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Effects of the protective factor of religiosity and risk factor of marijuana use on psychological outcomes among racially diverse female survivors of sexual victimization

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EFFECTS OF THE PROTECTIVE FACTOR OF RELIGIOSITY AND RISK FACTOR OF MARIJUANA USE ON PSYCHOLOGICAL OUTCOMES AMONG RACIALLY DIVERSE FEMALE SURVIVORS OF SEXUAL VICTIMIZATION

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DEDICATION

I would like to dedicate this manuscript to the many women in my life who have inspired me through the years, namely my Mother, Nana, and Aunties. I would also like to dedicate this dissertation to the countless survivors of sexual violence, whose voices and stories are too often silenced. May all of you continue to rise, and overcome.

As the late poet, Maya Angelou wrote, "Just like moons and like suns with the certainty of tides, just like hopes springing high, still I'll rise."

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ABSTRACT

The current study examines the utilization of religiosity as a protective factor and marijuana use as a risk factor for ethnically diverse female survivors of sexual victimization against the development of Posttraumatic Stress Disorder (PTSD), Major Depressive Disorder (MDD), Irritable Depression (ID), and sexual revictimization. A sample of ethnically diverse female adult participants who endorsed sexual victimization from the National Comorbidity Survey Replication (NCS-R) were included in the study (n = 1115). Logistic regression analyses were used determine the probability of the predictor variables of religiosity, religious identification and marijuana use impacting the outcome variables and whether or not the moderating variable (i.e., ethnicity) changed the relationship between the predictor and outcome variables. Results suggest that individuals who endorsed higher rates of PTSD were more likely to identify with a religious organization, with Latinas experiencing significantly higher rates of PTSD as compared to the other groups. Sexual assault victims who met criteria for Marijuana Abuse or Dependence were significantly more likely to have experienced MDD than sexual assault victims who did not meet criteria. The study highlights the importance of understanding religious coping strategies utilized by ethnically diverse survivors of sexual victimization. This study also highlights implications for providing culturally congruent care. Limitations and implications are discussed.

Keywords: sexual abuse, sexual assault, rape, religiosity, marijuana abuse, race, ethnicity, major depressive disorder, irritable depression, posttraumatic stress disorder, revictimization

Introduction

Background Literature ad Current Status of Theory and Research

Sexual victimization. Sexual victimization and revictimization of women, across ethnic lines, 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 current study defines the term, "sexual victimization" broadly to include individuals who have experienced any type of sexual violence. Sexual victimization captures the 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). Based on existing literature, female survivors of sexual victimization often experience an array of mental health challenges (Bryant-Davis et al., 2010). The present study will review literature on the following adverse mental health outcomes: MDD, ID, PTSD, and revictimization and its associations with survivors of sexual victimization.

Major depressive disorder. Research suggests that MDD is a significant psychological consequence of sexual victimization (Pillay & Schoubben-Hesk, 2001). 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). Some evidence supports the idea that depressive symptoms may be caused by sexual victimization (Becker, Skinner, Abel, Axelrod, & Treacy, 1984; Burgess, 1983; Burgess & Holmstrom, 1978; Ellis, 1983; Ellis, Atkeson, & Calhoun, 1981; 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 (Najdowski & Ullman, 2011; Pillay & Schoubben-Hesk, 2001). There is inconsistency in which ethnic groups endorse greater depressive symptoms; some studies show African Americans survivors exhibit greater depressive symptomatology (Axelrod, Myers, Durvasula, Wyatt, & Cheng, 1999), versus others showing Latina survivors as presenting more depressed (Phillips-Sanders, Moisan, Wadlington, Morgan, & English, 1995*).* Other studies have not found racial/ethnic differences in post assault depression (Elliot, Mok, & Briere, 2004; Frank & Stewart, 1984; McFarlane et al., 2005; Wyatt, 1992).

Irritable depression. Cultural views of depression and different levels of acceptability of the expression of sadness may lead to different symptom presentations across ethnic 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).

Posttraumatic stress disorder. Both child sexual abuse (CSA) and adult sexual assault (ASA) are related to PTSD (Briere & Runtz, 1987), and researchers have also found a strong relationship between PTSD and sexual revictimization (Arata, 2000; Bolstad & Zinbarg, 1997; Boney-McCoy & Finkelhor, 1995; Ullman & Brecklin, 2002). The general finding appears to be that women who are revictimized suffer more PTSD symptoms (Arata, 1999a, 1999b; Banyard,

Williams, & Siegel, 2001; Gibson & Leitenberg, 2001; Koverola, Proulx, Battle, & Hanna, 1996). In fact, two longitudinal studies have identified PTSD as a risk factor for sexual victimization. Acierno, Resnick, Kilpatrick, Saunders, and Best (1999) found that a diagnosis of PTSD increased women's risk for ASA, while Noll, Horowitz, Bonanno, Trickett, and Putnam (2003) found that PTSD symptoms mediated the relationship between CSA and subsequent revictimization. For example, Wilson, Calhoun, and Bernat (1999) found that arousal, but not re-experiencing or avoidance symptoms, increased the ability of sexually revictimized women to recognize risk in a scenario depicting date rape. Furthermore, numbing symptoms were associated with less risk recognition. Thus, a PTSD diagnosis in and of itself may not necessarily be a risk factor for sexual revictimization. Rather, the specific PTSD symptoms that predominate at any given moment may increase the likelihood of revictimization. Most studies have not found racial/ethnic differences in post assault PTSD (Campbell & Soeken, 1999; Elliot et al., 2004; Ullman & Brecklin, 2002; Ullman, Filipas, Townsend, & Starzynski, 2006). Although a study of survivors who had experiences of sexual victimization by an intimate partner identified Latina survivors as having significantly higher levels of PTSD than African American and Caucasian survivors (McFarlane et al., 2005). The authors suggested that the higher PTSD scores among Latinas may be related to immigration status and associated acculturation, because 28% of the women in the study were non-U.S.-born.

Comorbid PTSD and depression is of particular concern since comorbidity may increase symptom severity and lower global functioning of the affected individual (Shalev & Sahar, 1998), contribute to PTSD chronicity (Freedman, Brandes, Peri, & Shalev, 1999), and increase the risk of adverse health outcomes, particularly among low-income women (Kimerling, 2004). There is evidence to suggest that the relationship between depression and PTSD can be

reciprocal, with pre-existing major depression increasing the risk of exposure to traumatic events and PTSD and vice versa (Breslau, Davis, Peterson, & Schultz, 1997). Breslau, Davis, Perterson, and Shultz (1997) propose that the emergence of PTSD might identify a vulnerable subset among those who experience a traumatic event, with depression more likely to occur as a result of pre-existing vulnerabilities exposed and exacerbated by the trauma.

Revictimization. Many studies have found that revictimization is more strongly associated with negative psychological outcomes (e.g., PTSD, MDD) 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 distress 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 revictimization 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. There may be a positive relationship between psychological outcomes and revictimization. To date, two longitudinal studies have identified PTSD as a risk factor for sexual victimization. Substance use (problem drinking and/or illicit drug use) is also associated with risk of sexual revictimization (Abbey, Zawacki, Buck, Clinton, & McAuslan, 2003; Greene & Navarro, 1998; Koss, Dinero, Seibel, & Cox, 1989; Rich, Combs-Lane, Resnick, & Kilpatrick, 2004; Ullman, 2003).

Religiosity. In examining the use of religiosity as a protective factor against psychological outcomes and revictimization following sexual victimization, it is first important to distinguish between spirituality and religiosity. The terms religiosity and spirituality have been used interchangeably to refer to the experience of a spiritual connection (Mattis, 2000; Walker, Reid, O'Neil, & Brown, 2009). Spiritual and religious beliefs have been shown to be particularly useful for various ethnic groups, namely African Americans, impacting their understandings of several values including justice, salvation, and coping from oppression (Mattis, 2000). Spirituality refers to the transcendent belief in a higher power (Bryant-Davis, 2005) whereas religiosity can be conceptualized as an outward representation of spiritual beliefs manifested through engagement in an organized religion (Yick, 2008).

Religiosity is a cultural facet that has been largely ignored in literature that focuses on sexual victimization (Fontes, 1993). Spirituality is an aspect of the cultural domain, which should also be considered more thoroughly. Literature has demonstrated an interconnected relationship between religiousness and negative life events whereby religious belief can enhance an individual's ability to cope with negative life events and negative life events can concurrently lead to enhanced religious faith (Mcintosh, 1995; Pargament, 1990). Considering the cultural domain is particularly important when examining post-trauma functioning within communities of color. Much of the literature has focused on the individual and familial domains with limited examination of the cultural domain.

Womanist theology, which addresses the intersection of spirituality, gender and race, underscores the liberating function of spirituality, specifically, in African American women's lives (Heath, 2006). Overall, African Americans and Latinas report higher rates of religious

attendance than their Caucasian counterparts (Heath, 2006). Ethnicity can impact religious affiliation, associated beliefs as well as the type of services offered to attendees.

There is a paucity of literature related to the role that religiosity plays as a buffer against psychological outcomes and revictimization following sexual victimization. Turning to religion can be identified as a culturally based coping strategy, which helps foster connectedness and social support. For example, West (2002) notes that the African American church, commonly called "The Black Church" has traditionally served as a source of comfort as well as feminist activism for victimized African American women. Holt, Schulz, Williams, Clark and Wang (2014) suggest that social support has been consistently, positively associated with religious engagement, playing a mediating role between religious involvement and better physical and emotional functioning.

