. Non-intimate partner sexual assault was only a significant predictor of PTSD and only for African American women. These findings suggest that the victim-offender relationship is important when considering the impact of sexual assault. Specifically, sexual assault perpetrated by an intimate partner may be especially traumatic.
Thoits, P. A. (1986).	Social support as coping assistance.	It is useful to reconceptualize social support as coping assistance. If the same coping strategies used by individuals in response to stress are those that are applied to distressed persons as assistance, models of coping and support can be

		integrated. To illustrate the utility of such an integration, coping strategies and support strategies are derived from a more general theory of stress-buffering processes in this article. A variety of supportive strategies not previously identified by researchers are derived. Further, predictions regarding efficacious and non-efficacious types of support are made, and empathic understanding (based on sociocultural and situational similarities between a distressed person and a helper) is identified as a crucial condition for coping assistance to be sought, accepted, and found effective.
Thompson, N., & Gurney, A. (2003).	''He is everything'': Religion's role in the lives of immigrant youth. New directions for youth development: Understanding the social worlds of immigrant youth.	Using emergent theme analysis of qualitative interview data in combination with quantitative survey data, the role of religion in the lives of immigrant youth was explored. Latino, Haitian, and Chinese teenagers described, in their own rich words, the significance of religion to them; their responses are reflected in themes that point to the potential protective role of religion for some immigrant groups
Tjaden, P., & Thoennes, N. (1998).	Prevalence, incidence, and consequences of violence against women: Findings from the National Violence Against Women Survey.	Results of a nationally representative telephone survey of 8,000 women and 8,000 men about their experiences with rape, physical assault, and stalking cosponsored by the National Institute of Justice and the Centers for Disease Control and Prevention and conducted by the Center for Policy Research are reviewed.
Turner, H. A., & Muller, P. A. (2004).	Long-term effects of child corporal punishment on depressive symptoms in young adults: Potential moderators and mediators.	Approximately 40% of the sample reported experiencing some level of corporal punishment when they were 13 years old. Findings may be related to depressive symptoms, independent of any history of abuse and the frequency of other forms of punishment.
Ulibarri, M. D., Strathdee, S. A., Lozada, R., Magis-Rodriguez, C., Amaro, H., O'Campo, P., & Patterson, T. L.	Intimate partner violence among female sex workers in two Mexico–U.S. border cities: Partner characteristics and	The prevalence and correlates of IPV among female sex workers (FSWs) in Tijuana and Ciudad Juarez, two large Mexico-U.S. border cities where HIV prevalence is rising were examined. Using multivariate logistic regression, factors independently associated

(2010).	HIV risk behaviors as correlates of abuse.	with IPV included having experienced abuse as a child, a partner who had sex with someone else, and lower sexual relationship power. Findings suggest the need for previous abuse screening and violence prevention services for FSWs in the Mexico-U.S. border region. Careful consideration of relationship dynamics such as infidelity and relationship power is warranted when assessing for IPV risk.
Ulibarri, M. D., Ulloa, E. C., & Salazar, M. (2015).	Associations between mental health, substance use, and sexual abuse experiences among Latinas.	This study examined self-reported sexually abusive experiences in childhood and adulthood as correlates of current drug use, alcohol abuse, and depression and PTSD symptoms. Results indicated significant relationships between history of sexual abuse (regardless of age of occurrence), depression symptoms, PTSD symptoms, alcohol abuse, and drug use. When examined separately, childhood sexual abuse was associated with symptoms of depression, PTSD, and substance use but not alcohol abuse behaviors. Experiencing sexual abuse in adulthood was associated with symptoms of depression, alcohol abuse behaviors, and substance use but not PTSD symptoms. Structural equation modeling showed that substance use partially mediated the relationship between sexual abuse and mental health outcomes. These findings suggest mental health and substance use services should incorporate treatment for trauma, which may be the root of comorbid mental health and substance use issues.
Ullman, S. E. (1996a).	Correlates and consequences of adult sexual assault disclosure.	Delayed disclosure was associated with childhood sexual assault history, completed rape, and avoidance coping, whereas early disclosure was associated with offender pre-assault alcohol use and post-assault medical attention. Negative social reactions were more common among women who used avoidance coping and victims who told physicians or police about their assaults. Positive social reactions were associated with higher income, less physical injury due to the assault, less self-blame, less post-

