The Interface between Social Anxiety and Sexual Victimization: A Study of College Women’s Experiences

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This dissertation titled
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Abstract

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The Interface between Social Anxiety and Sexual Victimization: A Study of College Women’s Experiences

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Research has yet to examine thoroughly how the socio-evaluative fears that typify social anxiety affect the characteristics of sexual assault and post-assault recovery. Accordingly, the present study sought to examine how social anxiety influences sexual assault correlates (e.g., alcohol consumption, tactics used by a perpetrator to compel unwanted sexual activity, and victim resistance to assault) and sequelae (e.g., help-seeking behavior, and interpersonal and sexual functioning difficulties). College women ($N = 203$) completed a battery of online questionnaires for partial course credit. Results supported that social anxiety significantly predicted the frequency of coercion, attempted rape, and rape. Potential mediators of these relationships were examined. Difficulties with interpersonal functioning and sexual aversion (but not sexual dysfunction) were particularly pronounced for women high in social anxiety with past-year assault histories. In addition, although social anxiety exacerbated some psychological barriers to resistance, social anxiety also significantly predicted assertive, but not non-assertive, behavioral resistance to sexual assault. Further, social anxiety and victimization history independently predicted drinking-related consequences. Lastly, post-assault help-seeking was found to be particularly challenging for socially anxious individuals, although social anxiety may not act as a barrier to disclosure of sexual assault to others. In all, current
findings underscore the need for continued research to further elucidate the relationship between sexual assault and social anxiety to augment sexual assault prevention and treatment efforts.
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Introduction

Sexual assault pertains to an array of unwanted sexual behaviors including sexual contact, coercion (oral, vaginal, or anal penetration perpetrated by use of verbal tactics such as threats to end the relationship), and attempted rape and rape (attempted or completed oral, vaginal, or anal penetration perpetrated by use of force, threatened force, or incapacitation, respectively; Koss et al., 2007). Sexual victimization is a significant social and health problem in the United States that disproportionately affects college women: approximately 20% – 25% of female undergraduate students experience attempted or completed rape at some point during college (Fisher, Cullen, & Turner, 2000; Krebs, Lindquist, Warner, Fisher, & Martin, 2009). Extensive empirical support has established the short- and long- term adverse effects of sexual assault (see Briere & Jordan, 2004; Leserman, 2005) yet insufficient research has examined how certain psychological conditions relate to the precipitants and outcomes of sexual assault. Social anxiety disorder (SAD), a chronic mental health condition typified by pervasive fear of evaluation from others and related social avoidance behaviors (American Psychiatric Association [APA], 2013), appears to be a highly salient yet understudied factor that is theoretically related to sexual victimization in important ways.

The finding that both sexual assault and SAD are prevalent on college campuses, experienced at higher rates by women than men, and result in serious negative health outcomes underscores the need to examine the relationship between these two phenomena. Further, the socio-evaluative fears and associated behavioral impairment characteristic of social anxiety may exert a unique, negative influence upon specific
correlates and sequelae of sexual assault. Accordingly, the current study sought to examine the interface between social anxiety and sexual victimization in undergraduate women by investigating how social anxiety influences a) such sexual assault correlates as alcohol consumption, tactics used by a perpetrator to compel unwanted sexual activity, and victim resistance to assault, and b) such aspects of post-assault functioning as help-seeking behavior, and interpersonal and sexual functioning difficulties.

First, an important correlate of sexual assault that may be affected by social anxiety is alcohol consumption. Alcohol use plays an important role with regard to risk for sexual assault: motivated perpetrators may be more likely to target women within environments wherein excessive drinking occurs and sexual activity is desired (e.g., bars or parties), and alcohol-laden contexts may also increase the likelihood that women’s sexual interest cues will be misperceived (Abbey, McAuslan, & Ross, 1998; Ullman, 2003). Indeed, research has supported that the majority of sexual assaults occur when the perpetrator, the victim, and often both have consumed alcohol (Abbey, Zawacki, Buck, Clinton, & McAuslan, 2001). Further, alcohol consumption by both victims and perpetrators appears to be associated with more severe victimization, greater rape completion, and a lesser likelihood of victim resistance (Abbey & Ross, 1992; Harrington & Leitenberg, 1994; Ullman, Karabatsos, & Koss, 1999a; Ullman et al., 1999b).

Alcohol use is also related to social anxiety symptom management: socially anxious individuals’ (SAIs) beliefs about the anxiolytic properties of alcohol in social situations may enhance motives to consume alcohol, thereby leading to greater alcohol abuse potentials. Research has shown that the motivation to drink alcohol to cope with
social fears is related to increased problematic alcohol use in undergraduate students (Buckner & Heimberg, 2010; Cludius, Stevens, Bantin, Gerlach, & Hermann, 2013), and that SAIs are significantly more likely than non-SAIs to report using alcohol to feel comfortable in social situations (Cludius et al., 2013). Furthermore, a positive relationship between social anxiety and adverse alcohol-related consequences has been uniquely established for socially anxious women (Norberg, Norton, Olivier, & Zvolensky, 2010). Thus, provided that alcohol consumption is prevalent on college campuses and related to increased risk for, and severity of, sexual assault, it is particularly concerning that social anxiety is associated with problematic drinking behavior and adverse drinking-related consequences.

In addition, social anxiety symptomology exhibited by potential sexual assault victims may influence the way in which sexual violence is perpetrated (e.g., via physical/aggressive, or non-physical/coercive, tactics). Although personality characteristics of the perpetrator appear to differentially influence the way in which sexual violence is perpetrated (with sexual coercers endorsing enhanced ability to manipulate others’ emotional reactions, and sexual aggressors endorsing greater hostility toward women; DeGue, DiLillo, & Scalora, 2010), victim characteristics also appear to affect perpetration tactics. For example, it has been hypothesized that women who experience sexual coercion may possess personality characteristics that make it more difficult to resist sexual assault. Consistent with this notion, research has supported that sexually coerced women report lower levels of self-esteem and higher levels of
depression and social isolation than do women who had not been coerced or were violently coerced (Zweig, Barber, & Eccles, 1997).

Thus, it is problematic that SAIs are often perceived by others as fearful and unassertive individuals (Creed & Funder, 1998; Davila & Beck, 2002), given that potential perpetrators may be particularly skilled at detecting others’ psychological vulnerabilities (e.g., poor assertiveness) and more likely to target individuals who are perceived to be vulnerable (Grauerholz, 2000). In fact, the only study to date that has investigated the relationship between social anxiety and sexual victimization in college-aged women identified that social interaction anxiety significantly predicted coercion (but not other types of sexual victimization, including sexual contact, attempted rape, and rape; Schry & White, 2013), thereby providing preliminary evidence that certain personality characteristics, such as social anxiety, may affect the likelihood of experiencing particular types of victimization.

Further, social anxiety may theoretically affect rape avoidance responses, as the likelihood that socially anxious women would use such strategies may be impeded by their heightened fears of evaluation. Although perpetrators of sexual violence are exclusively responsible for their acts, examination of the factors that affect sexual assault resistance is necessary, provided that raped women have been found to have poorer psychological health outcomes than women who experienced attempted rape (Ullman & Brecklin, 2002; Ullman & Siegel, 1993) and that utilization of any form of rape resistance during sexual assault (even when rape is ultimately completed) results in better psychological outcomes for victims than non-resistance (Bart & O’Brien, 1985).
Research has broadly supported that women who employ assertive resistance strategies (including forceful and non-forceful physical resistance and forceful verbal resistance; e.g., fighting back or screaming) during sexual assault are more likely to prevent escalation of the assault from attempted to completed rape than are women who use non-assertive resistance strategies (e.g., trying to reason with the perpetrator or crying; Edwards et al., 2014; Ullman, 1997, 2007). Unfortunately, assertive resistance strategies are uncommonly used, with approximately only 20% – 25% of victims using forceful physical resistance during sexual assault (Gidycz, Van Wynsberghe, & Edwards, 2008; Ullman, 2007). Such a finding emphasizes the need to better understand factors, such as social anxiety, that may hinder utilization of assertive resistance. Further, research has established that psychological factors (e.g., embarrassment, fear of peer rejection, and fear of damaging a relationship with the perpetrator), in addition to situational factors (e.g., the intensity and type of perpetrator tactic), must be overcome in order for women to employ assertive resistance (Ullman, 2007). Indeed, prospective research conducted with college women identified that increased self-consciousness and fears of losing the relationship with the perpetrator predicted the use of non-forceful resistance strategies during sexual assault (Turchik, Probst, Chau, Nigoff, & Gidycz, 2007). Thus, provided that psychological barriers to resistance are particularly salient to rape avoidance, the finding that social anxiety is typified by elevated fears of evaluation, concerns of rejection from others, and preoccupation with embarrassment, is significant, insomuch that socially anxious women may be particularly unlikely to utilize assertive resistance strategies.
In addition to evaluating the hypothesized negative influence of social anxiety upon such sexual assault correlates as alcohol consumption, assault perpetration tactics, and resistance to assault, it is equally important to investigate how social anxiety may affect particular aspects of the recovery process following assault, such as help-seeking behavior, and interpersonal and sexual functioning difficulties. First, social anxiety may influence the process of disclosing sexual assault, which plays an important role in post-assault adjustment. Whereas negative social reactions to disclosure (e.g., blaming the victim) are related to poorer self-rated recovery and maladaptive coping, and predict posttraumatic stress severity (Littleton, 2010; Ullman, Townsend, Filipas, & Strazynski, 2007), victims who reported receiving positive (e.g., validating) social reactions evaluated their post-assault recovery more positively, reported fewer psychological symptoms, and engaged in greater coping behaviors (Orchowski, Untied, & Gidycz, 2013; Ullman & Filipas, 2001). However, it appears that negative social reactions to disclosure exert a greater adverse effect on recovery than can be counteracted by the benefits of positive reactions (Ullman, 2007; Campbell & Raja, 1999).

Further, victims’ perceptions of the damaging or helpful nature of others’ responses may be influenced by their relationship to the disclosure recipient. For example, research has shown that positive or neutral responses from friends were related to better recovery post-assault than were positive responses from all other support sources (Ullman, 1996, 2010). It is also important to note that many individuals refrain from disclosing their assault, often due to fears about how others will react or feelings of embarrassment (Ahrens, 2006; Kellogg & Huston, 1995). In fact, sexual assault among
women is one of the most underreported violent crimes (Tjaden & Thoennes, 2006). This notion is concerning when considering that individuals who withhold disclosure experience worse psychological outcomes than those who disclose (Ahrens, Stansell, and Jennings, 2010).