There is growing literature, which suggests beneficial aspects of religious coping (Ahrens, Abeling, Ahmad, & Hinman, 2010; Bryant-Davis, Ullman, Tsong, & Gobin, 2011; Frazier, Tashiro, Berman, Steger, & Long, 2004). Recent studies have attempted to examine the use of religious coping amongst culturally diverse trauma survivors. Bryant-Davis et al. (2011) conducted a study where they examined the degree to which religious coping and social support would serve as buffers against depression and PTSD symptoms within an African American subset of survivors. The results suggested that more frequent use of religious coping (e.g., prayer, meditation and comfort in religion) was related to greater endorsement of depression and PTSD symptoms (Bryant-Davis et al., 2011). However, this finding may have been found because survivors who were experiencing greater distress were more likely to engage in religious coping. Bryant-Davis et al. (2011) further illustrated the correlation between social support and religious coping, corroborating other research, which suggests that religious involvement and

adjustment are mediated through social support. In a similar study that examined religious coping among survivors of sexual victimization, Ahrens et al. (2010) found that religious coping was associated with posttraumatic growth among Caucasian survivors.

In one of the few studies to examine help-seeking behavior amongst victimized Latina women, the interplay of acculturation, religious coping and gender role ideology was considered (Sabina, Cuevas, & Schally, 2012). Approximately 70% of the women sampled reported use of informal help-seeking behavior compared to 30% of respondents who utilized formal help-seeking practices. The authors made a distinction between positive and negative religious coping. Sabina et al. (2012) found that Anglo orientation as well as negative religious coping was associated with formal help-seeking whereas positive religious coping, masculine gender role ideology as well as Anglo acculturation increased the likelihood of utilization of specific forms of informal help-seeking behaviors. Wang and Heppner (2011) in their analysis of Taiwanese experiences of CSA found that several Taiwanese women reported using religion as a coping strategy as well as engagement in activities which promoted positive self-reinforcement (e.g., reading self help books and taking particular classes). However, some women disclosed that the effect of religious coping was paradoxical with some turning away from religion because of the adherence to strict gender norms.

Marijuana use. The most common explanation for substance use in traumatized individuals is the self-medication model or tension reduction hypothesis, which has received extensive support from psychological research (Dansky et al.,1996; Epstein, Saunders, Kilpatrick, & Resnick, 1998; Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995; McFarlane, 1998; Stewart & Israeli, 2002). According to this model, survivors use substances in an attempt to cope with unpleasant affective experiences associated with PTSD. It has been suggested that

alcohol and other substances are used by survivors of sexual victimization as a form of self-medication to cope with overwhelming pain (Grice, Brady, Dustan, Malcolm, & Kilpatrick, 1995). Approximately 13% to 49% of survivors become dependent on alcohol, whereas 28% to 61% may use other illicit substances (Frank & Anderson, 1987; Ullman, 2007; Ullman & Brecklin, 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). Furthermore, violent assault increases substance use (Ireland & Widom, 1994); this, in turn, increases likelihood of revictimization, which increases the likelihood of further substance use. Maladaptive coping strategies, such as substance abuse, are associated with longer recovery time and higher levels of depression and PTSD (Burgess & Holmstrom, 1979; Gutner, Rizvi, Monson, & Resick, 2006; Frazier & Burnett, 1994; Frazier, Mortensen, & Steward, 2005; Meyer & Taylor, 1986; Santello & Leitenberg, 1993; Ullman, Townsend, Filipas, & Starzynski, 2007). The following section addresses substance use with alcohol as a risk factor of psychological outcomes in women who have been sexually victimized.

There is limited information available within the literature related to patterns of substance use and sexual revictimization. The studies that have examined substance use within the context of sexual victimization have primarily focused on alcohol-involved or incapacitated sexual assault (ISA) and its predominance amongst female college students (Messman-Moore, Ward & Zerubavel, 2013). There is a noticeable discrepancy within the literature related to marijuana consumption, potential development of adverse physical health, socio-emotional functioning and dependency following sexual victimization. Chu (2012) in a sample of female college students, demonstrated that CSA was associated with an increased level of marijuana use in high school

and that victimization in college appeared to override the influence of CSA on subsequent marijuana use. As one of the few studies to examine religiosity as a moderator, this study found that religiosity was negatively associated with marijuana use in high school as well as the second and fourth collegiate years.

In recent years, marijuana use has received increased attention due to its prevalence and potential emotional benefits. Marijuana use has been identified as a common coping mechanism adopted to quail posttraumatic stress (PTS) as well as PTSD (Kilpatrick et al., 2000; Potter, Vujanovic, Marshall-Berenz, Bernstein & Bonn-Miller, 2011). Very few studies have examined the association between PTSD and marijuana use motives (Bonn-Miller, Vujanovic, Feldner, Bernstein, & Zviolensky, 2007; Potter et al., 2011). Bonn-Miller et al. (2007) found that PTSD symptom severity was significantly related to coping-oriented marijuana use motives. Bonn-Miller et al. (2007) found that marijuana consumption was utilized by individuals with higher levels of PTSD in order to regulate their emotional experience (i.e., relieving negative emotional distress).

Messman-Moore et al. (2013) in a study examining the degree to which emotion dysregulation increases revictimization among women with a history of ISA found that even small increases in emotion dysregulation, particularly in impulsivity as well as marijuana use, have a substantial impact on sexual revictimization. The study normed on a female college population, determined that revictimized women reported higher levels of alcohol-related problems, greater marijuana use, greater emotion dysregulation and higher levels of fear and guilt prior to experiencing ISA. Overall, emotion dysregulation is thought to influence risky behavior linked to revictimization, including risky sexual behavior and substance use.

There is greater availability of literature related to marijuana use, depression and serious psychological distress. However, several of these studies have focused on adolescent populations. Shi (2014) found that adults with depression or serious psychological distress were at a significantly higher risk of being lifetime marijuana users, past year users, frequent users and dependent or abusing users compared with non-depressive or psychologically distressed adults. The association between depression, trauma exposure and marijuana use might be explained by the aforementioned tendency for individuals to use marijuana to relieve negative emotions. There is a need for this association to be examined in future studies in order to understand the relationship between depression, trauma, substance use and re-traumatization.

Attention to sociocultural factors has largely been ignored in the studies that have analyzed marijuana use coping follow traumatization and patterns of sexual revictimization. Literature has demonstrated that lifetime prevalence use of marijuana was equivalent to Caucasian (45.8%), African American (41.4%), and Latina (31.8%). It is important to take these prevalence rates into consideration when assessing marijuana consumption as a risk factor for revictimization. Given the prevalence of sexual victimization and the fact that African American women are disproportionately affected by sexual revictimization, literature that examines risk factors toward revictimization from a non-judgmental, sociocultural perspective is desired.

Critique and Need for Further Study

The literature on religiosity as a protective factor for ethnically diverse female survivors of sexual victimization against psychological outcomes and revictimization appears to be in its infancy as the research does not provide a review of women from different ethnic groups in regards to treating these outcomes. There is a continued need to examine the role that religiosity, specifically, religious identification and religious coping, play in protecting against the

psychological effects of sexual victimization among ethnically diverse survivors. Although there is ample research available examining the degree to which social support moderates maladjustment following sexual victimization, sociocultural perspectives have been largely ignored. Likewise, there is a continued need to examine the role that marijuana use may play in serving as a risk factor for revictimization and adverse mental health outcomes. It is also important to investigate the differences in mental health outcomes for ethnically diverse women of sexual victimization who engage in substance use. Overall, the research available on sexual victimization does not provide an understanding of the role ethnicity plays in the relationship between the protective factor of religiosity or risk factor of marijuana use, and psychological outcomes and revictimization.

Focus and Scope of the Proposed Project

In examining the literature, it is essential to recognize the lack of a cultural perspective in conceptualizing ethnically diverse women with a history of sexual victimization. There is limited research available on the impact of protective and risk factors of sexual revictimization and adverse outcomes in ethnically diverse females. Research is even more limited in the area of understanding the impact of race and ethnicity as moderators for these established relationships. By assessing how race and ethnicity play a role in the proposed protective factors of therapy, religiosity and social support, we will gain deeper understanding of the impact of these moderators. Specifically, information will be gained on how these moderators play a role against the development of mental health outcomes such as MDD, ID, and PTSD, as well as revictimization in this population. The study further attempts to understand the role of risk factors, such as alcohol and drug use, that are associated with psychological outcomes and revictimization and possible ethnic differences.

Observing coping behavior from a culturally based perspective helps conceptualize the coping methods used by ethnically diverse women (Fontes, 1993; Wang & Heppner, 2011). This allows for the values expressed within specific groups to be observed. The researchers attempt to inform the study with the belief that culture is essential and that attentiveness to nuances of culture, race, and ethnicity is necessary when designing health-promoting interventions (Harvey, 2007). Additionally, development of culturally relevant effective interventions requires attention not only to differences between groups but also to differences within racial, cultural, and ethnic groups and consideration of the ways in which these differences are expressed, highlighted, concealed, and negotiated in various social contexts. One of the major advantages of a cultural approach is that it can suggest multiple interventions, at multiple levels, for alleviating the harm caused by 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 reiterates many of the questions from the NCS and also broadens the questioning to include assessments based on the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) diagnostics system (Kessler & Merikangas, 2004; American Psychiatric Association, 1994).

Participants and Procedures

A sum 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 variables (Kalaydjian et al., 2009).

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).

Study Design

The following study employed a cross-sectional, ethnographic, quantitative design. Participants included within the study had all 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, of which Part I included mood disorders, and 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-tree 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).