		assault distress, and saying that a friend/relative or a rape crisis center was helpful regarding the assault.
Ullman, S. E. (1996b)	Do social reactions to sexual assault victims vary by support provider?	Tangible aid/information support was reported more often from women disclosing to rape crisis centers, police, and physicians, whereas emotional support/validation was commonly reported by those telling rape crisis centers. Being blamed, treated differently, distracted, and discouraged from talking about the assault were more common responses for women telling physicians or police. Analyses exploring whether the impact of social reactions on victim adjustment varied according to support provider type showed that, as hypothesized, emotional support from friends was related to better recovery than emotional support from other support sources. However, contrary to expectation, the impact of victim blame on adjustment did not vary according to type of support provider.
Ullman, S. E. (2000).	Psychometric Characteristics of the Social Reactions Questionnaire.	This study provides empirical support for the reliability and validity of a new self-report measure of social reactions to rape victims, the Social Reactions Questionnaire, which goes beyond past work in providing evidence for a valid and reliable instrument that assesses positive and negative reactions to sexual assault victims received from a variety of formal and informal support providers. Emotional support/belief was unrelated to most assault characteristics, but tangible aid was more common for victims of stereotypical rapes (e.g. stranger rapes with injury disclosed soon after assault). On the other hand, most negative reactions were more common for victims of alcohol-related assaults, whereas only certain negative reactions (e.g., being treated differently, having others take control, being blamed) characterized victims of stranger rapes, completed rapes, and those disclosing sooner. More negative reactions to victims of stereotypical assaults may in part reflect their

		greater disclosure to formal support providers (e.g. police, physicians) who typically respond more negatively to victims (see Ullman, 1999, for a review). This disturbing finding of more negative reactions to victims of more severe sexual assault confirms earlier research (Ullman & Siegel, 1995) showing more serious assaults were associated with more negative reactions and with more disclosure to police and physicians, both sources that are generally rates as less helpful by victims (Golding, Siegel, Sorenson, Burnam, & Stein, 1989). Positive social reactions were related to more social support and better psychological functioning (e.g. self-esteem, support satisfaction), whereas negative reactions were related to greater PPTSD symptom severity and poorer psychological functioning. In general, the more persons told, the more positive and negative social reactions respondents report receiving, although negative reactions more strongly predict poorer psychological symptomatology, whereas positive reactions show small positive or nonsignificant effects on adjustment in past research (Davis et al., 1991; Ullman, 1996a, 1999). This pattern was clearly replicated in this study. Although positive social reactions were related to higher self-esteem, they were not related to significantly less PTSD symptom severity. These results are consistent with past research showing small or nonsignificnt effects of positive social reactions on psychological symptoms (Davis et al., 1991, Ullman, 1996a). Conversely most negative social reactions were associated with less self-esteem and more PTSD symptom severity, consistent with past evidence showing strong negative effects of negative social reactions were associated with less self-esteem and more PTSD symptom severity, consistent with past evidence showing strong negative effects of negative social reactions on psychological symptoms

		(Davis et al., 1991; Ullman, 1996a). Current social integration and social support are related to social reactions one receives when disclosing sexual assault (see Sales, Baum, & Shore, 1984). For instance frequency of social contact was unrelated to two of the negative social reactions received when disclosing assault and related to more positive social reactions. This suggests that the size and perceived supportiveness of one's current social network are related to social reactions received at the time of the sexual assault disclosure. Golding et al. (1998) suggested that sexual assault may lead to subsequent decrements in the quality and quantity of social support networks and these results support that contention, even though causality cannot be determined because current support network measures were assessed at the time of the survey, after the assaults occurred. Received support, assessed as current number of helpful acts received from others, was related to receiving more positive social reactions on assault disclosure.
Ullman, S. E. (2003).	A critical review of field studies on the link of alcohol and adult sexual assault in women.	First, evidence is reviewed to evaluate whether there is a distal relationship between alcohol and risk of sexual assault victimization. Specifically, studies are examined to determine whether drinking may affect the risk of being victimized and how victimization may contribute to subsequent drinking. Second, evidence for a proximal role of drinking prior to a sexual assault victimization incident (by either victim and/or offender) is examined to determine alcohol's role in rape and injury outcomes to victims. Critical theoretical and methodological issues in these two types of studies are discussed with regard to the extant literature. Paralleling the two areas of research reviewed, two theoretical models are proposed to guide future research on (1) the global associations of drinking and sexual assault risk across the life span (macro level model) and (2) the role of