Social anxiety symptomology may affect victims’ process of disclosing sexual assault in numerous ways. The pronounced social anxiety-specific fears of judgment and embarrassment may act as a significant barrier to, or exacerbate one’s distress during, disclosure. In addition, the small social support networks often possessed by SAIs (Littleton & Breitkopf, 2006) may limit the options regarding to whom one can disclose. Further, as compared to non-SAIs, SAIs may be more likely to a) receive negative reactions to disclosure from others (i.e., as a result of their poor communication and support-seeking behaviors; Alden & Taylor, 2010), or b) perceive that others responded negatively (i.e., due to tendencies to negatively distort ambiguous social cues; see Heimberg, Brozovich, & Rapee, 2010). Thus, further evaluation of the influence of social anxiety on the disclosure of sexual assault is warranted.

In addition to influencing help-seeking behavior, social anxiety may exert a negative impact on other aspects of post-assault adjustment, such as interpersonal and sexual functioning difficulties, particularly given that difficulties within these domains are shared consequences of both sexual assault and social anxiety. That is, research supports that women with adult sexual abuse (ASA) histories, in comparison to women without abuse histories or with childhood sexual abuse (CSA) histories only, report more interpersonal problems, including difficulties with emotional intimacy, poor
assertiveness, social avoidance, and dysfunctional interpersonal schemas (Classen, Field, Koopman, Nevill-Manning, & Spiegel, 2001; Cloitre, Cohen, & Scarvalone, 2002). Prospective studies have also identified that interpersonal problems function as both a predictor and after-effect of ASA (Rich, Gidycz, Warkentin, Loh, & Wiland, 2005; Gidycz et al., 1995). Sexually abused women may exhibit interpersonal difficulties as a result of either carrying the feelings of betrayal and powerlessness experienced during abuse into adult relationships, or, incorporating abuse-related feelings of shame and guilt into one’s self-image (Finkelhor & Browne, 1985).

Many studies have also underscored the impact of sexual assault on sexual difficulties by demonstrating that victims of ASA, in comparison to women without abuse histories, are significantly more likely to report sexual dysfunction, lower sexual self-esteem, and reduced relationship quality in their most recent sexual relationship (Bartoi & Kinder, 1998; Shapiro & Schwarz, 1997; Turchik & Hassija, 2014; Weaver, 2009). Sexual functioning difficulties experienced by women with abuse histories may result from associations formed between sexual stimuli and negative emotions (e.g., shame) experienced during the assault event (Hayes, Wilson, Gifford, Follette, & Strosahl, 1996), or attempts to suppress trauma-related thoughts/emotions during sexual activity (Barlow, 1986). Trauma symptomology may also mediate the relationship between ASA and sexual functioning difficulties (Kelley & Gidycz, 2016).

Interpersonal and sexual functioning deficits are also significant consequences of social anxiety. For example, in comparison to non-SAI s or individuals low in social anxiety, SAI s report fewer friend and romantic relationships (Wittchen, Fuetsch, Sonntag,
Muller, & Liebowitz, 2000) and exhibit greater interpersonal functioning difficulties, including social skills deficits, dysfunctional communication styles, and lower perceptions of emotional/social intimacy (Cuming & Rapee, 2010; Davila & Beck, 2002). Theoretically, SAIs’ pervasive beliefs about their social inadequacy may result in social avoidance behaviors and the development of self-protective interpersonal styles that impede their ability to have close relations with others (Alden & Taylor, 2010). Additionally, research has supported that SAIs, in comparison to non- or less- SAIs, report reduced frequency of sexual experiences, diminished sexual enjoyment, sexual problems, fewer feelings of connectedness during sexual activity, and elevated fears of intimacy (Bodinger et al., 2002; Kashdan et al., 2011; Montesi et al., 2013). It also appears that the sexual lives of socially anxious women are more severely impaired than those of socially anxious men (see Bodinger et al., 2002; Kashdan et al., 2011). It has been speculated that the physical and emotional intimacy inherent in sexual encounters enhances SAIs’ fears of evaluation, thereby resulting in sexual avoidance behaviors or a reduction in one’s ability to focus on and enjoy sexual encounters (Kashdan et al., 2011).

It is problematic that interpersonal difficulties are correlates of both social anxiety and sexual assault, as the development and maintenance of strong social bonds are necessary for one’s overall health and wellbeing (Baumeister & Leary, 1995). In addition, the finding that sexual functioning problems typify both social anxiety and sexual assault is concerning, insomuch that a) sexual dysfunction can negatively affect one’s ability to form and maintain intimate relationships (Heiman, 2002), and b) the sexual aspects of intimate relationships are important determinants of overall relationship
quality (Christopher & Sprecher, 2000). Thus, women with social anxiety symptoms may be particularly vulnerable to interpersonal and sexual functioning difficulties following sexual assault, thereby highlighting the imperative to examine how social anxiety relates to these facets of post-assault functioning.

Taken together, it is unfortunate that there is a paucity of research examining the relationship between social anxiety and sexual victimization, given that the socio-evaluative fears unique to social anxiety may negatively affect sexual assault characteristics and exacerbate post-assault psychosocial functioning. In fact, only one previous study (i.e., Schry & White, 2013) has examined social anxiety as it relates to sexual assault among college-aged women. Results of this study revealed that social interaction anxiety had a significant indirect effect on both coercion and rape through decreased sexual refusal assertiveness, although social interaction anxiety was significantly and positively related to the likelihood of experiencing sexual victimization by coercive perpetration tactics only (Schry & White, 2013). In addition, an investigation conducted by Gren-Landell, Aho, Andersson, and Svedin (2011) examined the relationship between SAD and multiple types of victimization in an adolescent, community sample. Interestingly, findings from this investigation revealed that female SAIs reported significantly higher rates of sexual victimization than did non-SAIs (Gren-Landell et al., 2011). These studies represent important first steps toward understanding how social anxiety relates to sexual assault; however, more research is needed to further illuminate the nature of this relationship.
Additional research is also needed to further inform whether social anxiety increases, or protects against, susceptibility to sexual assault. Social anxiety may increase risk for sexual assault by potentially increasing the likelihood of problematic drinking within risky social situations, influencing how sexual violence is perpetrated, and impeding the use of assertive resistance. Conversely, it is possible that social anxiety protects against risk for sexual assault, given that social anxiety-specific avoidance behaviors may decrease exposure to risky situations, such as parties, wherein sexual assault commonly occurs. Lastly, limitations of previous studies, including limited empirical examination regarding how victim (as opposed to perpetrator) psychological characteristics relate to violence perpetration tactics, and over-utilization of community (as opposed to college) samples of women to examine post-assault disclosure processes, are in need of address. Thus, in order to expand the knowledge base regarding the relationship between social anxiety and sexual assault in undergraduate women, the present study sought to examine a number of hypotheses and research questions, presented below.

**Hypotheses and Research Questions**

**Hypothesis 1.** There will be a relationship between adverse drinking-related consequences, social anxiety, and history of past-year victimization. Specifically, it is expected that adverse drinking-related consequences will be positively related to social anxiety symptom severity (**Hypothesis 1a**), and that women with a history of victimization will more frequently report experiencing adverse drinking-related consequences than women without histories of victimization (**Hypothesis 1b**). Further,
the interaction effect between social anxiety and sexual victimization on adverse
drinking-related consequences will be explored, although no specific hypotheses will be
made. It is also expected that women with a history of ASA whose most recent assault
event during the past year involved alcohol will report higher levels of social anxiety than
women whose most recent assault event did not involve alcohol (Hypothesis 1c). Lastly,
a positive relationship between social anxiety and degree of intoxication experienced
during the most recent assault event is expected (Hypothesis 1d).

**Hypothesis 2.** Social anxiety symptom severity will be positively related to the
frequency of sexually coercive events reported. The relationship between social anxiety
and the frequency of other forms of victimization (e.g. attempted rape and rape) will be
explored, although no specific hypotheses will be made.

**Research question 1.** If support is found for Hypothesis 2, how does the
frequency of social engagement and social anxiety-specific drinking behaviors contribute
to the relationships between social anxiety and each form of past-year sexual
victimization (e.g., coercion, attempted rape, and rape)?

**Hypothesis 3.** Within the subsample of women with past-year ASA histories,
social anxiety symptom severity will be positively related to the extent to which
psychological barriers to resistance were encountered during the most recent assault
event.

**Hypothesis 4.** Within the subsample of women with past-year ASA histories,
social anxiety symptom severity will be positively related to use of non-assertive
resistance strategies, and negatively related to use of assertive resistance strategies, during the most recent assault event.

**Hypothesis 5.** Within the subsample of women with past-year ASA histories, social anxiety symptom severity will be negatively related to frequency of disclosure of the most recent sexual assault (**Hypothesis 5a**). Further, it is hypothesized that social anxiety will be positively related to both latencies to disclose (**Hypothesis 5b**) and distress levels when disclosing the most recent sexual assault (**Hypothesis 5c**). It is also expected that social anxiety symptom severity will be negatively related to the amount of perceived positive reactions to disclosure, and positively related to the amount of perceived negative reactions to disclosure (**Hypothesis 5d**). The relationship between social anxiety and mixed-valenced reactions will be explored, although no hypotheses will be made.

**Hypothesis 6.** There will be a relationship between social anxiety, history of past-year victimization, and interpersonal problems. Specifically, it is expected that there will be a positive relationship between social anxiety and interpersonal functioning difficulties (**Hypothesis 6a**). It is also expected that women with a history of victimization will report more interpersonal functioning difficulties in comparison to women without ASA histories (**Hypothesis 6b**), and that there will be an interaction between social anxiety and sexual victimization history (i.e., such that women with past-year ASA histories will report greater interpersonal functioning difficulties than women without ASA histories at high levels of social anxiety, but that there will be no significant difference in
interpersonal functioning across women with and without ASA histories at lower levels of social anxiety; **Hypothesis 6c**).

**Hypothesis 7.** There will be a relationship between social anxiety, history of past-year victimization, and sexual functioning difficulties (i.e., sexual aversion and sexual dysfunction, including increased inhibition of sexual desire, arousal, orgasm, and lubrication, and sexual pain). First, a positive relationship between social anxiety and sexual functioning difficulties is hypothesized (**Hypothesis 7a**). It is also expected that women with a history of victimization will report more sexual functioning difficulties in comparison to women without ASA histories (**Hypothesis 7b**). Further, it is expected that there will be an interaction between social anxiety and sexual victimization history (i.e., such that women with past-year ASA histories will report greater sexual functioning difficulties than women without ASA histories at high levels of social anxiety, but that there will be no significant difference in sexual functioning across women with and without ASA histories at lower levels of social anxiety; **Hypothesis 7c**).