Socio-demographic factors. Socio-demographic information obtained during the NCS-R administration, included age (at the time of the interview) categorized the following way: 18-29 years, 30-44 years, 45-59 years and 60 years, sex, race/ethnicity (non-Hispanic African American, non-Hispanic Caucasian, Hispanic/Latino and Other). Additional categories for race-ethnicity in the NCS-R included the following ethno-cultural groups: Vietnamese, Filipino, Chinese, all other Asian, Cuban, Puerto Rican, Mexican, all other Hispanic and Afro-Caribbean (Shim, Compton, Rust, Druss & Kaslow, 2009). Other socio-demographic factors assessed included region of the country (Northeast, Midwest, South, and West), educational attainment (< 12 years, 12 years, 13-14 years, and > 16 years), 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 et al., 2009; see Table 1). The cultural groups included in this study are Caucasian, African American and Latina. All individuals who endorsed Hispanic or Latino, regardless of country of origin or racial background, are considered Latino.

In order to assess for racial and ethnic designation, interviewers used the 2-question format recommended by the US Census Bureau on the basis of the Race and Ethnic Targeted Test (US Census Bureau, 1997). Consistent with this approach, respondents were first asked if

they were "of Hispanic or Latino descent" (see Appendix B). 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 C). For analysis purposes, the variable "Other" was used to capture those that did not identify as either Caucasian, African American, or Latina, and included Asian or Pacific Islanders and at least one participant identified as Native American.

Sexual victimization and revictimization. Sexual victimization questions were embedded within the section measuring for PTSD (Molnar, Buka, Kessler, 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 D) and being molested or inappropriately touched (see Appendix E). Information for sexual victimization was obtained from the restricted dataset. The Sexual Assault Victim was identified as a female respondent who indicated having experienced a sexual assault or rape.

Data collected on revictimization was gathered from the follow-up question to victimization: "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 F). A binary score was calculated for re-victimization based on more than one experience of rape or sexual assault.

Religiosity. The current study is particularly concerned with religious affiliation, religious coping and the way in which religiosity functions as a form of social support. Data on

respondents' religious affiliation was captured within the sociodemographic information. Participants were asked to identify their religious denomination represented within five distinct categories: Protestantism, Catholicism, Judaism, Eastern and Others. The latter category of 'Others' accounted for individuals who identified as Agnostic, Atheist and Non-religious as well (see Appendix P). The Religious identification code was reduced to identifying with a religious faith (1) or not (0), and included no religious preference, no religion, and atheist.

Follow-up questions assessed for frequency of religious attendance (see Appendix Q) as well as level of religiosity and degree of importance in respondents' lives (see Appendix R). Religious coping and comfort seeking was assessed by the following question, "When you have problems or difficulties in your family, work or personal life, how often do you seek comfort through religious or spiritual means, such as praying, meditating, attending religious or spiritual service or talking to a religious or spiritual advisor-often, sometimes, rarely or never?" (see Appendix S). Degree of religious salience was also assessed by the question, "When you have decisions to make in your daily life how often do you think about what your religious or spiritual beliefs suggest?" (Appendix T). In the analysis of religiosity three separate items measuring this construct were submitted to a reliability analysis and the output indicated two things: 1. The items are all related to each other and 2. The Cronbach's alpha is 0.71. Bivariate correlations were conducted (average of z-scores of these 3 items) and indicated that each item for religious coping was significantly, positively correlated with the others (Cronbach $\alpha = 0.71$).

Most frequent attendance, most importance, and most seeking comfort indicated by the lowest interval on each item (1 on original item). Least frequent attendance, least importance, and less seeking comfort indicated by highest interval on each item (4/5 on original item), in that

low scores on religiosity indicate having the most religiosity, whereas high scores on religiosity indicates having the least religiosity.

Marijuana use. The current study is concerned with the way in which substance abuse/dependence, in the form of marijuana use serves as a risk factor for revictimization as well as development of adverse psychological conditions (i.e. MDD, ID, and PTSD). Marijuana consumption is captured within the substance module of version 3.0 of the World Health Organization Composite International Diagnostic Interview (CIDI). Substance abuse and dependence were assessed using CIDI criterion (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 drug. 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 (a repetitive pattern of drug use causing legal or interpersonal problems, increasing physical danger, or preventing fulfillment of major role obligations; see Appendix U). The MarijuanaAD code was used for those who met criteria for Substance Abuse or Dependence and indicated use of Marijuana.

Posttraumatic stress disorder. PTSD was assessed with the World Health Organization-Composite International Diagnostic Interview (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 to specify traumatic events that caused distress (see Appendix G), followed by an assessment of which caused the most upsetting reaction (see Appendix H). In the NCS-R, the most upsetting trauma occurrence

was used. DSM-IV PTSD criterion was further assessed (see Appendix I) in addition to the severity of symptoms (see Appendix J). A binary score was used for the PTSD variable.

Major depressive disorder. The CIDI assessment of 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 (i.e., irritability, euphoria, and symptoms of mania-hypomania to distinguish between depressive episodes from mixed episodes) (Appendix K; Appendix L). A binary score was calculated for MDD/MDE 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 irritable depression. 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 irritable depression 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 N). A binary score was calculated for the irritable depression variable based on those who met criteria for MDD/MDE and endorsed at least 2 weeks of a moderate episode of MDE.

Specific Aims

The present study aimed to expand past research related to adjustment patterns of ethnically diverse survivors of sexual victimization. There were three primary objectives associated with this study. The first objective was to examine the use of religiosity as a protective factor against the development of psychological outcomes (PTSD, MDD, ID) for ethnically diverse survivors of sexual victimization. The literature on the potential for religiosity

to buffer adverse outcomes is sparse. While there is exhaustive literature related to the beneficial effects of social support following sexual victimization (Burgess & Holstrom, 1979; Hyman, Gold, & Cott, 2003), there has been minimal attention shown to understanding the way in which religiosity can function as a source of healing. The second objective was to examine the way in substance abuse/dependence, particularly marijuana type consumption can serve as a risk factor for revictimization and development of adverse psychological conditions. Marijuana use has been identified as a common coping strategy to protect against symptoms of PTS as well as PTSD (Kilpatrick et al., 2000; Potter et al., 2011). However, literature has focused mainly on alcohol use (Messman-Moore et al., 2013) and there has been a lack of attention to understanding the degree to which marijuana might contribute to revictimization. The third objective was to examine the way in which religious identification functions as a form of social support from a sociocultural perspective.

Hypotheses

The current study made the following hypotheses:

1.The likelihood that religiosity will predict lower rates of psychological outcomes is lowest for Caucasian survivors since this groups does not utilize religious coping as much as African Americans and Latinas (Bryant-Davis et al., 2011; Mattis, 2000; Sabina et al., 2012; Yick, 2008).

2. Religious identification versus no identification will weaken the relationship between ethnicity and outcome variables, across ethnicities.

3. The likelihood that marijuana abuse/dependence will predict higher rates of psychological outcomes is highest for Caucasian survivors who have higher lifetime prevalence rates of marijuana use.

Results

Analysis

Logistic regression analyses were used to determine if the predictor variables (religiosity, religious identification, and marijuana abuse/dependence) were related to the outcome variables (MDD, PTSD, and ID, as well as revictimization) and then to determine if the moderating variable (ethnicity) changed the relationship between the predictor variable and the outcomes variables. Each logistic model has two predictors (listed as χ^2).

The first step was to represent the predictor variables, religiosity, religious identification, and marijuana abuse/dependence and the moderator variable, ethnicity, with code variables. Within this study, ethnicity was a categorical variable, with three levels (Caucasian, Latina, and African-American). Caucasian was used as the reference category for the variable "Race" in all the regressions. The χ^2 in every equation represented the likelihood of suffering the outcome for that race (African Americans, Latinas, or "Other") compared to Caucasians. The "Other" group consisted predominately of Asian or Pacific Islanders, although there was at least one participant who identified as Native American. Because the number of code variables depends on the number of levels minus one, two code variables were needed. Marijuana abuse/dependence, which is a categorical variable with two levels (marijuana abuse/dependent positive or marijuana abuse/dependent negative), will require one code variable. Contrast coding was used to make comparisons between groups (Caucasian, Latina, African American and "Other"). Religious identification, which is a categorical variable with two levels (religious identification-yes or religious identification-no), required one code variable.

After code variables were created to represent categorical variables (ethnicity and marijuana abuse/dependence), product terms were created that represented the interaction

between the predictor (religiosity, religious identification and marijuana abuse/dependence) and moderator (ethnicity). To form product terms, the predictors (religiosity, religious identification and marijuana abuse/dependence) and moderator (ethnicity) variable were multiplied using the newly coded categorical variables and centered continuous variable. A product term was created for each coded variable (ethnicity and marijuana abuse/dependence).

After product terms were created, all variables were structured for 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 (ethnicity and marijuana abuse/dependence) and categorical variable (religiosity) representing the predictors (religiosity, religious identification and marijuana abuse/dependence) and the moderator (ethnicity) variable. 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

Socio-demographic factors. In the current study, a total of 1,115 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 recognized within the "Other" category. 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 (MSE) = 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 χ^2 (6) = 69.56, $p < 0.001$. Compared to every other group, African American respondents were more likely to have been never 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. The sample was comprised of 14 religious groups. Of those who responded to the religious identification demographics question, 55% identified as Protestant Christian, 20% as Catholic, 16.2% as "no religion" (i.e., Agnostic/Atheist, No religious preference, and No religion). Lastly, 8.8% reported a religious faith that was not Christian. Table 1 provides a comprehensive overview of the distribution of demographic variables.

Table 1
Demographic Characteristics

Race	n	%
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

(continued)

Income	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
$15,000 - $15,999	13	1.2
$16,000 - $16,999	16	1.4
$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

In terms of religious identification, given that majority of participants responded to this item (n = 1,102), subsequent analyses with respect to religiosity best represent or generalize to Christian religious faith as opposed to other religious denominations. In terms of the protective factor, religiosity was a scaled measure. Table 2 provides a comprehensive overview of the distribution of religious identification among survivors of sexual victimization. The original 14

denominational categories were synthesized and recoded into 4 smaller reference groups. Of those who responded to the items, 55% were Protestant Christian, 20% were Catholic, 16.2% had "no religion" and 8.8% reported a religious faith that was not Christian.