		drinking in the outcomes of actual sexual assault incidents (micro level model). Suggestions are made for future research and intervention in this area.
Ullman, S. E. (2007).	A 10-year update on "review and critique of empirical studies of rape avoidance."	Fighting, feeling and screaming/yelling are all associated with decreased odds of completed rape. Researchers have identified different types of rapists that differ according to various psychological and behavioral characteristics.
Ullman, S. E., & Brecklin, L. R. (2002).	Sexual assault history, PTSD, and mental health service seeking in a national sample of women.	Factors related to correlates of PTSD and mental health service seeking varied according to sexual assault history. Ethnic minority women with less formal education, more traumatic and stressful life events, and longer duration of sexual abuse had greater odds of PTSD within certain sexual assault history subgroups. Mental health service seeking was predicted by demographics (e.g., more education, Caucasian race), as well as other psychosocial factors (e.g., life events, social support), and medical insurance status, especially for adult sexual assault victims.
Ullman, S. E., & Brecklin, L. R. (2003).	Sexual assault history and health-related outcomes in a national sample of women	This study examined correlates of past-year chronic medical conditions and lifetime contact with health care professionals for mental health and substance abuse problems in women with differing histories of sexual victimization (*n* = 627) identified from the National Comorbidity Survey (e.g., assault in childhood, adulthood, or both life phases). PTSD and stressful life events were associated with greater odds of chronic medical conditions among women sexually assaulted in childhood only. Additional traumatic events were associated with greater odds of chronic medical conditions among victims of adult sexual assault. Older age and being married were associated with greater odds of lifetime health care professional contact for mental health/substance abuse issues among certain victim subgroups. Stressful life events were related to greater help-seeking for child victims, and traumatic events were related to greater help-seeking in adult victims. Alcohol dependence

		symptoms and PTSD were each associated with greater odds of lifetime health care professional contact among women victimized in both life phases, whereas depression was related to greater odds of help-seeking for women victimized in one life phase only. Psychosocial factors may play unique roles in health outcomes for women with different sexual assault histories.
Ullman, S. E., & Filipas, H. H. (2001).	Predictors of PTSD symptom severity and social reactions in sexual assault victims.	Less education, greater perceived life threat, and receipt of more negative social reactions upon disclosing assault were each related to greater PTSD symptom severity. Ethnic minority victims reported more negative social reactions from others. Victims of more severe sexual victimization reported fewer positive, but more negative reactions from others. Greater extent of disclosure of the assault was related to more positive and fewer negative social reactions. Telling more persons about the assault was related to more negative and positive reactions.
Ullman, S. E., & Filipas, H. H. (2005).	Ethnicity and child sexual abuse experiences of female college students.	This research examines the understudied issue of race/ethnicity in relation to CSA in a cross-sectional convenience sample of 461 female college students completing a survey. Comparisons of students' abuse experiences revealed ethnic differences in sexual abuse prevalence, severity of abuse, the victim-offender relationship and post-abuse coping. Black students reported more sexual abuse than other ethnic groups, followed by Hispanics, Whites, and Asians. Although timing and extent of disclosure of sexual abuse did not vary by ethnicity, negative social reactions to disclosure were more common for certain ethnic groups than others. No ethnic differences emerged for