**Research question 2.** Is social anxiety symptomology related to the type of support source to whom sexual assault victims disclose?
Method

Participants

Women participants from introductory psychology courses at a mid-sized Midwestern university were recruited for the current study using the online research sign-up system, SONA. A final sample of 203 participants (from an original sample of 249 participants) was utilized for analyses. All participants self-identified as female and reported that they had been gender assigned as female at birth; six participants reported that they had been born with an intersex condition. Participants’ ages ranged from 18 – 25 years old ($M = 19.01$, $SD = 1.13$), with the majority of participants (65.5%) reporting being in their first year of college. The sample was predominantly comprised of women identifying as White/Caucasian (88.2%), followed by Asian (3.9%), Black or African American (3.9%), Multiracial (2.5%), and Alaskan Indian or Alaska Native (0.5%). In addition, the majority of the sample reported identifying their sexual orientation as heterosexual (96.1%), followed by bisexual (2.5%), gay or lesbian (1%), and asexual (0.5%). Half of the sample (50.2%) reported that they are not currently involved in a dating, romantic, or intimate relationship. Table 1 presents additional demographic information. Participants also reported prior receipt of the following psychological diagnoses: depression (14.3%), attention deficit hyperactivity disorder (8.4%), SAD (4.4%), and PTSD (1.5%). Table 2 presents information about participants’ mental and physical health conditions. Regarding the onset of social anxiety symptomology, participants reported that they first noticed symptoms of social anxiety within the past
year (23.6%), 1 – 2 years ago (22.7%), 2 – 5 years ago (29.6%), and more than 5 years ago (24.1%).

Measures

The measures utilized in the current study are described below and are listed in the order in which they were administered to participants in the online survey. Table 3 presents a summary of the questionnaires that were administered, and identifies for which hypotheses/research questions each measure was utilized. Additional information about the psychometric properties of the following measures is provided in Appendix A1.

Demographics History Questionnaire (DHQ; Appendix A2). The DHQ was used to obtain participant demographic information, including age, race/ethnicity, religion, sexual orientation, family income, and household structure. Items also inquired about participants’ relationship status and history.

Social Interaction Anxiety Scale (SIAS; Mattick & Clarke, 1998; Appendix A3). The SIAS is a 20-item, self-report measure that assesses fears of general social interactions using a five-point rating scale. Higher total scores indicate greater severity of social interaction anxiety. The SIAS has demonstrated strong convergent and discriminant validity (Brown et al., 1997), high internal consistency across clinical, student, and community samples (Heimberg, Mueller, Holt, Hope, & Liebowitz, 1993), and strong test-retest reliability in samples of SAD patients (Mattick & Clarke, 1998). The SIAS total score in the current study was calculated by summing only the 17 straightforwardly-worded SIAS items (i.e., SIAS – Straightforward; SIAS – S) provided that previous research has suggested that this total score more validly assesses social
interaction anxiety within student and clinical populations (Rodebaugh, Woods, & Heimberg, 2007). An additional item was appended to the SIAS – S that inquired about when participants first noticed experiencing difficulty interacting with others. The internal consistency of the SIAS-S total score in the current sample was excellent, Cronbach’s α = .96.

**The Brief Young Adult Alcohol Consequences Questionnaire – 30-day version** (BYAACQ; Kahler, Hustad, Barnett, Strong, & Borsari, 2008; Read, Kahler, Strong, & Colder, 2006; Appendix A4). The BYAACQ is a brief version of the Young Adult Alcohol Consequences Questionnaire (YAACQ; Read et al., 2006), which assesses a broad range of alcohol-related consequences experienced by college students. The 24-item BYAACQ asks participants to indicate whether or not they have experienced specific adverse alcohol-related consequences over the past month. Total scores indicate the total number of consequences the respondent has experienced over the past 30 days. The BYAACQ demonstrated strong internal consistency, concurrent validity, and test-retest reliability in an undergraduate sample (Kahler et al., 2008). The internal consistency of the BYAACQ total score in the current sample was excellent, Cronbach’s α = .93.

**Drinking Due to Social Anxiety Questionnaire** (DDSAQ; Wagner, Stangier, Heidenreich, & Schneider, 2004; Appendix A5). The DDSAQ is a self-report measure that inquires about the use of alcohol to relieve social fears in various social situations over the past month. The measure consists of 28 items rated on a five-point rating scale. Participants also indicated how often each situation occurred over the past thirty days.
Items are summed to create a total score, with higher scores indicating greater use of alcohol to manage social anxiety symptoms. The construct and discriminant validity of the DDSAQ, in addition to the scale’s unidimensional factorial validity, has been established (Wagner et al., 2004). The internal consistency of the DDSAQ total score in the current sample was excellent, Cronbach’s α = .95.

**Social Engagement Measure** (SEM; Appendix A6). The SEM was designed for the current study to obtain information about the frequency of participants’ social engagement over the past year. Items inquired about the average frequency (over the past year) with which participants have attended a party or informal social gathering, gone to a bar, engaged in a one-on-one social activity, willingly met new people, engaged in a dating situation, and engaged in a consensual sexual activity. Participants also indicated how often they have engaged in each type of social gathering as a percentage of the social opportunities in which they were offered to engage, although this was not analyzed in the study. The total score utilized for analyses was calculated by summing the number of reported social engagements over the past month, with higher scores indicating greater frequency of social engagement.

**Female Sexual Function Index** (FSFI; Rosen et al., 2000; Appendix A7). The FSFI is a 19-item measure that assesses six domains of female sexual functioning: desire, subjective arousal, lubrication, orgasm, satisfaction, and pain. Respondents were asked to answer items as they relate to their sexual experiences over the past month. Participants responded to items using a five-point scale; items generally inquire about how often, and to what extent, participants experienced difficulties within each sexual functioning
domain. Higher FSFI total scores indicate fewer sexual functioning problems (Rosen et al., 2000). Provided that the FSFI was utilized as a measure of sexual dysfunction in the current study, the total score was calculated using only the desire, subjective arousal, lubrication, orgasm, and pain subscales. The internal consistency, discriminant validity, and strong test-retest reliability of the FSFI has been established within clinical samples (Meston, 2003; Rosen et al., 2000). The internal consistency of the FSFI total score in the current sample was excellent, Cronbach’s $\alpha = .98$.

**Sexual Aversion Scale** (SAS; Katz, Gipson, Kearl, & Kriskovich, 1989; Appendix A8). The SAS is a 30-item, self-report measure that assesses sexual anxiety and avoidance occurring over the past thirty days using a four-point scale. The SAS is comprised of five subscales pertaining to sexual avoidance, sexual inadequacy, sexual anxiety/self-consciousness, fear of sexually transmitted infections (STIs), and experiences of childhood sexual abuse. Higher SAS total scores indicate greater sexual fears and avoidance. Items loading onto the fear of STIs and CSA experiences subscales were not utilized in the current study, provided that a) assessment of the fear of STIs was not relevant to current study aims, and b) CSA experiences were more comprehensively assessed by the CSVQ. The SAS has demonstrated temporal reliability (Katz, Gipson, & Turner, 1992; Katz et al., 1989) and concurrent validity (Katz & Jardine, 1999; Katz et al., 1992). The internal consistency of the SAS total score in the current sample was excellent, Cronbach’s $\alpha = .93$.

**Diagnostic Questionnaire (DQ;** Appendix A9). The DQ is a self-report measure designed for the current study to inquire about participants’ psychological/medical
history and medication use. Items asked whether participants have ever had concerns about, or received diagnoses of, attention-deficit hyperactivity disorder, social anxiety disorder, type I or II diabetes, depression, or posttraumatic stress disorder. Participants who endorsed that they are currently prescribed psychiatric medication were also asked to report which medications they take.

**Beck Depression Inventory – II** (BDI-II; Beck, Steer, & Brown, 1996; Appendix A10). The BDI-II is a 21-item, self-report measure of affective, cognitive, vegetative, and somatic symptoms of depression occurring over the past two weeks. Respondents rate the intensity of symptoms using a four-point scale, with higher total scores indicating higher levels of depression. The BDI-II has demonstrated excellent internal consistency and test-retest reliability (Beck et al., 1996). BDI-II total scores have also been found to index depression even when general negative affect is accounted for (Hill, Musso, Jones, Pella, & Gouvier, 2013). The BDI-II was administered to participants but not utilized in analyses.

**The Inventory of Interpersonal Problems – Short Circumplex** (IIP-SC; Soldz, Budman, Demby & Merry, 1995; Appendix A11). The IIP-SC is a self-report measure that assesses interpersonal problems as they relate to the eight octants of the interpersonal circumplex (i.e., interpersonal traits related to being domineering, vindictive, cold, socially avoidant, non-assertive, exploitable, overly nurturing, and intrusive). The IIP-SC is a shortened, 32-item version of the 64-item Inventory of Interpersonal Problems – Circumplex (IIP-C; Alden, Wiggins, & Pincus, 1990). The IIP-SC assesses behaviors a) that are difficult to do and b) that one does too much. Each item is rated using a five-
point scale. A subscale score corresponding to each octant of the interpersonal circumplex can be calculated and summed to produce a total score. Higher scores indicate greater interpersonal problems. The IIP-SC has demonstrated structural validity and strong construct validity (Hopwood, Pincus, DeMoor, & Koonce, 2008). The internal consistency of the IIP-SC total score in the current sample was excellent, Cronbach’s $\alpha = .94$.

Child Sexual Victimization Questionnaire (CSVQ; Finkelhor, 1979; Appendix A12). The CSVQ is a self-report questionnaire that consists of eight behaviorally-specific items used to assess sexual victimization experiences that occurred prior to the age of 14. Participants who endorsed having experienced an item were then asked additional questions about specifics of the victimization experience, such as relationship to, and age of, their perpetrator and perceived reason for the abuse. Experiences were classified as childhood sexual abuse if the perpetrator was at least five years older than the victim, if the individual was coerced to engage in the sexual activity, and/or if the perpetrator was a caregiver or authority figure. The concurrent validity of the CSVQ has been established (Risin & Koss, 1987). Child sexual victimization history was categorized dichotomously as history or no history of CSA (with CSA history including acts of sexual exhibition, fondling, and penetration).

Sexual Experiences Survey – Short Form Victimization (SES-SFV; Koss et al., 2007; Koss & Oros, 1982; Appendix A13). The SES-SFV is the revised version of the original Sexual Experiences Survey (SES; Koss & Oros, 1982) that assesses the nature and frequency of seven unwanted sexual experiences and five perpetration tactics used to
compel unwanted sex. Participants responded to each item twice in order to indicate the number of times each form of victimization has occurred a) during the past year, and b) since the age of 14 (excluding the past year). The SES-SFV has been found to exhibit excellent internal consistency in both internet and in-person survey administrations, good test-retest reliability, and good construct validity (Johnson, Murphy & Gidycz, in press). The SES-SFV was used in the current study to classify victimization history (i.e., categorized dichotomously as history or no history of ASA). Only women who met the criteria for having experienced sexual coercion, attempted rape, and rape within the past year were included in the victimization category.