Table 2

Distribution of Religious Identification Among Female Sexual Assault Survivors

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Catholic (All Others)	4	0.4	0.4	75
	Agnostic or Atheist	16	1.4	1.5	76.5
	Presbyterian	25	2.2	2.3	42.3
	Pentecostal	36	3.2	3.3	40
	Lutheran	46	4.1	4.2	31.5
	Methodist (All Types, Including United Brethren)	58	5.2	5.3	36.8
	Catholic, Roman	63	5.7	5.7	74.7
	No Religious Preference	77	6.9	7	83.5
	No Religion	85	7.6	7.7	91.2
	Other (Specify)	97	8.7	8.8	100
	Protestantism/Protestant, No Denomination Mentioned	104	9.3	9.4	9.4
	Protestant, Other (Please Specify)	140	12.6	12.7	55
	Catholicism/Catholic, No Denomination Mentioned	154	13.8	14	69
	Baptist (All Types)	197	17.7	17.9	27.3
	Total	1102	98.8	100	
Missing System	Refused	4	0.4		
	Don't Know	2	0.2		
	Total	13	1.2		
Total		1115			

Regarding the risk factor for substance abuse/dependence: 13.4% of the sample met criteria for marijuana abuse/dependence. Additionally, 44.0% of the sample endorsed

revictimization, 42.5% met criteria for a MDE, 9.1% met criteria for PTSD, and 0.7% met criteria for ID. Table 3 presents a summary of these results.

Table 3
Protective, Risk, and Outcome Variables

	n	%
Sexual Victimization	1115	100%
Protective Factor		
Religiosity	1102	
Risk Factor		
Marijuana Abuse/Dependence	149	13.4
Outcome Variables		
Posttraumatic Stress Disorder	102	9.1
Major Depressive Disorder	474	42.5
Irritable Depression	8	0.7
Revictimization	491	44

The interaction terms proposed in the dissertation proposal were not formally modeled in any of the binary logistic regression presented below; there were collinearity problems with interaction terms included in the model. Findings are presented with respect to religiosity, religious identification (protective factors), marijuana abuse/dependence (risk factor) and observed racial differences across analyses. Table 4 summarizes the data for outcomes by ethnicity.

Table 4
Outcomes by Race

Religiosity	Revictimization		PTSD		MDD		ID	
	B	Wald	B	Wald	B	Wald	B	Wald
Ethnicity								
Caucasian	.061	.108	.124	.145	-.155	.677	16.514	.000
African-American	.287	1.853	.729	5.839	-.108	.252	.397	.130
Latina	.588	3.175	.727	2.836	.336	1.200	1.858	4.679

(continued)

Marijuana Abuse/Dependence

	Revictimization		PTSD		MDD		ID	
	B	Wald	B	Wald	B	Wald	B	Wald
Ethnicity								
Caucasian	.048	.071	.136	.180	0.149	.647	16.174	.000
African-American	.286	1.831	.649	4.477	0.143	.440	.516	.219
Latina	.582	3.108	.830	3.620	0.369	1.435	1.902	4.980

Religious Identification

	Revictimization		PTSD		MDD		ID	
	B	Wald	B	Wald	B	Wald	B	Wald
Ethnicity								
Caucasian	.060	.106	.165	.264	-.137	.538	-16.199	.000
African-American	.286	1.839	.778	6.559	-.096	.202	.372	.114
Latina	.587	3.165	.779	3.228	.349	1.290	1.904	4.983

Religiosity.

Depression associated with race and religiosity. In examining depression predicted by race and religiosity, the model was not significant ($\chi^2(4) = 2.59$, $p = 0.63$). Race was not a significant predictor of a MDE (Wald $\chi^2(3) = 2.30$, $p = 0.51$) and religiosity was not a significant predictor of a major depressive episode (Wald $\chi^2(1) = 4.23$, $p = 0.71$). However, there was a nonsignificant trend found where those who reported experiencing greater religiosity were 1.03 times more likely to have experienced depression.

Irritable depression associated with race and religiosity. With respect to ID predicted by religiosity and race, the model was significant ($\chi^2(4) = 10.67$, $p = 0.03$). Race was not a significant predictor of ID (Wald $\chi^2(3) = 4.69$, $p = 0.20$). Religiosity was not a significant predictor of irritable depression (Wald $\chi^2(1) = 3.07$, $p = 0.08$), however they was a nonsignificant trend whereby sexual assault survivors who reported greater religiosity were 0.32 less likely to report ID. The discrepancy between the model being significant and the nonsignificant individual variables might be attributable to the low frequency of racial and religious identification within the sample. This might also be attributable to unequal cell sizes.

Revictimization associated with race and religiosity. In examining revictimization by race and religiosity, the model was not significant ($\chi^2(4) = 5.80$, $p = 0.22$). Race was not a significant predictor of revictimization ($\chi^2(3) = 5.56$, $p = 0.14$). Likewise, religiosity was not a significant predictor of revictimization for sexual assault survivors (Wald $\chi^2(1) = 0.98$, $p = 0.78$).

PTSD associated with race and religiosity. Results indicated that the model was not significant ($\chi^2(4) = 7.58$, p = 0.11) for PTSD predicted by religiosity and race. While race was a significant predictor of PTSD (Wald χ^2 (3) = 7.79, p = 0.05) for sexual assault survivors, this finding may have been due to experimental error. Compared to Caucasians, there was a trend for those within the "Other" category to have experienced more PTSD symptoms, whereas Latinas were significantly more likely to have experienced PTSD across ethnic groups. Specifically, results with respect to ethnicity, suggest that Latinas were twice as likely as Caucasians to experience PTSD (x2=5.84, p=0.02). Religiosity was not a significant predictor (Wald $\chi^2(1)$ = 0.64, p = 0.43) of PTSD experienced by sexual assault survivors.

Marijuana Use.

Depression associated with marijuana and race. With respect to depression predicted by marijuana use and race, the model was significant ($\chi^2(4) = 9.58$, p = 0.05). Race was not a significant predictor of a MDE (Wald $\chi^2(3) = 2.71$, $p = 0.44$). However, marijuana was a significant predictor of a MDE (Wald $\chi^2(1) = 7.13$, $p < 0.01$). Sexual assault victims who met criteria for marijuana abuse or dependence were 1.61 times more likely to report having experienced depression.

Irritable depression associated with marijuana use and race. In examining irritable depression by marijuana use and race, the model was marginally significant ($\chi^2(4) = 8.52$, p = 0.07). Race was not a significant predictor of irritable depression (Wald $\chi^2(3) = 4.98$, $p = 0.17$)

experienced by survivors. Furthermore, marijuana use was a not a significant predictor of irritable depression (Wald $\chi^2(1) = 3.07$, $p = 0.08$).

Revictimization associated with marijuana and race. With respect to revictimization by marijuana use and race, the model was not significant ($\chi^2(4) = 5.77$, $p = 0.22$). Race was not significant predictor of revictimization ($\chi^2(3) = 5.40$, $p = 0.15$). There was a trend for API to have been less likely to experience revictimization compared to Caucasians, Wald $\chi^2(1) = 3.11$, $p = 0.08$. Marijuana was not a significant predictor of revictimization, (Wald $\chi^2(1) = 0.05$, $p = 0.82$).

PTSD associated with marijuana and race. In examining, PTSD predicted by marijuana use and race, the model was significant ($\chi^2(4) = 24.23$, $p < 0.001$). There was a nonsignificant trend for race as a predictor of PTSD (Wald χ^2 (3) = 7.23, $p < 0.07$). Compared to Caucasians, there was a trend for individuals within the "Other" category to have experienced more PTSD, whereas Latinas were significantly more likely to have experienced PTSD. Latinas were 1.91 times more likely than Caucasians to experience PTSD (Wald $\chi^2(1) = 4.48$, $p = 0.03$). There was a trend for "Other" survivors to be more than twice as likely as Caucasians to report having suffered from PTSD (Wald $\chi^2(1) = 3.62$, $p < 0.10$). Marijuana use was not significant predictor (Wald $\chi^2(1) = 19.42$, $p < 0.001$) of PTSD.

Religious Identification.

Depression associated with religious identification and race. The model was not significant ($\chi^2(4) = 3.65$, $p = 0.46$) for depression predicted by religious identification and race. Race was not a significant predictor of a MDE (Wald $\chi^2(3) = 2.20$, $p = 0.53$). Religious identification was not a significant predictor of a MDE (Wald $\chi^2(1) = 1.41$, $p = 0.24$).

Irritable depression associated with religious identification and race. The model was marginally significant ($\chi^2(4) = 8.95$, $p = 0.06$) for irritable depression by religious identification and race. Race was not a significant predictor of irritable depression (Wald $\chi^2(3) = 5.00$, $p = 0.17$). A nonsignificant trend was found whereby compared to Caucasians individuals within the "Other" category were 6.71 times more likely to have experienced ID (Wald $\chi^2(1) = 4.98$, $p = 0.03$). Religious identification amongst sexual assault survivors was not a significant predictor of irritable depression (Wald $\chi^2(1) = 0.00$, $p = 1.00$).

Revictimization associated with religious identification and race. In examining revictimization by religious identification and race, the model was not significant ($\chi^2(4) = 5.75$, $p = 0.22$). Race was not a significant predictor of revictimization ($\chi^2(3) = 5.53$, $p = 0.14$). Also, there was a nonsignificant trend for individuals within the "Other" category to have been less likely to experience a subsequent sexual assault compared to Caucasian sexual assault survivors (Wald $\chi^2(1) = 3.17$, $p = 0.08$). Religious identification was not a significant predictor of revictimization (Wald $\chi^2(1) = 0.00$ $p = 1.00$).