		depressive or PTSD symptoms.
Ullman, S. E., Filipas, H. H., Townsend, S. M., & Starzynski, L. L. (2005).	Trauma exposure, posttraumatic stress disorder and problem drinking in sexual assault survivors.	This study examined how trauma histories, alcohol-related cognitive mediators and PTSD relate to past-year problem drinking in adult female sexual assault survivors. These analyses suggested that trauma exposure, drinking to cope with distress and tension-reduction expectancies are the most consistent factors associated with problem drinking, whereas PTSD symptoms are not. Drinking to cope and tension-reduction expectancies were both related to greater PTSD symptoms, consistent with self-medication theory.
Ullman S. E., Najdowski C. J., Filipas H. H. (2009).	Child sexual abuse, post-traumatic stress disorder, and substance use: Predictors of revictimization in adult sexual assault survivors.	Child sexual abuse predicted more post-traumatic stress disorder symptoms in adult sexual assault victims. Posttraumatic stress disorder numbing symptoms directly predicted revictimization, whereas other post-traumatic stress disorder symptoms (re-experiencing, avoidance, and arousal) were related to problem drinking, which in turn predicted revictimization. Thus, numbing symptoms and problem drinking may be independent risk factors for sexual revictimization in adult sexual assault victims, particularly for women with a history of childhood sexual abuse.
Ullman, S. E., Relyea, M., Peter-Hagene, L., & Vasquez, A. L. (2013).	Trauma histories, substance use coping, PTSD, and problem substance use among sexual assault victims.	This study examined how various types of trauma, substance use coping, and PTSD relate to past-year problem drinking and drug use in women who experienced sexual assault. Results show that PTSD symptoms fully mediated the association between non-interpersonal trauma and the use of substances to cope. However, the association between both interpersonal trauma and child sexual abuse severity on substance use to cope was only partially mediated by PTSD symptoms. In turn, use of substances to cope fully mediated the relationship between PTSD and problem drug use as well as partially mediated the effect of PTSD on problem drinking. These results suggest that different trauma types and substance use coping may be important risk factors

		distinguishing sexually assaulted women who develop PTSD and problematic substance use from those who do not. Identifying women's histories of different traumas may help to identify those at greater risk for substance use problems.
Ullman, S. E., & Siegel, J. M. (1995).	Sexual assault, social reactions, and physical health.	This study examined the role of post-assault social reactions in the association between sexual assault and physical health in a convenience sample of 155 women completing a mail survey. Regression analysis showed that tangible aid/information support and depressive symptoms were each related to poorer perceived health, whereas other positive social reactions (e.g., emotional support/validation) were related to better health perceptions. More severe (e.g., physically violent) assaults were associated with poorer current perceptions of one's physical health. Negative social reactions (e.g., distraction/discourage talking) mediated this association, suggesting that the link between assault severity and poorer health may be due to increased negative social reactions to victims of these assaults.
Ullman, S. E., Townsend, S. M., Filipas, H. H., & Starzynski, L. L. (2007)	Structural models of the relations of assault severity, social support, avoidance coping, self-blame, and PTSD among sexual assault survivors.	The results suggest that negative social reactions and avoidance coping are the strongest correlates of PTSD symptoms and that the association typically observed between victim self-blame and PTSD symptoms may be partially due to the effect of negative social reactions from others. These reactions may contribute to both self-blame and PTSD.
Urquiza, A. J., & Goodlin-Jones, B. L (1994)	Child sexual abuse and adult revictimization with women of color.	Significant differences (i.e., higher rates of rape associated with a prior history of child sexual abuse) were found for white women, African-American women, and Latinas, but not for Asian-American women.
United States Census Bureau (1997).	Results of the 1996 race and ethnic targeted test.	This paper reports the results of 1996 census report on race and ethnicity.
U.S. Department of Justice, Office of Justice Programs,	Nature, and Consequences of Intimate Partner	This report presents findings from the National Violence Against Women (NVAW) Survey on the extent, nature, and