The Characteristics of Sexual Victimization Scale (CSVS; Appendix A14). The CSVS is a measure designed for use as a supplemental measure to the SES-SFV (Kelley, 2015). Items on the CSVS are comprised of questions regarding participants’ most recent unwanted sexual experience, and assessed such assault characteristics as how long ago the incident occurred, age/sex of the perpetrator, relationship to the perpetrator, and how one describes what happened to them. Participants were asked to complete the CSVS if they endorsed any item on the SES-SFV.

Behavioral Response Questionnaire (BRQ; Nurius, Norris, Young, Graham, & Gaylord, 2000; Appendix A15). The BRQ is 25-item self-report questionnaire that assesses direct (i.e., assertive) and indirect (i.e., non-assertive) responses to sexual assault. Participants were asked to indicate how they reacted to their most recent unwanted sexual experience by responding to items using a five-point scale. A total score was produced for each type of resistance tactic, with higher subscale scores indicating
that the response was more like what the participant did during the assault. The construct validity of the BRQ has been supported (Macy, Nurius, & Norris, 2006; Norris, Nurius, & Dimeff, 1996; Stoner et al., 2007). The internal consistencies of the direct and indirect subscales of the BRQ in the current sample were acceptable, Cronbach’s $\alpha = .70$ and .76, respectively.

**Alcohol Questionnaire** (Appendix A16). The alcohol questionnaire was designed to assess victim and perpetrator alcohol use at the time of the most recent assault (Wilson, 2011). Items inquired about the number of alcoholic drinks that were consumed by participants, and how intoxicated the participant felt at the time of the assault. Participants were also asked to report whether their perpetrator had consumed alcohol at the time of the assault, and if so, how many drinks had been consumed and how intoxicated he appeared to be.

**Psychological Barriers to Responding to Sexual Aggression Instrument** (PBRSAI; Nurius et al., 2000; Appendix A17). The PBRSAI is a 21-item, self-report measure that assesses the extent to which certain psychological factors impeded one’s ability to protect oneself during a sexual assault. Items are rated on a five-point scale. Due to a lack of consensus in previous literature regarding factor structure and composition (e.g., see Macy, Nurius, & Norris, 2007; Stoner et al., 2007; Turchik et al., 2007), an exploratory factor analysis using principal axis factoring (PAF) was conducted in order to identify the best-fitting PBRSAI factor structure for the current sample. See Appendix B1 and Appendix B2 for information regarding how the factor analysis was conducted. Results of the factor analysis revealed four subscales: self-consciousness
(four items, \( \alpha = .82 \)), concerns about preserving the relationship with the perpetrator (three items, \( \alpha = .75 \)), concerns that alcohol impeded one’s ability to respond (three items; \( \alpha = .94 \)), and concern for potentially exacerbating injury inflicted by the perpetrator (three items; \( \alpha = .91 \)). Higher scores on each subscale reflect greater difficulty protecting oneself due to the relevant psychological barrier.

**Social Reactions Adjunct Questionnaire (SRAQ; Appendix A18).** The SRAQ was designed for the current study to inquire about whether or not participants had disclosed their most recent sexual assault, and if so, obtain additional information related to participants’ disclosure. If participants indicated that they have told another person of their most recent unwanted experience, additional items inquired about the amount of time that lapsed following the assault event before someone else was first told, to what extent they described the assault event to others, to whom they disclosed, and how difficult/distressing it was to tell various support sources.

**Social Reactions Questionnaire (SRQ; Ullman, 2000; Appendix A19).** The SRQ is a self-report, 48-item instrument designed to measure social reactions to disclosure of sexual assault. Only participants who reported that they had disclosed their most recent unwanted sexual experience were administered the SRQ. Participants indicated how often they received different types of reactions from various support providers following disclosure of sexual assault on a five-point scale. Research has supported a three-factor model of the SRQ consisting of positive, negative (i.e., “turning against”), and mixed-valenced (i.e., “unsupported acknowledgment”) reactions. Discriminant validity has been established (Relyea & Ullman, 2015). The internal consistencies of the SRQ subscales
related to “unsupportive acknowledgment,” “turning against,” and “positive” reactions ranged from moderately acceptable to excellent, Cronbach’s $\alpha$s = .65, .86, and .93, respectively.

**Integrity Check Questions** (Appendix A20). Participants were asked to answer three simple questions in order to ensure the integrity of their responses. The questions were embedded within the online survey at the beginning, middle, and end of the survey, respectively. Participants’ data were not utilized for analyses if they responded incorrectly to any of the three integrity check questions.

**Procedure**

The current study was advertised as “Women’s Social Experiences” in order to reduce possible selection bias. Participants were recruited for the current study using SONA systems. The study utilized a one-time-point design; accordingly, all participants filled out a battery of measures online that was administered through the Qualtrics online survey system. Participants were able to read a description of the study on SONA and, if interested in taking part in the study, could access the Qualtrics survey by obtaining a link posted on SONA. Upon accessing the survey, participants were provided with an electronic version of the informed consent form (Appendix C1). Consent to study participation was provided by clicking a button to continue to the survey. Following provision of informed consent, all participants were administered a battery of measures assessing for demographic information, adulthood and childhood victimization history and characteristics, social interaction anxiety, adverse alcohol-related consequences, interpersonal problems, sexual dysfunction and aversion, and depression. Additionally,
women who reported victimization histories were also asked to complete questionnaires inquiring about assault event-specific alcohol consumption, psychological barriers to resistance, behavioral resistance, and social reactions to disclosure. Following completion of the survey, participants received a debriefing form (Appendix C2) that provided more detail regarding the purpose of the study, resources for psychological and physical health services, and the contact information for the research investigators. Upon completion of the study, participants received 1.5 course credits for their participation. The Ohio University Internal Review Board approved all study procedures.
Results

Descriptive and Preliminary Analyses

All data were analyzed using the statistical software PASW, version 18 (Allen & Bennett, 2010). Descriptive statistics were computed to examine sample characteristics. Table 4 presents the means and standard deviations of all study variables. Table 5 presents the correlations between all continuous study variables. Descriptive statistics revealed that 33% of participants \( n = 67 \) exceeded the empirically-validated cut-off score of 28 on the SIAS-S (Rodebaugh et al., 2011), indicating probable social anxiety. With regard to the frequency of ASA in the full sample, descriptive statistics revealed that 79.3% of participants \( n = 161 \) reported no ASA history and 20.7% of participants \( n = 42 \) reported being the victim of coercion, attempted rape, and/or rape during the past year. Frequency statistics of adult sexual victimization are presented in Table 6. With regard to the frequency of CSA in the full sample, 91.6% of participants \( n = 186 \) reported no history of CSA and 8.4% \( n = 17 \) reported having been victimized in childhood. Of the women with past-year ASA histories, all perpetrators were reported to be male \( n = 33 \), and the reported age of the perpetrator ranged from 17 – 29 years old \( M = 20.16, SD = 2.53 \). The most commonly reported relationship to the perpetrator (reported by 26.2% of the sample) was an acquaintance relationship. Please see Table 7 for further information about assault characteristics.

Preliminary analyses were conducted to determine if CSA history was significantly related to any outcome variables of interest. A series of \( t \)-tests indicated that CSA history was significantly related to the SAS total score, \( t(198) = -2.15, p = .03 \), the
SRQ “turning against” subscale score, $t(17) = 3.35, p = .004$, and the PBRSAS “concerns about preserving the relationship with the perpetrator” subscale score, $t(27.60) = 2.57, p = .02$. Accordingly, CSA history was controlled in the analyses involving these variables. CSA history was not significantly related to any other outcome variables of interest, all $ts < |1.95|$, all $ps > .07$.

**Hypothesis 1**

A series of analyses was conducted to examine the relationship between social anxiety, adverse drinking-related consequences, and past-year victimization history. First, a one-tailed Pearson bivariate correlation conducted in the full sample of women revealed a positive relationship between social anxiety and adverse drinking consequences, $r = .20, p = .002$, as hypothesized (**Hypothesis 1a**). Second, a hierarchical multiple regression was conducted in the full sample of women to examine whether women with ASA histories would more frequently report experiencing adverse drinking-related consequences over the past thirty days than women without ASA histories (**Hypothesis 1b**), and explore the interaction between social anxiety and sexual victimization on adverse drinking-related consequences. ASA history, social anxiety, and the interaction between social anxiety and ASA history were independently entered as predictors in the first, second, and third steps of the regression model, respectively. The frequency with which adverse drinking-related consequences were experienced over the past month served as the dependent variable.

Omnibus results showed that all predictors jointly accounted for significant variance in the frequency of adverse drinking-related consequences, $F(3, 196) = 5.11, p$
Consistent with Hypothesis 1b, results revealed that women with ASA histories reported significantly higher frequencies of adverse drinking-related consequences over the past thirty days ($M = 7.51$, $SD = 6.06$) than did women without ASA histories ($M = 4.79$, $SD = 5.42$), $B = .20$, $p = .01$. However, the interaction between social anxiety and ASA history did not significant predict drinking-related consequences ($B = -.06$, $p = .66$). See Table 8.

Third, an independent samples $t$-test was conducted in the subsample of women with ASA histories to examine the hypothesis that women with a history of ASA whose most recent assault event during the past year involved alcohol would report higher levels of social anxiety than women whose most recent assault event did not involve alcohol (Hypothesis 1c). Inconsistent with the hypothesis, results revealed that women who had consumed alcohol during the most recent event did not report significantly higher levels of social anxiety symptomology ($M = 23.82$, $SD = 15.30$) than women who had not consumed alcohol during the most recent assault event ($M = 21.62$, $SD = 17.13$), $t(33) = 0.39$, $p = .70$, Cohen’s $d = 0.14$. Lastly, a one-tailed Pearson bivariate correlation was conducted in the subsample of women with ASA histories to examine whether there was a positive relationship between social anxiety and the degree of victims’ intoxication during the most recent assault event, as hypothesized (Hypothesis 1d). Results confirmed a significant, positive relationship between social anxiety and victims’ degree of intoxication during the most recent assault event over the past year, $r = .44$, $p = .02$. 