PTSD associated with religious identification and race. With respect to examining PTSD by religious identification and race, the model was significant ($\chi^2(4) = 12.37$, $p < 0.05$. Race was a significant predictor of PTSD ($\chi^2(4) = 12.37$, $p < 0.05$). Compared to Caucasians, there was a trend for "Other" survivors to have experienced more PTSD, whereas Latinas were significantly more likely to have experienced PTSD. Latinas were 2.18 times more likely than Caucasian survivors to experience PTSD (Wald $\chi^2(1) = 6.56$, $p = 0.01$). There was a trend for "Other" survivors to be more than twice as likely as Caucasians to report having suffered from PTSD (Wald $\chi^2(1) = 3.23$, $p < 0.10$). Furthermore, religious identification was significant (Wald

$\chi^2(1) = 5.64, p < 0.05$). Those who identified with a religious faith were almost half as likely to report having suffered from PTSD than those who did not identify with any religion.

Discussion

Findings

This study was the first cross sectional study examining the role of religiosity as a potential protective factor and marijuana use as a potential risk factor in a sample of ethnically diverse sexually victimized adults from the NCS-R dataset. The study examined the role of race and its relationships to adverse psychological outcomes including PTSD, MDD, ID, and sexual revictimization. Several prior studies have examined various protective and risk factors associated with sexual victimization, however, few have taken a more in-depth, ecological based examination of the way in which racial background impacts adoption of protective and risk factors, respectively (Wang & Heppner, 2011).

Religiosity

With respect to religiosity, one main finding was found. Those who identified with a religious faith were almost half as likely to report having suffered from PTSD than those who did not identify with any religion. This finding is consistent with a study conducted by Bryant-Davis et al. (2011) which found that more frequent use of religious coping (e.g. prayer, meditation, and comfort in religion) was related to greater endorsement of depression and PTSD symptoms. This finding may also corroborate prior studies, which have found an interconnected relationship between religiousness and negative life events whereby religious belief can enhance an individuals's ability to cope with negative life events and negative life events can concurrently lead to enhanced religious faith (Mcintosh, 1995; Pargament, 1990). Given this result, it is important to distinguish between causation and correlation; this finding may have been found because survivors who were experiencing greater distress were more likely to engage in religious coping. With respect to irritable depression and religious identification, a nonsignificant trend

was found whereby compared to Caucasians individuals within the "Other" category were 6.71 times more likely to have experienced ID. Results from this study highlight the importance of continuing to understand the way in which religious identification as well as religious practices are implemented by diverse survivors of sexual violence. Furthermore, there is a need to examine more thoroughly the religious based coping strategies enacted by survivors.

Several authors have highlighted the need to discern between positive and negative religious coping practices (Pargament, 1990). There is growing literature which supports the beneficial use religious coping, making a distinction between positive and negative qualities of coping strategies enacted (Ahrens et al., 2010; Bryant-Davis et al., 2011; Frazier et al., 2004). Positive religious coping includes such methods as religious purification/forgiveness, religious direction/conversion, seeking support from clergy members and spiritual connection. These strategies are associated with positive psychological adjustment outcomes such as acceptance, happiness, optimism, and purpose in life. Conversely, negative religious coping is characterized by spiritual discontent, punishing God reappraisal, reappraisal of God's powers, pleading for direct intercession; coping methods associated with anxiety, burden, negative mood and callousness (Pargament, 1990). Further examination of the quality of coping methods utilized by survivors of sexual victimization might have provided more context to further examine the association between religiosity and psychological outcomes. There continues to be a paucity of literature that thoroughly examines religious coping following sexual victimization as well as other forms of interpersonal violence. Lastly, given the heterogeneity of various religious denominations, more research within this domain should examine the way in which different denominational beliefs impact religious coping following sexual victimization and other forms of trauma.

Furthermore, this result highlights the importance of continuing to explore intersections of identity (e.g., gender, race, religious orientation) and understanding how coping strategies are shaped by these factors. Given that African Americans and Latinas report higher rates of religious attendance than their Caucasian counterparts (Heath, 2006), it is important to explore the way in which religious identification impacts their coping behavior, and beliefs about self. Results from prior studies have shown that African Americans' spiritual and religious beliefs have impacted their understanding of several values including justice, salvation, and coping from oppression. In a study by Sabina et al. (2012), the interplay of acculturation, religious coping and gender role ideology was considered and found to impact help-seeking behavior of Latinas. Future research should apply an intersectional lens to understanding adopted coping behavior within specific ethnic groups.

Marijuana Abuse/Dependence

There was one main finding with respect to marijuana abuse/dependence. As hypothesized, individuals who endorsed sexual victimization who also met criteria for marijuana abuse/dependence were more likely to report adverse psychological outcomes, specifically depression. In fact, sexual assault survivors who met criteria for marijuana abuse or dependence were 1.61 times more likely to report experiencing depression. This is consistent with literature on the self-medication model, whereby survivors of sexual victimization utilize substances to cope with unpleasant affective experiences and emotional pain (Kessler et al., 1995; McFarlane, 1998; Stewart & Israeli, 2002). This result is also consistent with literature that has suggested that maladaptive coping strategies are associated with longer recovery times and higher rates of depression and PTSD (Burgess & Holmstrom, 1978; Gutner et al., 2006; Frazier & Burnett,

1994; Frazier, Mortensen, & Steward, 2005; Meyer & Taylor, 1986; Santello & Leitenberg, 1993; Ullman et al., 2007).

Studies that have examined substance use behavior following sexual victimization have primarily focused on alcohol involved and incapacitated sexual assault (Messman-Moore et al., 2013) with limited attention to other substances such as a marijuana. Given its prevalence within the general public, it is important to continue examining the potential associations between marijuana abuse/dependence, sexual victimization, and socio-emotional functioning. This finding from the study is consistent with findings from Shi (2014) whereby adults with depression or serious psychological distress were at a significantly higher risk of being lifetime marijuana users, past year users, frequent users, and dependent or abusing users compared with non-depressive or psychological distressed adults. While the association between marijuana use and PTSD was not found to be significant within this study, prior studies have suggested that individuals who have experienced traumatization may have a tendency to utilize marijuana as a coping mechanism to quail emotional distress caused by posttraumatic stress (Bonn-Miller et al., 2007). Given the minimal research available on marijuana use amongst sexual assault survivors, and the lifetime prevalence use of marijuana across ethnic groups, there is a need to continue exploring the way in which marijuana use may be utilized over the lifetime to cope with psychological distress. Furthermore, given the evidence suggesting the bidirectional relationship between substance use and sexual victimization (Wilsnack et al., 2004), more research should be conducted with respect to the adoption of marijuana-specific coping and the way in which it correlates with sexual victimization and revictimization.

Impact of Sociodemographic Variables

Several notable trends with respect to race and ethnicity were observed within the data. Specifically, there was a trend for those in the reference group "Other" primarily comprised individuals of Asian American/Pacific Islander and Latinas to have experienced PTSD. Several sociocultural variables might contribute to these findings such as experiences of racism, migration, and acculturative stress, all factors, which have been associated with distress following trauma. Despite experiencing pervasive societal based traumatic stressors, there is limited research on sexual violence within these communities. Available data suggest an overall low rate of reported abuse, however this might be accounted for by the types of sexual abuse acts perpetrated, symptomatology, relationship of victim to perpetrator and family's belief in the child's disclosure (Ahrens et al., 2010). Ahrens et al. (2010) argue that there is a need to develop culturally competent, value laden research strategies in order to unravel the inconsistent findings. The trends found within the study results highlights the importance of understanding varied experiences of traumatization within these communities.

With respect to religious identification, there was also a trend for Latinas and Asian American/Pacific Islanders to endorse greater experiences of PTSD than their Caucasian counterparts. Related to religious values, both Asian American Pacific Islanders and Latinas place a high value on virginity, which may be related to increased psychological distress following sexual victimization. It is essential to note that while certain aspects of religion may lead to negative outcomes such as self-blame, religion also can also serve as a protective factor. The aforementioned distinctions between positive and negative religious coping practices are particularly helpful in terms of understanding how individuals make meaning following their experiences of traumatization. Of note, there were no particular trends with respect to African

American survivors, suggesting that there is a continued need to examine protective, risk, and outcome factors within this population.

Conceptual and Methodological Limitations

Despite data being derived from a sizable sample of socio-demographically, 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 made it difficult to rule out alternative hypotheses accounting for correlations. Another limitation related to the use of archival data related 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 and the ability to explore cultural variables from more of an ecological perspective (Fontes, 1993). Despite the sample being comprised of an ethnically diverse population, there are notable sociocultural limitations. First, the data does not ask about immigration status, which has been associated with various psychological outcomes as well as sexual victimization. Secondly, the data does not allow individuals who are multiracial or biracial to select more than one category. While "Other" is listed as an option, this does not sufficiently capture the self-identification of multiracial/multiethnic individuals. Thirdly, there is an absence of representation of Asian American/Pacific Islander descendent individuals, and while this population is best represented within the category of "Other" it is difficult to generalize these findings to this population with certainty. Lastly, the data is normed on the previous version of the 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.

Innovation and Potential Contributions

The existing literature on the protective and risk factors of sexual revictimization in ethnically diverse females is scarce and warrants more research due to prevalence rates of assault in this population. Examining religiosity will help strengthen research and clinical support by first acknowledging the importance of this factor and second, understanding how it is associated with mental health outcomes such as MDD, ID, and PTSD, in addition to revictimization. Thus far, we have identified the existing and predicted relationships seen between these variables. The current study is unique in its position of understanding how the addition of ethnicity and race between the predictive and risk factors of this group will play a role in those relationships. Using a sizable sample and ethnically diverse group from the NCS-R, this study aimed to understand how these differences may help inform effective prevention interventions. The study also sought to examine the way in which marijuana use may impact adverse psychological outcomes, potential for revictimization across ethnically diverse populations. Several prior studies focused on alcohol and cocaine use (Greene & Navarro, 1998) with limited attention to examining the potentiality for marijuana use to serve as a risk factor.