National Institute of Justice. (2000).	Violence: Findings From the National Violence Against Women Survey.	consequences of intimate partner violence in the United States.
Valentiner, D. P., Riggs, D., Foa, E. B., & Gershuny, B. S. (1996).	Coping strategies and PTSD in female victims of sexual assault and nonsexual assault.	Post-trauma symptom severity significantly decreased during the 3-month study period, but PTSD severity levels at Times 1 and 2 were highly correlated. Three coping scales were constructed on the basis of exploratory factor analyses: Mobilizing Support, Positive Distancing, and Wishful Thinking. Three months post-assault, rape victims showed higher levels of wishful thinking and PTSD than nonsexual assault victims. Wishful thinking showed a positive association and positive distancing a negative association with PTSD severity, controlling for assault type, initial levels of PTSD severity, and other coping strategies.
Vera, M., Alegria, M., Pattatucci-Aragon, A. M., & Peña, M. (2005).	Childhood sexual abuse and drug use among low-income urban Puerto Rican women.	This study examines the relationship between childhood sexual abuse and adult drug use among low-income urban Puerto Rican women. Results demonstrate a strong association between childhood sexual abuse and adult drug use. The impact of childhood sexual abuse was greater for women reporting greater abuse severity, abuse by a family member, and increased abuse duration. Findings support a direct effects model of childhood sexual abuse on adult drug use. The increased rates of drug use among victims of childhood sexual abuse did not appear to be mediated by other childhood maltreatment or family background factors.
Warner, L. A., Alegria, M., & Canino, G. (2012).	Childhood maltreatment among Hispanic women in the United States: An examination of subgroup differences and impact on psychiatric disorder.	Prevalence rates of childhood maltreatment among Hispanic women in the United States are presented separately for nativity status and ethnic origin subgroups, and the associations between different types of maltreatment and the development of anxiety and depressive disorders are examined. Foreign-born Hispanic women compared to U.S.-born Hispanic women reported significantly lower rates of sexual assault and witnessing interpersonal violence, and a significantly higher rate of being beaten.

		Ethnic subgroups reported similar rates of maltreatment, with the exception of rape. Bivariate analyses were remarkably consistent in that regardless of nativity status or ethnic subgroup, each type of maltreatment experience increased the risk of psychiatric disorder. In multivariate models controlling for all types of victimization and proxies of acculturation, having been beaten and witnessing interpersonal violence remained significant predictors of both disorders, but sexual abuse increased risk of anxiety only. A significant interaction effect of family cultural conflict and witnessing violence on anxiety provided very limited support for the hypothesis that acculturation moderates the influence of maltreatment on mental health outcomes.
Walsh, K., Resnick, H. S., Danielson, C. K., McCauley, J. L., Saunders, B. E., & Kilpatrick, D. G. (2014).	Patterns of drug and alcohol use associated with lifetime sexual revictimization and current posttraumatic stress disorder among three national samples of adolescent, college, and household-residing women.	Revictimized adolescents and household-residing women reported more other illicit and non-medical prescription drug use; revictimized college women reported more other illicit drug use. Past 6-month PTSD was associated with increased odds of drug use for adolescents, non-medical prescription drug use for college women, and all substance use for household-residing women. Revictimization and PTSD were associated with more deviant substance use patterns across samples, which may reflect self-medication with substances. Findings also could be a function of high-risk environment or common underlying mechanisms.
Weller, S., Baer, R., de Alba Garcia, J., & Rocha, A. (2008).	Susto and nervios: Expressions for stress and depression.	This study explored the relationship between the Latin American folk illnesses susto and nervios and mental health. Susto was significantly associated with stress and depressive symptoms, but nervios had a much stronger association, even after controlling for gender.
West, C. M., Kaufman Kantor, G., & Jasinski, J. L. (1998).	Sociodemographic predictors and cultural barriers to help-seeking behavior by Latina	Data from a national survey were used to investigate the help-seeking efforts of Latinas (Mexican, Mexican American, Puerto Rican) and Anglo American women who experienced battering by intimate