Hypothesis 2

To test the hypothesis that social anxiety symptom severity would be positively related to the frequency of sexually coercive events reported, a negative binomial regression was conducted in the full sample of women with social anxiety as a predictor. A negative binomial regression model was utilized due to its appropriateness for modeling count variables (Hilbe, 2011). A preliminary goodness-of-fit test indicated that the negative binomial model form was a good fit to the data, Pearson $\chi^2(201) = 148.76$, $p = .99$, thereby supporting the appropriateness of using the negative binomial regression model to analyze the data. The omnibus test comparing the fitted model against the intercept-only model was significant, Likelihood Ratio $\chi^2(1) = 5.49$, $p = .02$. Subsequent examination of social anxiety as a predictor in the model revealed that a one point increase in social anxiety was associated with a 0.06 increase in the expected log frequency of coercive events, $B = 0.06$, $SE = 0.03$, 95% Wald CI [0.01, 0.11].

To explore the relationship between social anxiety symptom severity and the frequency of attempted rape and rape events over the past year, two additional negative binomial regression analyses were conducted in the full sample of women. Social anxiety was the predictor in each analysis, and the frequency of attempted rape and rape events, respectively, were the dependent variables in each analysis. Negative binomial regression models were utilized due to their appropriateness for modeling count variables (Hilbe, 2011). For the analysis utilizing the frequency of attempted rape as the outcome variable, the negative binomial model form was found to be a good fit to the data, Pearson $\chi^2(200) = 151.23$, $p = .99$, and the omnibus test comparing the fitted model
against the intercept-only model was significant, Likelihood Ratio $\chi^2 (1) = 7.00, p = .01$. Examination of social anxiety as a predictor in the model revealed that a one point increase in social anxiety was associated with a 0.05 increase in the expected log frequency of attempted rape events, $B = 0.05, SE = 0.02, 95\%$ Wald CI [0.02, 0.09]. For the analysis utilizing the frequency of rape as the outcome variable, a preliminary goodness-of-fit test supported that the negative binomial model form was a good fit to the data, Pearson $\chi^2 (200) = 141.33, p = .99$. The omnibus test comparing the fitted model against the intercept-only model was significant, Likelihood Ratio $\chi^2 (1) = 8.75, p = .003$. Examination of social anxiety as a predictor in the model revealed that a one point increase in social anxiety is associated with a 0.07 increase in the expected log frequency of rape events, $B = 0.07, SE = 0.02, 95\%$ Wald CI [0.02, 0.11].

**Research Question 1**

Six follow-up mediation analyses were conducted in the full sample of women in order to examine whether the frequency of social engagement or social anxiety-specific drinking behaviors contributed to the relationships between social anxiety and the frequency of coercion, attempted rape, and rape, respectively. The mediation analyses were conducted utilizing the macro established by Hayes (2012). A nonparametric bootstrapping procedure was used to test the indirect effect of the independent variables on the dependent variables through the mediator given that such an approach does not make assumptions about the sampling distribution or the distribution of the variables (Preacher & Hayes, 2004). Bias-corrected and accelerated bootstrapped confidence intervals were obtained using 5000 resamples. In the first three mediation analyses, the
independent variable was social anxiety, with drinking due to social anxiety as the mediator. The frequencies of coercion, attempted rape, and rape events were the outcome variables in each respective analysis. Results revealed that drinking due to social anxiety did not mediate the relationship between social anxiety and the frequency of coercion ($B = 0.001, 95\% CI [-0.01, 0.01]$), attempted rape ($B = 0.01, 95\% CI [-0.01, 0.03]$), or rape ($B = 0.003, 95\% CI [-0.01, 0.02]$).

In the latter three mediation analyses conducted in the full sample of women, the independent variable was social anxiety, with social engagement as the mediator. The frequencies of coercion, attempted rape, and rape events were the outcome variables in each respective analysis. Results revealed that social engagement did not mediate the relationship between social anxiety and the frequency of coercion ($B = 0.004, 95\% CI [-0.002, 0.01]$), attempted rape ($B = -0.002, 95\% CI [-0.01, 0.01]$), or rape ($B = 0.002, 95\% CI [-0.01, 0.01]$).

**Hypothesis 3**

To test the hypothesis that social anxiety symptom severity would be positively related to the extent to which psychological barriers to resistance were encountered during the most recent assault experienced over the past year, three one-tailed Pearson correlation analyses were conducted in the subsample of women with ASA histories (i.e., with each analysis correlating social anxiety with one form of a psychological barrier to resistance). The Bonferroni-Holm correction for multiple comparisons (i.e. a simple sequentially rejective multiple test procedure) was utilized due to the fact that it confers a lower probability of type II error than other correction tests, such as the Bonferroni
correction (Holm, 1979). Consistent with the hypothesis, results provided support for positive and significant relationships between social anxiety and concerns about exacerbating injury inflicted by the perpetrator ($r = .57, p < .001, \alpha = .0125$), and concerns that alcohol impeded one’s ability to respond ($r = .41, p = .01, \alpha = .0167$). Further, results revealed a positive relationship between social anxiety and self-consciousness ($r = .33, p = .03, \alpha = .025$), as hypothesized, although this effect only trended toward significance. Lastly, a semi-partial correlation was conducted to examine the relationship between social anxiety and relationship preservation concerns while controlling for the effect of CSA history. Inconsistent with the hypothesis, the relationship between social anxiety and concerns about preserving the relationship with the perpetrator was non-significant when controlling for CSA history ($r = .17, p = .16$).

Given that social anxiety was significantly related to two particular psychological barriers to resistance, six follow-up, exploratory mediation analyses were conducted in the subsample of women with past-year ASA histories in order to further examine how the relationship between social anxiety and barriers to resistance might impact the frequency of assault. The mediation analyses were conducted using the macro established by Hayes (2012) and utilized a bootstrapping procedure wherein bias-corrected and accelerated bootstrapped confidence intervals were obtained using 5000 resamples.

In the first three mediation analyses, the independent variable was social anxiety, with concerns that alcohol impeded one’s ability to respond as the mediator. The frequencies of coercion, attempted rape, and rape events were the outcome variables in each respective analysis. Results revealed that alcohol concerns mediated the relationship
between social anxiety and the frequency of rape ($B = 0.03$, 95% CI [0.003, 0.08]), such that social anxiety was positively related to concerns that alcohol impeded one’s ability to respond, which was then positively related to the frequency of rape. However, concerns about alcohol impeding resistance did not mediate the relationship between social anxiety and the frequency of coercion ($B = 0.001$, 95% CI [-0.02, 0.04]) or attempted rape ($B = 0.02$, 95% CI [-0.004, 0.10]).

In the latter three mediation analyses conducted in the subsample of women with past-year ASA histories, the independent variable was social anxiety, with concerns of injury exacerbation as the mediator. The frequencies of coercion, attempted rape, and rape events were the outcome variables in each respective analysis. Results revealed that concerns of injury exacerbation did not mediate the relationship between social anxiety and the frequency of coercion ($B = 0.01$, 95% CI [-0.06, 0.04]), attempted rape ($B = 0.01$, 95% CI [-0.04, 0.04]), or rape ($B = 0.01$, 95% CI [-0.08, 0.06]).

**Hypothesis 4**

To examine whether social anxiety symptom severity would be positively related to use of non-assertive resistance strategies, and negatively related to use of assertive resistance strategies, during the most recent assault event, two one-tailed Pearson correlation analyses were conducted in the subsample of women with ASA histories. The Bonferroni-Holm correction for multiple comparisons was utilized (Holm, 1979). Contrary to the hypothesis, social anxiety was positively and significantly related to assertive resistance, ($r = .36$, $p = .02$, $\alpha = .025$). Results also revealed a positive relationship between social anxiety and non-assertive resistance, as hypothesized,
although the correlation only trended toward statistical significance ($r = .27$, $p = .06$, $\alpha = .05$).

**Hypothesis 5**

A series of analyses was conducted to examine the relationship between social anxiety and disclosure-related processes. First, to test the hypothesis that social anxiety would be negatively related to the frequency of disclosure of the most recent sexual assault (**Hypothesis 5a**), a negative binomial regression was conducted in the subsample of women with ASA histories. Social anxiety was the predictor and the frequency of disclosure was the outcome variable. A negative binomial regression model was utilized due to its appropriateness for modeling count data (Hilbe, 2011) and as a result of the overdispersion of the outcome variable, frequency of disclosure (dispersion parameter $\phi = 1.17$). A preliminary goodness-of-fit test indicated that the negative binomial model form was a good fit to the data, Pearson $\chi^2 (30) = 22.58, p = .75$. Inconsistent with the hypothesis, the omnibus test comparing the fitted model against the intercept-only model was non-significant, Likelihood Ratio $\chi^2 (1) = 0.04, p = .83$.

Following, a number of analyses examining disclosure processes were conducted in the subsample of women with ASA histories who reported that they had disclosed their most recent assault event to another person ($n = 22$). First, a one-tailed Pearson correlation analysis was conducted to examine if social anxiety symptom severity was positively related to latencies to disclose (**Hypothesis 5b**). Inconsistent with the hypothesis, the relationship between social anxiety and latencies to disclose was non-significant ($r = .13, p = .28$). Second, another one-tailed Pearson correlation analysis was
conducted to determine if social anxiety was positively related to distress levels when disclosing the most recent assault event. Support for this hypothesis was found, $r = .51, p = .01$ (Hypothesis 5c).

Lastly, three analyses were conducted in the subsample of women with ASA histories who had disclosed their most recent assault event in order to examine the relationship between social anxiety symptom severity and perceived reactions to disclosure (Hypothesis 5d). The Bonferroni-Holm correction for multiple comparisons was utilized. First, to determine if social anxiety symptom severity would be negatively related to the amount of perceived positive reactions to disclosure, a one-tailed Pearson correlation was conducted. Contrary to the hypothesis, results revealed a positive but non-significant relationship between social anxiety and positive reactions to disclosure ($r = .31, p = .08, \alpha = .0167$). Next, a semi-partial correlation was conducted to examine if social anxiety symptom severity was positively related to negative social reactions (i.e., the “turning against” subscale of the SRQ), as hypothesized. Results revealed that social anxiety, when controlling for CSA status, was not significantly related to “turning against” reactions to disclosure ($r = -.03, p = .44$). Lastly, results of an exploratory, one-tailed Pearson correlation analysis revealed that social anxiety was not significantly related to “unsupported acknowledgement,” $r = .03, p = .44$.

Hypothesis 6

A series of analyses was conducted to examine the relationship between social anxiety, history of past-year victimization, and interpersonal problems. First, a one-tailed Pearson correlation analysis was conducted in the full sample of women to examine the
hypothesis that social anxiety would be positively related to interpersonal problems (Hypothesis 6a). Consistent with the hypothesis, results supported a positive relationship between social anxiety and interpersonal functioning difficulties, \( r = .58, p < .001 \).