Potential contributions may include highlighting the importance of educating diverse communities of the significant role social support plays in protecting survivors of sexual victimization against revictimization and psychological outcomes. The distribution of these findings in therapeutic settings and public health forums may encourage community members to be supportive of survivors. It may also encourage survivors of sexual victimization to utilize community-based resources such as their faith communities, and local support agencies. Often

survivors have a difficult time seeking help in formal therapeutic settings, therefore, it is imperative that mental health providers develop partnerships with community-based agencies to disseminate information with particular attention to cultural nuances. The research may also highlight the importance of educating women on how substance use places them at higher risk for sexual victimization, psychological outcomes, and revictimization. The dissemination of these findings may encourage women to reduce their use or abstain from substances as a way of reducing their risk of psychological outcomes and revictimization. The research may also stress the importance of having affordable mental health care and resources, as substances are often a less expensive way of coping but increase risk of psychological outcomes and revictimization. Likewise, the research may underscore the importance of dual diagnosis programs for those who need treatment for both trauma and addiction. In sum, it is essential that women from ethnically diverse groups, are able to access community-based, informal and formal culturally sensitive treatment, to promote adaptive recovery following sexual victimization in order to lessen the risk of revictimization and psychological distress.

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Appendix A

Extended 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. Limitations with existing research and methodological challenges associated with conducting research on this topic are described. Suggestions are made for future research which can inform prevention and

		treatment programs.
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.
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.
Axelrod, J., Myers, H. F., Durvasula, R. S., Wyatt, G. E., & Cheng, M. (1999).	The impact of relationship violence, HIV, and ethnicity on adjustment in women.	Of the 415, 27% (n = 112; 79% HIV positive, 21% HIV negative) reported a history of relationship violence. Results indicated that HIV-positive women reported significantly more depressive symptoms, slightly more anxiety, but no differences on posttraumatic stress disorder (PTSD) symptoms than HIV-negative women. Women victimized by relationship violence also reported more depressive symptoms and anxiety and evidenced significantly more PTSD symptoms than nonabused women. Indeed, 58 % of victimized women evidenced significant PTSD symptoms. Contrary to expectations, however, there were no significant ethnic differences on anxiety, but differences on depressive and PTSD symptoms emerged and were moderated by social undermining. Social support and dyadic satisfaction were not significant moderators of distress or dysfunction.
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.
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.
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.
Bierbrauer, G. (1992).	Reactions to violation of normative standards: A cross-	Subjects from collectivistic cultures responded with more shame *and* guilt than subjects from the individualistic cultures.

	cultural analysis of shame and guilt.	
Bolstad, B. R., & Zinbarg, R. E. (1997).	Sexual victimization, generalized perception of control, and posttraumatic stress disorder symptom severity.	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 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	This article examines whether a convenience sample of 123 undergraduate women, living in dormitories and

	acknowledge their assaults.	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., & Schultz, L. (1997).	Psychiatric sequelae of posttraumatic stress disorder in women.	The lifetime prevalence of traumatic events was 40% and of PTSD, 13.8%. Posttraumatic 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.	American Indian and African American women are particularly vulnerable to sexual assault. Psychological impact of sexual assault includes higher rates of PTSD, depression, substance abuse, suicidality, lowered self-esteem and somatic symptoms. Risk factors for African American women include age, sexual assault by an intimate partner, socioeconomic status, childhood

		sexual abuse, Depression is a common experience among African American sexual assault survivors. Risk factors to depression include African American adolescent girls who reported a long duration of childhood sexual abuse and African American battered women who report multiple incidents of sexual assault such as marital rape.
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., &	Sexual assault and mental disorders in a community population.	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. Finally,

Telles, C. A. (1988).		major depression, drug abuse or dependence, antisocial personality, and phobia were all associated with a higher probability of subsequent sexual assault.
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.
Cho, Y. B. (2003).	Suicidal ideation, acculturative stress and perceived social support among Korean adolescents.	The results of this study showed a diversity of responses within an ethnic-minority group in processing the impact of acculturation, as well as the varying levels of acculturative and psychological stress.
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. Existing research on prevention efforts and treatment is discussed. More longitudinal studies on sexual revictimization are needed.
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.
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 iheir 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 Hkely to identify cocaine as their primary drug than Caucasian patients. Given the strikingly high rate

		of comorbid CR-PTSD among substance use disordered patients, exploration of the type and timing of interventions would be of clinical interest.
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.	More than 80% of women in both samples had a history of sexual and/or physical assault and approximately one-quarter had current PTSD.
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 nonassaulted 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 nonassaulted men reported less symptomatology than nonassaulted women
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 nonvictim 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.	Childhood rape victims had significantly more affirmative responses than non-victims on six out of the seven items. A history of childhood rape doubled the number of alcohol abuse symptoms that women experienced in adulthood. PTSD may be a mediating variable that many women raped in childhood experience prior to using alcohol. Childhood rape may alter women's cognitive and/or emotional view of their social environment so that they perceive their environment as uncontrollable, unpredictable and potentially hostile or dangerous. The study hypothesizes that alcohol use and it's effects could serve as a means for women to cope with this negative view of

		life. The present study's use of PTSD as a mediating variable should be interpreted as only one of many possible variables that may affect the relationship between childhood rape and subsequent substance use. One third of the sample reported an age of first alcohol abuse symptoms prior to their age of first PTSD symptom.
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 (SES), 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: Results from the national comorbidity survey replication	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.
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.
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.
Fontes, L. A.	Considering culture	This article urges the adoption of an

(1993).	and oppression: Steps toward an ecology of sexual child abuse.	ecological view of sexual child abuse, with attention to the individual, the family, the ethnic culture, and wider society. Case material is drawn from work with Puerto Rican families and research with Puerto Ricans in the United States on issues of sexual child abuse. Implications for the practice of family therapy are outlined.
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.	Findings from hierarchical regression analysis indicated that PTSD symptoms remain significantly related to partner abuse after controlling for the effects of social 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., & Stewart, B. D. (1984).	Depressive symptoms in rape victims: A revisit.	The results suggested 43% of the subjects met Research Diagnostic Criteria for major depressive disorder, with sleep disturbance and dysphoria being the most frequently endorsed symptoms. Older subjects and subjects who had been sexually victimized prior to the current assault were at significantly higher risk for developing major depressive disorder post-assault. Follow-up assessments

		revealed a diminution of depressive symptoms by 3 months after initial assessment and a continuing stabilization of mood at 6 and 12 months.
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.
Frazier, P., Tashiro, T., Berman, M., Steger, M., & Long, J. (2004).	Correlates of levels and patterns of positive life changes following sexual assault.	The factors most related to reporting positive life change soon after the assault were social support, approach and religious coping, and perceived control over the recovery process. Increases in these factors also were associated with increases in self-reported positive life changes over time. The relations between social support and positive change also were mediated by coping strategies and control appraisals, particularly perceived control over the recovery process.
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.	Loglinear 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.	Implications of	Childhood sexual abuse is an important

L., Parker, G. B., Mitchell, P. B., Malhi, G. S., Wilhelm, K., & Austin, M. P. (2004).	childhood trauma for depressed women: an analysis of pathways from childhood sexual abuse to deliberate self-harm and revictimization.	risk factor to identify in women with depression. Depressed women with a childhood sexual abuse history create a subgroup of patients 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.
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).
Goldenberg, I. M, Mueller, T., Fierman, E. J., Gordon, A., Pratt, L., Cox, K., Park, T., Lavori, P., Goisman, R. M., Keller, M. B. (1995).	Specificity of sub-stance 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 are of onset data,

		specific substance association, there was no indirect support for 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.
Greene, 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.
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 posttraumatic distress in female crime victims.	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 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.
Hahm, H. C., Lahiff, M., & Barreto, R. M. (2006).	Asian American adolescents' first sexual intercourse: Gender and acculturation differences	Twenty four percent of young women and 20% of young men had had sexual intercourse. Among young women, the most acculturated were more likely to have had sexual intercourse than the least acculturated (odds ratio, 4.9); acculturation was not associated with

		sexual intercourse for young men. Medium and high levels of parental attachment were associated with decreased odds of sexual experience for young women (0.4 and 0.2), but not for young men. Binge drinking was associated with an increased risk of sexual experience for young women (6.4), and tobacco use was associated with increased risk for young men (3.0).
Herman, J. (1992).	Trauma and recovery.	This book draws draws on cutting-edge research in domestic violence as well as on the vast literature of combat veterans and victims of political terror, to show the parallels between private terrors such as rape and public traumas such as terrorism. The book puts individual experience in a broader political frame, arguing that psychological trauma can be understood only in a social context.
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.
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.
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 item functioning analysis.	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 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.
Kalaydjian, A., Swendsen, J., Chiu, W. T., 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.	Age at first sexual assault and current	This article explores how the association between sexual violence and substance

(2005).	substance use and depression.	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.
Kilpatrick, D. G., Acierno, R., Resnick, H. S., Saunders,	A 2-year longitudinal analysis of the relationship between violent assault and	Use of drugs, but not abuse of alcohol, increased odds of revictimization. Reciprocally, after revictimization, odds of both alcohol abuse and drug use were

B. E., & Best, C. L. (1997)	substance use in women.	significantly increased. For illicit drug use, 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., 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 (PTSD).
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 nonvictims 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 pretrauma risk factors (e.g., family instability, childhood antisocial behavior), war-zone stressors (e.g., combat, perceived threat), posttrauma resilience-recovery variables (e.g., hardiness, social support), and posttraumatic stress disorder (PTSD) symptom severity were examined. For both genders, direct links to PTSD from pretrauma, war-zone, and posttrauma variable categories were found; several direct associations between pretrauma and posttrauma variables were documented. Although war-zone stressors appeared preeminent for PTSD in men, posttrauma resilience-recovery variables were more salient for women.