	and Anglo American battered women.	partners. The findings revealed that battered Latinas were significantly younger, less educated, and more impoverished than Anglo women. Additionally, Latinas more often categorized their marriages as male dominated and their husbands as heavy drinkers. Bivariate analyses showed that Latinas who sought help were significantly more acculturated and more likely to have a heavy drinking husband than those who did not seek help. Although battered women were active help seekers, Latinas underutilized both informal and formal resources relative to Anglo women, with Mexican women least likely to seek assistance. When sociodemographic predictors of help seeking were analyzed, being youthful and Anglo significantly increased the odds of help-seeking efforts. Low acculturation, as measured by preference for the Spanish language, was the only significant cultural barrier to help seeking by Latinas.
Wilsnack, S. C., Wilsnack, R. W., Kristjanson, A. F., Vogeltanz-Holm, N. D., & Harris, T. R. (2004).	Child sexual abuse and alcohol use among women: Setting the stage for risky sexual behavior.	CSA has been associated with increased risk for a variety of negative sexual and reproductive health outcomes, among them high-risk sexual behavior and its sequelae. Although many studies show that CSA is associated with risky sexual behavior in adulthood, it is still unclear how CSA is connected with risky sex. Various biological, psychological, and social processes have been identified that may lead from CSA to unsafe sexual behavior. The hypothetical process discussed in this chapter is that the experience of CSA may lead women to use alcohol in ways that make them more likely to engage in risky sexual behavior or that make them more vulnerable to the imposition of risky sex. This chapter focuses on women because (1) the large majority of research on CSA has included only female participants and (2) the national survey whose data are used to evaluate connections among CSA, alcohol use, and sex later in this chapter sampled only women.

Wilson, A. E., Calhoun, K. S., & Bernat, J. A. (1999).	Risk recognition and trauma related symptoms among sexually revictimized women.	Results supported the hypothesis that revictimized women would exhibit longer latencies than either single-incident victims or non-victims in signaling that an audiotaped date rape should be halted. Revictimized women with greater PTSD symptoms, arousal symptoms in particular, exhibited latencies similar to those of non-victims, whereas revictimized women with lower levels of PTSD symptoms had significantly longer latencies. Dissociative symptoms were not related to latency. These findings suggest that PTSD-related arousal symptoms may serve a buffering effect, increasing sensitivity to threat cues that portend a sexually coercive interaction.
Wilson, L. C., & Scarpa, A. (2013).	Childhood abuse, perceived social support, and posttraumatic stress symptoms: A moderation model.	The findings suggest that perceived social support can be either a protective or risk factor when predicting posttraumatic stress symptoms depending on the type of abuse and social support. Greater perceived family and friend support appears to be a protective factor against the development of posttraumatic stress symptoms only in physical abuse survivors, and not in sexual abuse survivors. Conversely, perceived significant other support is a risk factor in sexual abuse survivors, whereas it is not related to posttraumatic stress symptoms in physical abuse survivors. The current study has important implications for understanding the complex picture of child abuse outcomes and explanations for the findings are provided.
Xu, Y., Sun, J., Zhang, J., & Xu, Z. (2001).	Health-seeking behaviors and barriers to health care of Southeast Asian immigrants: Implications for the home health nurse.	This article provides an emic view of the health-seeking behaviors and barriers to health care of Southeast Asian immigrants. In addition, in light of the changing demographics of the U.S. population reflected in Census 2000 and the recently released national standards for culturally and linguistically appropriate services, the article also discusses the challenges and implications of implementing the national standards to reduce and eventually eliminate

		racial and ethnic disparities in health care.
Xu, X., Campbell, J., & Zhu, F. (2001).	Health-seeking behaviors and barriers to health care of Southeast Asian immigrants: Implications for the home health nurse.	This article provides an emic view of the health-seeking behaviors and barriers to health care of Southeast Asian immigrants.
Yeh, C. J. (2003).	Age, acculturation, cultural adjustment, and mental health symptoms of Chinese, Korean, and Japanese immigrant youth.	This study of Chinese, Japanese, and Korean immigrant junior high and high school students (*n* = 319; aged 12-18 years) investigated the association between age, acculturation, cultural adjustment difficulties, and general mental health concerns. Hierarchical regression analyses determined that among all of the independent variables, age, acculturation, and cultural adjustment difficulties had significant predictive effects on mental health symptoms. Implications for theory, research, and practice are addressed, particularly as they relate to developmental issues among immigrant youths.
Zhang, A.Y., Snowden, L.R., & Sue, S. (1998).	Differences between Asian and White Americans' help seeking and utilization patterns in the Los Angeles area.	This study examines help seeking and utilization patterns of 161 Asian or Pacific Islander Americans and 1332 White Americans randomly selected in the Los Angeles area. Results show that Asian Americans are more reticent than White Americans about mental distress regardless of whether they speak with professionals or family and friends, and that they are unwilling to use mental health services of any type.