Second, a hierarchical multiple regression was conducted in the full sample of women to assess whether 1) women with a history of ASA would report more interpersonal functioning difficulties than women without ASA histories (Hypothesis 6b), and 2) there would be an interaction between social anxiety and sexual victimization history (i.e., such that women with past-year ASA histories would report greater interpersonal functioning difficulties than women without ASA histories at high levels of social anxiety, but that there would be no significant difference in interpersonal functioning across women with and without ASA histories at lower levels of social anxiety; Hypothesis 6c).

Interpersonal problems was the outcome variable; ASA history, social anxiety, and the interaction between social anxiety and ASA history were independently entered as predictors into the first, second, and third steps of the analysis, respectively.

Omnibus results revealed that all predictors jointly accounted for significant variance in the extent of interpersonal problems, \( F(3, 199) = 38.15, p < .001, R^2 = .37 \). Consistent with Hypothesis 6b, results revealed that women with ASA histories reported greater interpersonal functioning difficulties (\( M = 36.10, SD = 25.70 \)) than did women without ASA histories (\( M = 28.58, SD = 21.10 \)), although this finding only trended toward significance (\( B = .14, p = .05 \)). In the presence of all other predictors, social anxiety also accounted for unique variance in interpersonal problems (\( B = .49, p < .001 \)). In addition, consistent with Hypothesis 6c, the interaction between social anxiety and
ASA history accounted for unique variance in interpersonal problems when in the presence of all other predictors ($B = .32, p = .004$), revealing a significantly more positive relationship between social anxiety and interpersonal problems among women with ASA histories in comparison to women without ASA histories. Post-hoc analyses (utilizing the process macro established by Hayes, 2012) were conducted to further probe this interaction effect. Results revealed that there was no significant difference in interpersonal problems between women with and without ASA histories at low levels of social anxiety (i.e., one standard deviation below the sample mean), $t = -1.29, p = .20$, but that women with ASA histories reported significantly greater interpersonal problems than did women without ASA histories at high levels of social anxiety (i.e., one standard deviation above the sample mean), $t = 3.01, p = .003$. ASA history (in the presence of all other predictors in the model) did not account for unique variance in interpersonal problems, $B = -.17, p = .10$. See Table 9 and Figure 1 for additional information.

**Hypothesis 7**

A series of analyses was conducted to examine the relationship between social anxiety, history of past-year victimization, and sexual functioning difficulties (i.e., sexual aversion and sexual dysfunction). First, two analyses were conducted in the full sample of women in order to test the hypothesis that social anxiety would be positively related to sexual functioning problems (**Hypothesis 7a**). First, a semi-partial correlation analysis revealed a positive relationship between sexual aversion and social anxiety when controlling for CSA history, $r = .42, p < .001$, as hypothesized. Second, consistent with
hypothesis, a one-tailed Pearson correlation analysis revealed a positive relationship between social anxiety and sexual dysfunction \((r = -.24, p < .001)\).vi

Second, in order to test the hypotheses that 1) women with a history of ASA would report more sexual functioning difficulties than women without ASA histories (Hypothesis 7b), and 2) there would be an interaction between social anxiety and sexual victimization history (i.e., such that women with past-year ASA histories would report greater sexual functioning difficulties than women without ASA histories at high levels of social anxiety, but that there would be no significant difference in sexual functioning difficulties at low levels of social anxiety; Hypothesis 7c), two hierarchical multiple regression analyses were conducted in the full sample of women. In the first regression analysis, sexual aversion was the dependent variable, and CSA history, ASA history, social anxiety, and the interaction between social anxiety and ASA history were independently entered as predictors in the first, second, third, and fourth steps of the analysis, respectively.\(\text{v}\) In the second analysis, sexual dysfunction was the dependent variable, and ASA history, social anxiety, and the interaction between social anxiety and ASA history were independently entered as predictors into the first, second, and third steps of the analysis, respectively.

Omnibus results of the first regression analysis revealed that all predictors jointly accounted for significant variance in sexual aversion, \(F(4, 195) = 22.86, p < .001, R^2 = .32\). Consistent with Hypothesis 7b, results revealed that women with ASA histories reported significantly higher levels of sexual aversion \((M = 39.93, SD = 14.35)\) than women without ASA histories \((M = 30.84, SD = 9.08), B = .32, p < .001\) (when CSA
history was controlled). In the presence of all other predictors, social anxiety ($B = .26$, $p < .001$) and the interaction between social anxiety and ASA history ($B = .42$, $p = .001$) each accounted for unique variance in sexual aversion, providing support for **Hypothesis 7c**. The significant interaction effect revealed a more positive relationship between social anxiety and sexual aversion among women with ASA histories in comparison to women without ASA histories. Post-hoc analyses (utilizing the process macro established by Hayes, 2012) were conducted to further probe this interaction effect. Results revealed that there was no significant difference in sexual aversion between women with and without ASA histories at low levels of social anxiety (i.e., one standard deviation below the sample mean), $t = 0.48$, $p = .63$, but that women with ASA histories reported significantly greater sexual aversion than did women without ASA histories at high levels of social anxiety (i.e., one standard deviation above the sample mean), $t = 6.21$, $p < .001$. ASA history (when in the presence of all other predictors in the model) did not account for unique variance in sexual aversion ($B = -.05$, $p = .67$). Figure 2 displays the effect of social anxiety and ASA history on sexual aversion (when CSA was controlled).

Omnibus results of the second regression analysis revealed that all predictors jointly accounted for significant variance in sexual dysfunction, $F(3, 199) = 6.12$, $p = .001$, $R^2 = .08$. Inconsistent with **Hypothesis 7b**, results revealed no significant difference in the degree of sexual dysfunction experienced across women with ASA histories ($M = 16.61$, $SD = 8.45$) and women without ASA histories ($M = 16.14$, $SD = 10.00$), $B = .02$, $p = .78$. ASA history, social anxiety, and the interaction between social anxiety and ASA history each accounted for unique variance in sexual dysfunction when
in the presence of all other predictors ($B = .28, p = .02$; $B = -.17, p = .03$; and $B = -.30, p = .02$, respectively). However, contrary to expectation (Hypothesis 7c), the significant interaction effect revealed a more negative relationship between social anxiety and sexual functioning problems among women with ASA histories in comparison to women without ASA histories. More specifically, post-hoc analyses (utilizing the process macro established by Hayes, 2012) that were conducted to further probe this interaction effect revealed that women with ASA histories reported significantly less sexual dysfunction than did women without ASA histories at low levels of social anxiety (i.e., one standard deviation below the sample mean), $t = 2.17, p = .03$, but that there was no significant difference in sexual dysfunction between women with and without ASA histories at high levels of social anxiety (i.e., one standard deviation above the sample mean), $t = -1.04, p = .30$. See Table 10 and Figure 3.

A follow-up Fisher’s $r$-to-$z$ transformation test was also conducted on an exploratory basis in the full sample of women in order to evaluate whether social anxiety was more strongly related to sexual aversion or dysfunction. Results revealed that social anxiety was significantly more strongly related to sexual aversion than dysfunction, Fisher’s $z = 2.34, p = .02$.

**Research Question 2**

To explore whether social anxiety is related to the type of support source to whom sexual assault victims disclose, a series of $t$-tests was conducted in the subsample of women with past-year ASA histories that compared the severity of social anxiety symptoms across women who did and did not disclose to various formal and informal
support sources (including casual friends, acquaintances, family members, and legal or medical personnel). The Bonferroni-Holm correction for multiple comparisons was utilized. Results revealed no significant differences in the extent of social anxiety symptoms across women who did and did not disclose to various support sources, all $t_s < 2.21$, all $p_s > .04$, $\alpha = .006$ ($\alpha = .05/9$). See Appendix D for full statistical results.
Discussion

The present study sought to examine the interface between social anxiety and sexual victimization in undergraduate women as it pertains to sexual assault correlates (i.e., alcohol consumption, tactics used by a perpetrator to compel unwanted sexual activity, and victim resistance to assault) and post-assault functioning (i.e., help-seeking behavior, and interpersonal and sexual functioning difficulties). Despite theoretical links tying social anxiety to sexual victimization, research has yet to examine thoroughly how the socio-evaluative fears that typify social anxiety affect the characteristics of sexual assault and post-assault recovery. Cultivating greater understanding of the interface between these two phenomena is crucial, as both social anxiety and sexual assault are prevalent on college campuses, are experienced more often by women than men, and can result in poor health outcomes for women (APA, 2013; Briere & Jordan, 2004; Grant et al., 2005; Krebs et al., 2009). To the author’s knowledge, this study is the first to examine the intersection between social anxiety and the aforementioned sexual assault correlates and sequelae in an undergraduate sample of women.

Examination of the overarching relationship between social anxiety and the frequency of past-year victimization within the full sample of women demonstrated that social anxiety significantly predicted the frequency of all forms of sexual assault. Specifically, an increase in social anxiety was related to increases in the expected log frequencies of coercion, attempted rape, and rape. These findings differed from those of Schry and White (2013), the only prior investigation to examine social anxiety as it pertains to sexual assault among college-aged women. Findings from Schry and White...
(2013) revealed that an increase in social anxiety was only directly associated with an increase in the odds of being coerced, although significant indirect effects of social anxiety on both coercion and rape (via decreased sexual refusal assertiveness) were found. Although Schry and White (2013) dichotomously categorized sexual assault (i.e., such that each form of assault either occurred or did not occur), the present researcher elected to examine the frequency (as opposed to occurrence) of each form of sexual assault so that a complementary albeit distinct research question about the relationship between social anxiety and sexual assault could be evaluated. Taken together, these results provide preliminary evidence supporting the relationship between social anxiety and some, if not all, forms of sexual assault. The present findings expand upon those of Schry and White (2013) by highlighting that the relationship between social anxiety and sexual victimization may be more concerning than previously suggested, insomuch that women with social anxiety may be not only at particular risk for coercion, but potentially, multiple forms of sexual assault as well.

Investigation of the relationship between social anxiety, past-year victimization history, and interpersonal problems in the full sample of women revealed a trend toward greater interpersonal problems among women with ASA histories than women without ASA histories, and a positive relationship between social anxiety and interpersonal difficulties. These results are consistent with literature that posits that women with adult ASA histories experience greater interpersonal problems than do non-victimized women (Classen et al., 2001; Cloitre et al., 2002; Rich et al., 2005), and that SAIs exhibit greater interpersonal difficulties than do non-SAI (Davila & Beck, 2002; Wenzel, Graff-
Dolezal, Macho, & Brendle, 2005; Sparrevoorn & Rapee, 2009). Further, a significant interaction effect between social anxiety and victimization history on interpersonal problems was revealed, highlighting that interpersonal functioning may be especially problematic for women high in social anxiety who have assault histories.