Koenig, L. J., Doll, L. S., O'Leary, & W. Pequegnat (Eds.),	From child sexual abuse to adult sexual risk: Trauma, revictimization, and intervention	Identifies the theory and research-based cognitive, affective, social, and behavioral consequences of trauma that influence both sexual health and sexual risk behaviors in adulthood.
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 postrape 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 nonabused control group with the revictimized group reporting significantly moe PTSD symptomatology than other victimization groups. The victimization groups differed significantly from the nonabused 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 nonabused group.
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 nonvictims 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., Leach, M., Yeh, C., &	Suicide among Asian Americans: What do we know? What do	In analyzing what is known and what still needs to be learned about suicide among Asian Americans, this article provides a

Chou, E. (2007).	we need to know?	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.
Lewis, M. (1992).	The exposed self.	Drawing theories and research this book offers an empirically account of the development of shame.
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.
Lowe, W., Packov, T. W., Casanova, G. M., & Wetchler, J. L. (2005).	Do American ethnic cultures differ in their definitions of child sexual abuse?	There are no significant differences between the ethnic groups' recognition of, or willingness to report, CSA except at the lowest levels of severity, where ethnic minorities are somewhat more likely to recognize or report CSA than are white Americans.
Luo, T. (2000).	“Marrying my Rapist?!” The cultural trauma among Chinese rape survivors.	This study conceptualizes rape trauma as embedded in the cultural construction of rape and consequently manifested in the psychological process of individual rape survivors. The author conducted indepth interviews with 35 female rape survivors in Taiwan to examine their self-reported traumatic experiences in relation to the cultural meaning of rape in Chinese society. In analyzing the interview accounts, this study identified several kinds of trauma predominantly experienced among the interviewed rape

		survivors. This study found that the psychological trauma among individual rape survivors in Taiwan, although similar to rape trauma symptoms documented in Western literature, seems to manifest a relatively distinct cultural construction of rape in Chinese society.
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. V. (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.
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 behaviour. 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., (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%.
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.	Childhood sexual abuse (CSA) survivors were more likely than nonvictims 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 child sexual abuse (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. Future research may benefit from a focus on the function of psychological distress that is

		expressed as psychological vulnerability, as opposed to individual forms of psychopathology or maladaptive behavior. An ecological framework may be useful as a guide to future investigations, as this model focuses on factors outside of the victim, including childhood factors such as family environment, contextual factors including the behavior of the perpetrator, and societal and cultural factors that impact revictimization. Future investigations should focus on the interaction between victim vulnerability and perpetrator behavior. Implications for prevention programming, clinical intervention, and future research are discussed.
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 nonabused 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 chronicitiy 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.
Morrow, K. B., & Sorell, G. T. (1989).	Factors affecting self-esteem, depression, and negative behaviors in sexually abused female adolescents.	Results revealed that the type of sexual act was the single most powerful predictor of distress levels, with coitus being associated with lower self-esteem, higher levels of depression, and greater numbers of antisocial and self-injurious behaviors than noncoital sexual contact. Negative response by the victim's mother and/or the perpetrator after disclosure and greater self-blame were also found to be related to higher scores on certain of the dependent measures.
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.
Mulliken, B. (2006).	Rape myth acceptance in college students: The influence of gender, racial, and religious attitudes.	The current study examined the rape myth acceptance and attitudes towards rape victims of 330 racially diverse male and female college students from a public, southeastern university. It was found that men displayed significantly greater rape myth acceptance and greater negative attitudes toward rape victims. Additionally, participants with more traditional gender role beliefs, racist beliefs and fundamentalist religious beliefs displayed more rape myth acceptance and more negative attitudes towards rape victims. Asian/Pacific Islander participants had more rape myth acceptance and more negative attitudes towards rape victims than did White participants. Higher levels of religiosity were not found correlated with, nor were they predictive of, rape myth acceptance or negative attitudes toward rape victims. Finally, it was found that when controlling for the influences of race and sex, belief in traditional gender roles and racism were significant predictors of rape myth acceptance and negative attitudes toward rape victims.
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., & Ullman, S. E. (2011).	The effects of revictimization on coping and depression in female sexual assault victims.	Women who were revictimized reported more depression. This effect was explained in part by revictimized women's increased maladaptive coping.

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 posttraumatic stress disorder symptoms (PTSD), peritraumatic dissociation, and sexual preoccupation. Physical revictimization was positively correlated with PTSD symptoms, pathological dissociation, and sexually permissive attitudes. Selfharm was positively correlated with both peritraumatic and pathological dissociation
Ortega, A. N., & Rosenheck, R. (2000).	Posttraumatic stress disorder among Hispanic Vietnam veterans.	The purpose of this study was to examine posttraumatic stress disorder (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.

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) posttrauma 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.
Perilla, J. L., Bakerman, R., & Norris, F. H. (1994).	Culture and domestic violence: The ecology of abused Latinas.	This study examined the predictors of domestic violence within a sample of 60 immigrant Latinas, of whom 30 had sought assistance for abuse and 30 had sought other family services. Findings

		related to the specific formulations were subsequently combined into a model of abuse in which the mutuality of communication within the couple mediates the effects of husband's intoxication and environmental stressors on the occurrence/severity of abuse.
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.
Phillips-Sanders, K., Moisan, P. A., Wadlington, S., Morgan, S., and English, K. (1995).	Ethnic differences in psychological functioning among Black and Latino sexually abused girls.	Latino girls received significantly higher 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,	Why are Hispanics at greater risk for PTSD?	The authors found that greater peritraumatic dissociation, greater wishful thinking and self-blame coping, lower

C. R. (2005).		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 nonvictims'. 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 adult sexual assault (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 child sexual abuse (CSA), which has been associated with these potential mediating risk factors, has been identified as the strongest predictor of ASA.
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 nonpsychiatrist physicians or clergy, even after adjustment was made for health and economic factors.
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).
Rush, L. O., & Hennessey, M. (1982)	Sexual assault: Victim and attack dimensions.	Results reveal 4 statistically significant factors, two describing the type of attack and two characterizing attributes of the victim herself. Factor 1 dealt with the kind of rape encounter, whether it was an armed, forced entry into the home by a stranger or an unarmed, unforced entry into the home or rape situation by someone who may have known the victim. Factor 2 defined the means of intimidation used by the assailant, victim resistance, and physical injury. Factor 3 represented the combined effect of different kinds of life crises. Factor 4 contained 2 variables relating to potential social support for the victim.
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., &	Sexual aggression by an acquaintance:	Two years on average after the assault, these women reported more psychological

Leitenberg, H. (1993).	Methods of coping and later psychological adjustment.	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., & Sierra, J. C. (2012).	Sexual victimization among Spanish college women and risk factors for sexual revictimization.	Results showed that 30.4% of them engaged 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. Results reflect some cultural differences from previous research.
Schnitt J. M., & Nocks J. J. (1984).	Alcoholism treatment of Vietnam veterans with post-traumatic stress disorder.	Vietnam veterans with alcoholism and Post-Traumatic Stress Disorder (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.
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.

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 of intimate violence.	The authors first examine the mental health correlates of exposure to familial childhood physical and sexual abuse, including both psychiatric disorders and substance-related 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.
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 nonefficacious 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.
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.
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 preassault alcohol use and postassault 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 postassault distress, and saying that a friend/relative or a rape crisis center was helpful regarding the assault.
Ullman, S. E.	Do social reactions to	Tangible aid/information support was

(1996b)	sexual assault victims vary by support provider?	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 (macrolevel model) and (2) the role of drinking in the outcomes of actual sexual assault incidents (microlevel 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., & 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., Townsend, S. M., & Starzynski, L. L. (2006).	Correlates of comorbid PTSD and drinking problems among sexual assault survivors.	Results showed that survivors with less education, histories of other traumas, who blamed their character more for the assault, believed drinking could reduce distress, drank to cope with the assault's effects, and received negative social reactions were more likely to have comorbid PTSD and drinking problems than those with PTSD only.
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 (reexperiencing, 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., & Siegel, J. M. (1995).	Sexual assault, social reactions, and physical health.	This study examined the role of postassault 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.
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.	Posttrauma 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 postassault, 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.
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.
Wang, Y.W., & Heppner, P. P. (2011).	A qualitative study of childhood sexual abuse survivors in Taiwan: Toward a transactional and ecological model of coping.	This investigation was grounded on a feminist paradigm, and the consensual qualitative research method (Hill et al., 2005; Hill, Thompson, & Williams, 1997) was utilized as the strategy of inquiry. The transactional and ecological model of coping that emerged from the data describes the dynamic interplay among (a) intrapersonal, interpersonal, and sociocultural factors and (b) the coping process and outcomes of CSA survivors.
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.
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.	Child sexual abuse (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 nonvictims in signaling that an audiotaped date rape should be halted. Revictimized women with greater posttraumatic stress disorder (PTSD) symptoms, arousal symptoms in particular, exhibited latencies similar to those of nonvictims, 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.
Wyatt, G. E**.** **(**1992).	The sociocultural context of African American and white American women's rape.	The possibility that African Americn women may not perceive themselves as rape victims or their experiences as meeting the criteria of "real rape" has implications or the disclosure of incidents, as well as the initial and lasting effects of sexual victimization. Researchers are urged to include ethnicity as a factor contributing to women's self-perceptions as rape survivors.
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 yrs) 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.