It may be that women with social anxiety are at particular risk for the interpersonal difficulties that women with sexual assault histories often experience, as social anxiety might weaken women’s general coping abilities and overall resilience. In this way, social anxiety may further impair the overall post-assault recovery process. This notion is particularly troubling when considering the importance of adequate interpersonal functioning to one’s overall health (Baumeister & Leary, 1995).

The current investigation also revealed interesting findings related to sexual functioning. First, consistent with literature that has evidenced greater impairment in the sexual functioning of SAIs in comparison to those lower in social anxiety (Bodinger et al., 2002; Kashdan et al., 2011), positive relationships between social anxiety and sexual aversion and dysfunction, respectively, were established in the full sample of women. However, although results revealed that women with past-year ASA histories experienced greater levels of sexual aversion than did women without ASA histories, which is in line with findings of previous research (e.g., van Berlo & Ensink, 2000), the sexual functioning of women with and without past-year ASA histories did not significantly differ in the current investigation.

Further, there was a significant interaction effect of social anxiety and past-year ASA histories on both sexual aversion (when CSA was controlled) and sexual
dysfunction, respectively. However, whereas women with past-year ASA histories demonstrated significantly greater sexual aversion than did women without ASA histories at high (but not low) levels of social anxiety, women with past-year ASA histories demonstrated significantly better sexual functioning than did women without ASA histories at low, but not high, levels of social anxiety. Given that sexual aversion is typified by sexual anxiety and beliefs of sexual inadequacy, and that prior research has demonstrated that social anxiety is strongly and positively associated with fears of intimacy (Montesi et al., 2013), it makes theoretical sense that increasing levels of social anxiety would exacerbate sexual aversion. This notion, taken with the finding that sexual assault may result in diminished sexual self-esteem (Shapiro & Schwartz, 1997), aptly illuminates the interaction effect between social anxiety and sexual assault on sexual aversion that was observed in the present investigation.

Indeed, although it had been expected that there would be a similar interaction effect of social anxiety and past-year ASA histories on sexual dysfunction as on sexual aversion, it is reasonable that results pertaining to sexual functioning evidenced a different pattern, as sexual aversion may be more strongly tied to social anxiety than sexual dysfunction on a construct level. Consistent with this notion, a follow-up Fisher’s $r$-to-$z$ transformation test confirmed that social anxiety was significantly more strongly related to sexual aversion than dysfunction. In addition, given that the only research to date that has provided strong support for sexual dysfunction in SAIs (i.e., Bodinger et al., 2002) was conducted using a clinical sample of SAD patients, it is possible that the unexpected finding that women with ASA histories exhibited enhanced sexual
functioning at low (but not high) levels of social anxiety may be related to the non-clinical nature of the current sample. Different findings pertaining to the relationship between social anxiety, sexual victimization, and sexual dysfunction may have emerged had a clinical sample of socially anxious individuals been used.

In addition, previous research has underscored the complexity of women’s sexual functioning by demonstrating that women may report significantly impaired sexual function without the experience of subjective distress (King, Holt, & Nazareth, 2007; Rosen et al., 2009), or high distress about sexual function in the absence of objective sexual functioning problems (Stephenson, Hughan, & Meston, 2012). These findings highlight the importance of understanding a woman’s subjective distress regarding her sexual function, such that obtaining information about objective indices of sexual function without understanding how a woman’s sexual functioning affects her emotionally (as was the case in the current investigation) may be insufficient in capturing a comprehensive picture of sexual function. For example, it is possible that women with ASA histories who reported enhanced sexual function in comparison to women without ASA histories at low levels of social anxiety may have indeed demonstrated fewer sexual problems, but could have experienced greater distress about their sexual function, which is an important facet of sexual functioning. However, despite speculation about factors that may account for the unexpected finding that women with ASA histories reported enhanced sexual function at low levels of social anxiety, such conjecture does not obscure the perplexing nature of this finding and highlights the need for further research to clarify the relationship between social anxiety, sexual victimization, and sexual
dysfunction. Further, the current study examined the relationship between social anxiety and the extent to which psychological barriers to resistance were encountered during the most recent assault. Results revealed that social anxiety was positively and significantly related to concerns about exacerbating injury inflicted by the perpetrator and concerns that alcohol impeded one’s ability to respond, which provides preliminary support for the notion that social anxiety exacerbates some of the psychological barriers that play an important role in sexual assault resistance.

Follow-up exploratory mediation analyses revealed that concerns about alcohol impeding resistance mediated the relationship between social anxiety and the frequency of rape, although this psychological barrier did not mediate the relationship between social anxiety and the frequency of coercion or attempted rape. Further, concerns about injury exacerbation did not mediate the relationship between social anxiety and the frequency of coercion, attempted rape, or rape. Thus, despite the positive association between social anxiety and some psychological barriers to resistance, the increased barriers experienced by SAIs do not necessarily influence the frequency of all forms of assault, although it appears that the relationship between social anxiety and rape may be accounted for by concerns that alcohol impeded one’s ability to respond.

With regard to other psychological barriers to resistance encountered during the most recent assault, there was only a trend toward social anxiety predicting self-consciousness, and a non-significant but positive relationship between social anxiety and concerns about preserving the relationship with the perpetrator (when accounting for CSA history). Given that social anxiety is typified by extreme fears of evaluation, it was
unexpected that social anxiety did not demonstrate a significant and positive association with self-consciousness, as hypothesized. This finding, however, may be attributable to construct validity issues: the factor structure of the instrument measuring psychological barriers to resistance has been variable across prior studies (see Macy, Nurius, & Norris, 2007; Stoner et al., 2007; Turchik et al., 2007), leading this researcher to utilize subscales that were independently identified by factor analysis in the present sample but have not been empirically-validated. In addition, the nonsignificant relationship between social anxiety and relationship preservation concerns may be accounted for by the heterogeneous nature of social anxiety-specific socio-evaluative fears, such that the specific nature of a relationship (e.g., an acquaintance versus a romantic relationship) may elicit differential degrees of anxiety based upon an individual’s idiosyncratic fears of judgment (Heimberg et al., 2010). It is also plausible that concerns about preserving the relationship with the perpetrator would become more pronounced with increasing levels of social anxiety when the perpetrator was well-known to the victim (e.g., a romantic partner); the fact that the largest percentage of reported past-year assaults were perpetrated by acquaintances (26.2%) may partially explain this finding.

Notable findings related to social anxiety and behavioral resistance to assault also emerged in the current investigation: social anxiety symptom severity was positively related to both assertive and non-assertive resistance, although the latter relationship only trended toward significance. Given that social anxiety is associated with both behavioral and interpersonal submissiveness (Alden & Taylor, 2010; Heimberg et al., 2010), it had been hypothesized a priori that social anxiety would be positively related to non-assertive
resistance, and negatively related to assertive resistance. However, it is not entirely unexpected that social anxiety was positively associated with both forms of resistance in the present study. That is, given that previous research has documented that women often use an array of various resistance strategies during sexual assault (Edwards et al., 2014; Ullman, 2007), it is plausible that women’s responses during their most recent assault entailed both assertive and non-assertive tactics, regardless of one’s degree of social anxiety.

Furthermore, a great deal of research, guided by the cognitive ecological model of resistance (Nurius & Norris, 1996) has evidenced that myriad factors (including historical, relational, situational, and personal factors) shape the particular way in which women respond to sexual assault (Macy et al., 2006; Ullman, 2007). As a result, it seems that women’s responses to sexual assault must be examined within the context of other factors salient to behavioral resistance (e.g., such as perpetration tactic) in order to be most adequately understood. Due to the nature of the questionnaires administered to participants in the present investigation, the type of resistance that was characteristic of the most recent assault could not be tied specifically to the form of perpetration enacted during that assault. That is, women with past-year ASA histories identified how they responded to their most recent assault event only, and although all past-year assaults could be categorized, the specific form of the most recent assault could not be conclusively determined for all women, thereby precluding the ability to examine the unique interaction between social anxiety, perpetration tactic, and behavioral resistance, which may have allowed for more informed conclusions about resistance to be made.
In addition, the present study examined the relationship between social anxiety, sexual victimization, and adverse drinking consequences. Significantly higher frequencies of adverse drinking consequences over the past 30 days were reported by women with past-year ASA histories than women without ASA histories, consistent with the extant literature suggesting that excessive alcohol consumption and associated negative drinking consequences may serve as a predictor and/or aftereffect of victimization (Abbey et al., 2001). Current results also revealed a positive relationship between social anxiety and adverse drinking consequences among the full sample of women, which is in line with previous research that supports that social anxiety is related to increased problematic alcohol use (Buckner & Heimberg, 2010; Cludius et al., 2013). Further, although no significant difference in the degree of social anxiety was detected across women with ASA histories who had consumed alcohol during the most recent assault event as compared to those who had not, the present study found a positive relationship between social anxiety and degree of intoxication during the most recent assault event. This finding is concerning in light of previous research suggesting that alcohol consumption may be related to increased severity of assault (Abbey & Ross, 1992; Ullman et al., 1999a).

Although no a priori hypotheses were made, results did not support a significant interactive effect of social anxiety and victimization on alcohol-related consequences, indicating that social anxiety and victimization history may uniquely and independently influence alcohol consumption and drinking-related consequences. However, an investigation of the frequency distribution of drinking consequences demonstrated a
highly positively skewed distribution (skewness statistic = 1.24, SE = 0.17), such that 80.5% of the sample scored a 9 or below despite the drinking consequences measure having a possible range of scores between 0 – 24. Therefore, it is possible that a floor effect pertaining to the outcome variable (as a product of its effective truncated range) prevented detection of a genuine interaction effect. Consistent with this notion, visual inspection of the simple slopes evidenced that women high in social anxiety with ASA histories reported the most drinking-related consequences.

Interestingly, however, the consumption of alcohol to relieve social fears did not mediate the relationship between social anxiety and the frequency of coercion, attempted rape, or rape when examined in the full sample of women. These results suggest that social anxiety exerts its effect on sexual victimization via means outside of drinking due to social anxiety. Similarly, the current investigation did not find support for the mediating role of the frequency of social engagement on the relationship between social anxiety and the frequency of each form of assault, also suggesting that differential social engagement (i.e., as a function of social anxiety) does not provide the mechanism through which social anxiety influences the frequency of assault.