Appendix B

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 C

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 D

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 E

Sexual Assault II

INTERVIEWER: FOR EACH ENDORSED EVENT, ASK THE FOLLOW-UP QUESTIONS AT RIGHT.			**AGE** How old were you the first time?	**# TIMES** How many times (did that happen in your life)? IF "ONGOING" FOR A PERIOD IN R'S LIFE, CODE 995.
YES (1)	**NO (5)**			
***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 99 8 RF 99 9	*PT46b. TIMES DK 9 98 RF 9 99

Appendix F

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 G

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 H

PTSD II

*****PT267. Of these events, was there one that caused you the most 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	9

Appendix I

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 J

PTSD IV

No Interference	Mild		Moderate			Severe			Very Severe Interference	
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

***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 K

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 L

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 M

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 N

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**

Appendix O

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
*IR8l. 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 P

Religious Identification

*****DA31b.1. What is your religious preference?
(IF NEC: Is that a Christian religion?)
(PROBE "OTHER": What denomination is that?)

RECORD ALL MENTIONS
_____RELIGION CODE(S) **GO TO *DA33**

DON'T KNOW .....98 **GO TO *DA33**
REFUSED .....99 **GO TO *DA33**

PROTESTANTISM
01. PROTESTANT, NO DENOMINATION MENTIONED
02. PROTESTANT, INTERDENOMINATIONAL (IF YOU GO TO TWO OR MORE PROTESTANT CHURCHES)
03. APOSTOLIC
04. ASSEMBLY OF GOD
05. BAPTIST (ALL TYPES)
06. BORN-AGAIN CHRISTIAN
07. BRETHREN
08. DISCIPLES OF CHRIST / CHRISTIAN CHURCH
09. CHRISTIAN REFORMED
10. CHURCH OF GOD
11. CONGREGATIONAL
12. EPISCOPALIAN OR ANGLICAN/CHURCH OF ENGLAND
13. EVANGELICAL
14. HOLINESS
15. JEHOVAH'S WITNESS
16. LUTHERAN
17. MENNONITE
18. METHODIST (AL TYPES, INCLUDING UNITED BRETHREN)
19. MORMON, LATTER DAY SAINTS
20. NAZARENE
21. PENTECOSTAL
22. PRESBYTERIAN
23. QUAKER, SOCIETY OF FRIENDS
24. SALVATION ARMY
25. SANCTIFIED
26. SEVENTH DAY ADVENTIST
27. SPIRITUAL
28. UNITARIAN
29. UNITED CHURCH OF CHRIST
30. PROTESTANT, OTHER (PLEASE SPECIFY:)

_____

CATHOLICISM
31. CATHOLIC, NO DENOMINATION MENTIONED
32. CATHOLIC, ROMAN
33. CATHOLIC, UKRANIAN

34. ORTHODOX (RUSSIAN, GREEK, SERBIAN)
35. CATHOLIC (ALL OTHERS)

JUDAISM

36. JEWISH, NO DENOMINATION MENTIONED
37. JEWISH ORTHODOX
38. JEWISH CONSERVATIVE
39. JEWISH REFORM
40. JEWISH RECONSTRUCTIONIST
41. JEWISH (ALL OTHERS)

EASTERN

42. BUDDHIST (ALL TYPES, INCLUDING ZEN)
43. HINDU
44. MUSLIM

OTHERS

45. RASTAFARIAN
46. AGNOSTIC OR ATHEIST, **GO TO *DE34**
47. NO RELIGIOUS PREFERENCE
48. NO RELIGION, **GO TO *DE34**
49. OTHER (SPECIFY): _____ _____

Appendix Q

Religious Attendance

DA33. How often do you usually attend religious services?

ONLY READ OPTIONS IF NEC TO PROMPT.

MORE THAN ONCE A WEEK.....1
ABOUT ONCE A WEEK.....2
ONE TO THREE TIMES A MONTH.....3
LESS THAN ONCE A MONTH.....4
NEVER.....5
DON'T KNOW.....8
REFUSED.....9

Appendix R

Religious Coping I

DA34. In general, how important are religious or spiritual beliefs in your daily life – very important, somewhat, not very, or not at all important?

VERY IMPORTANT.....1
SOMEWHAT IMPORTANT.....2
NOT VERY IMPORTANT.....3
NOT AT ALL IMPORTANT.....4 **GO TO *DA37**
DON'T KNOW.....8 **GO TO *DA37**
REFUSED.....9 **GO TO *DA37**

Appendix S

Religious Coping II

*DA35. When you have problems or difficulties in your family, work, or personal life, how often do you seek comfort through religious or spiritual means, such as praying, meditating, attending a religious or spiritual service, or talking to a religious or spiritual advisor – often, sometimes, rarely, or never?

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

Appendix T

Religious Coping III

*DA36. When you have decisions to make in your daily life, how often do you think about what your religious or spiritual beliefs suggest you should do – often, sometimes, rarely, or never?

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

Appendix U

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 *SU65c**	8 **GO TO *SU65c**	9 **GO TO *SU65c**
*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 anything else? (KEY PHRASE: jeopardized your safety because you sometimes used in situations where you could get	1	5	8	9

hurt)				
*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

Appendix V

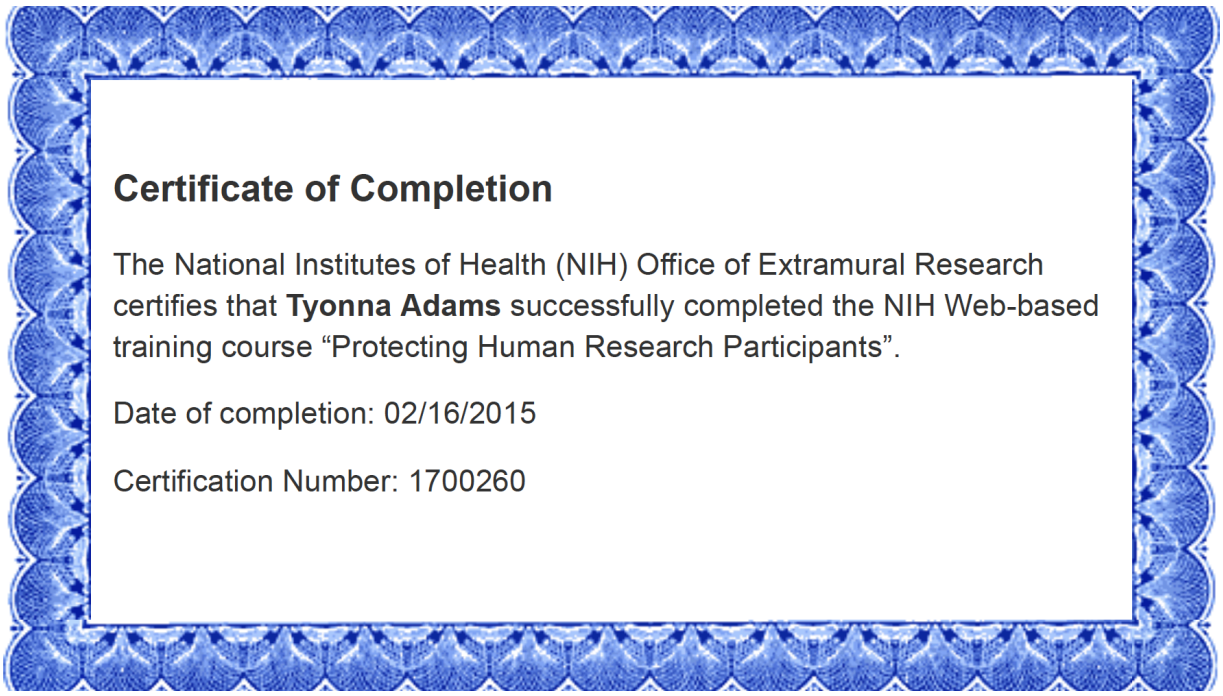
Substance Dependence

INTERVIEWER INSTRUCTION: IF R PROTESTS OR REFUSES TWO QUESTIONS, CODE ALL UNANSWERED ***SU72 SERIES** QUESTIONS '9' AND **GO TO *SU73**.	**YES (1)**	**NO (5)**	**DK (8)**	**RF (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 experienced symptoms like fatigue, headaches, diarrhea, the shakes, or emotional problems?	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 hashish or cocaine / ALL OTHERS: drugs) to keep from having problems like these?	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/ ALL OTHERS: drugs) and found that you were not able to do so?	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	1			

cocaine / ALL OTHERS: drugs) or recovering from the effects of using that you had little time for anything else? for anything else time 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

Appendix W

Certificate of Completion



Certificate of Completion

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

Date of completion: 02/16/2015

Certification Number: 1700260

Appendix X

IRB Letter I

PEPPERDINE UNIVERSITY

Graduate & Professional Schools Institutional Review Board

February 26,

2015 Tyonna [redacted]
Adams

Protocol #: P0215D06
Project Title: Understanding the Buffers and Risk Factors Among Ethnically Diverse Female Survivors of Sexual Victimization

Dear Ms. Adams:

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

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

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

Appendix Y

IRB Letter II

PEPPERDINE UNIVERSITY

Graduate & Professional Schools Institutional Review Board

April 17, 2015

Tyonna Adams
[redacted]

Protocol #: P0215D06
Project Title: Understanding the Buffers and Risk Factors Among Ethnically Diverse Female Survivors of Sexual Victimization

Dear Ms. Adams:

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.

Sincerely,

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

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

Appendix Z

IRB Letter III

PEPPERDINE UNIVERSITY

Graduate & Professional Schools Institutional Review Board

June 3, 2015

Tyonna [redacted]
Adams

Protocol #: P0215D06-AM1
Project Title: Understanding the Buffers and Risk Factors Among Ethnically Diverse Female Survivors of Sexual Victimization

Dear Ms. Adams:

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.

Sincerely,

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

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