The current study also investigated the relationship between social anxiety and sexual assault disclosure processes. Unexpectedly, results revealed that social anxiety did not significantly predict frequency of disclosure after the most recent assault, and was not significantly and positively correlated with latencies to disclose post-assault. Further, social anxiety was not significantly related to the extent to which negative social reactions (e.g., “turning against” reactions, when in the presence of CSA) and mixed-
valenced reactions to disclosure (i.e., “unsupported acknowledgement” reactions) were perceived, indicating that social anxiety may not negatively distort how a social reaction is perceived, or elicit more negative reactions from others. In addition, there was a positive and non-significant relationship between social anxiety and positive reactions to disclosure. Given that current findings also revealed that social anxiety demonstrated a strong, positive relationship with general distress experienced during the most recent disclosure of sexual assault, it is possible that SAIs experienced heightened distress during disclosure as a result of elevated socio-evaluative fears, which then served to elicit positive reactions (intended to assuage anxiety) from disclosure recipients. On the other hand, it is also possible that SAIs experienced greater distress during disclosure as a result of perceiving positive reactions from others, as research has documented that SAIs may experience distress in response to any form of evaluation from others, including positive evaluation (Weeks & Howell, 2014). Taken together, these findings suggest that although social anxiety may not act as a barrier to disclosure for SAIs, the often-times difficult experience of seeking help from others after sexual assault may be particularly challenging for SAIs.

Lastly, exploratory results examining whether social anxiety symptoms were related to the type of support source to whom victims disclosed revealed that social anxiety symptom severity did not significantly differ across women who did and did not disclose to all support sources, including romantic partners, close or casual friends, acquaintances, coworkers, family members, legal or medical personnel, or counselors. However, large differences in social anxiety symptoms were observed across women who
did and did not disclose to certain support sources. For example, the largest mean difference in social anxiety across women who did or did not disclose was found among women who did or did not disclose to a psychologist (social anxiety mean difference = 21.40, Cohen’s $d = 1.64$). However, low power in the subsample of women who disclosed their most recent sexual assault likely contributed to the lack of significant findings. Consistent with this notion, post-hoc power analyses yielded 58.84% power, suggesting a high likelihood of a Type II error.

Although the empirical examination of the relationship between social anxiety and sexual victimization is undoubtedly still in its infancy, the present investigation meaningfully contributed to the advancement of knowledge within this particular area of research. However, limitations of the present study should be noted. First, this study utilized a largely homogenous sample of Caucasian, heterosexual, college-aged women. Accordingly, future research should seek to incorporate samples that have greater diversity across a number of demographic variables (e.g., age, race/ethnicity, sexual orientation) in order to enhance the generalizability of pertinent findings. Second, the current study relied upon retrospective, self-report data utilizing a one time-point design. This prevented the ability to infer causality in the mediation models that were tested in the present sample. However, given that social anxiety is often stable over significant periods of time when untreated (APA, 2013), and only victimization histories experienced over the past year were examined in the current investigation, the temporal precedence of social anxiety may be loosely inferred. Furthermore, insomuch that the present study can be considered to be a preliminary investigation of the relationship
between social anxiety and sexual victimization (given the dearth of prior research within this particular area), this researcher sought to evaluate the association between social anxiety and a multitude of peri- and post-assault correlates. Consequently, many of the empirical foci of the present investigation (e.g., drinking consequences, interpersonal functioning) were assessed via a singular instrument, which was likely insufficient in adequately allowing for the nuances of such complex domains of research to be captured.

Future research would benefit from utilizing more comprehensive and multi-faceted assessment of such empirical domains. Lastly, future studies should seek to further validate the empirical soundness of some instruments that are often used in the field of sexual violence research, such as the PBRSAI (Nurius et al., 2000), so that researchers can utilize empirically-valid measures in a way that is consistent across research groups.

With regard to pertinent clinical implications, it is clear that clinicians who work with college women need to inquire about sexual victimization histories, given the high rates of sexual assault among undergraduate women. Similarly, clinicians should be mindful of the high prevalence of social anxiety among college women so that such symptomology can be accurately detected and treated. However, findings from the present investigation also suggest that clinicians should take particular care to evaluate the unique sexual assault prevention and treatment needs of women who have social anxiety and may or may not also have sexual assault histories. That is, clinicians may wish to place a greater emphasis upon providing psychoeducation to socially anxious women about a) the way in which social anxiety may potentially increase susceptibility to sexual violence, and b) how this increased risk can be combatted. For example, treatment
for social anxiety often involves social skills training that is designed to enhance interpersonal effectiveness and assertiveness (Trower, 1986). Such training for SAIs (regardless of assault history) could be extended to incorporate education on utilizing assertive behaviors in risky situations, in particular. In addition, women with histories of both sexual assault and social anxiety may potentially derive greater benefit from psychological interventions that focus on improving sexual and interpersonal functioning (in addition to other important areas of therapeutic focus), as the present research indicates that these areas of functioning may be particularly impaired for this subset of women.

Furthermore, sexual assault risk-reduction programs for college women might be able to confer unique benefit to victims of sexual assault who have a history of social anxiety. For example, feminist self-defense training seeks to empower women by challenging societal scripts that promote women’s passivity and cultivating an appreciation of oneself as strong and powerful (Brecklin, 2008; Gidycz & Dardis, 2014). Indeed, research has shown that participation in self-defense training resulted in enhanced self-confidence (Hollander, 2004) and positive mental health outcomes (David, Simpson, & Cotton, 2006). Thus, the focus of such programs on empowering women may be particularly helpful for women with ASA histories who have social anxiety, given that SAIs’ beliefs regarding their social inadequacy often results in globally diminished self-esteem (Cox, Fleet, & Stein, 2004). In addition, the focus of some risk-reduction programs on addressing psychological barriers to resistance may be also be particularly important for victims of sexual assault who have social anxiety, as the present research
provides support for the notion that social anxiety may exacerbate some psychological barriers, which may then influence the frequency of some forms of assault. Thus, risk-reduction program developers could consider an expanded focus on ways in which barriers to resistance can be overcome, particularly in light of the pre-existent assertiveness difficulties that many women experience. In all, it is evident that continued research is needed to augment sexual assault prevention efforts and improve psychotherapeutic treatment for young women with histories of social anxiety and sexual assault.
**References**


Hughes, J., & Barkham, M. (2005). Scoping the inventory of interpersonal problems, its


function. *Journal of Sex & Marital Therapy*, 26, 191 - 208. doi: 10.1080/009262300278597


Table 1

Demographic Information of Full Sample (N = 203)

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Table 2

*Frequency of Participants’ Endorsement of Concerns About, or Prior Diagnoses of, Mental and Physical Health Conditions*

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<th>Health condition</th>
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<td>Diagnosis</td>
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*Note. ADHD = Attention deficit-hyperactivity disorder; PTSD = Posttraumatic stress disorder.*
Table 3

Survey Measures

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<th>Relevant Hypotheses</th>
<th>Type of Variable</th>
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<td>1</td>
<td>Demographics History Questionnaire (Appendix A2)</td>
<td>General participant demographic information</td>
<td>Descriptive analyses</td>
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<td>2</td>
<td>Social Interaction Anxiety Scale (SIAS; Mattick &amp; Clarke, 1998; Appendix A3)</td>
<td>Social interaction anxiety</td>
<td>All hypotheses</td>
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<td>3</td>
<td>Brief Young Adult Alcohol Consequences Questionnaire (BYAACQ; Kahler et al., 2008; Appendix A4)</td>
<td>Frequency of alcohol-related consequences experienced over past thirty days</td>
<td>Hypotheses 1a &amp; 1b</td>
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<td>4</td>
<td>Drinking Due to Social Anxiety Questionnaire (DDSAQ; Wagner et al., 2004; Appendix A5)</td>
<td>Frequency of use of alcohol to cope with social fears over past thirty days</td>
<td>Research Question 1</td>
</tr>
<tr>
<td>5</td>
<td>Social Engagement Measure (SEM; Appendix A6)</td>
<td>Frequency of social engagements over the past month</td>
<td>Research Question 1</td>
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<tr>
<td>6</td>
<td>Female Sexual Function Index (FSFI; Rosen et al., 2000; Appendix A7)</td>
<td>Extent of female sexual functioning difficulties occurring over the past thirty days</td>
<td>Hypothesis 7</td>
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<td>7  Sexual Aversion Scale (SAS; Katz et al., 1989; Appendix A8)</td>
<td>Extent of sexual avoidance occurring over the past thirty days</td>
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<td>DV, Continuous</td>
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<td>8  Diagnostic Questionnaire (DQ; Appendix A9)</td>
<td>Participants’ psychological/medical history and medication use</td>
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<td>9  Beck Depression Inventory _ II (BDI – II; Beck, Steer, &amp; Brown, 1996; Appendix A10)</td>
<td>Depressive symptoms over the past two weeks</td>
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<td>10 The Inventory of Interpersonal Problems – Short Circumplex (IIP-SC; Soldz et al., 1995; Appendix A11)</td>
<td>Extent to which interpersonal problems with others are typically experienced</td>
<td>Hypothesis 6</td>
<td>DV, Continuous</td>
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<tr>
<td>11 Child Sexual Victimization Questionnaire (CSVQ; Finkelhor, 1979; Appendix A12)</td>
<td>Childhood sexual victimization experiences occurring before age 14</td>
<td>Hypotheses 3, 5d, 7a, &amp; 7c</td>
<td>IV, Categorical (History/No History of CSA)</td>
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<tr>
<td>12 Sexual Experiences Survey – Short Form Victimization (SES-SFV; Koss et al., 2007; Appendix A13)</td>
<td>Adulthood sexual victimization experiences occurring during the past year</td>
<td>Hypothesis 1b, Hypothesis 6, Hypothesis 7</td>
<td>IV, Categorical (History/No history of ASA)</td>
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<td>Hypothesis 2, Research Question 1</td>
<td>DV, Continuous (Frequency of each type of assault)</td>
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<td>13 Characteristics of Sexual Victimization Scale (CSVS; Appendix 14)</td>
<td>Characteristics of sexual assault experience, including relationship to perpetrator</td>
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<td>14 Behavioral Response Questionnaire (BRQ; Nurius et al., 2000; Appendix A15)</td>
<td>Extent to which one used assertive and non-forceful resistance strategies during most recent sexual assault</td>
<td>Hypothesis 4</td>
<td>2 DVs, Continuous (Subscales: Assertive and non-assertive resistance)</td>
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<tr>
<td>15 Alcohol Questionnaire (Appendix A16)</td>
<td>Victim and perpetrator use of alcohol, and extent of intoxication, during assault event</td>
<td>Hypothesis 1c</td>
<td>IV, Categorical (Consumption/ No consumption of alcohol during assault event)</td>
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<td></td>
<td>Hypothesis 1d</td>
<td>DV, Continuous (Degree of intoxication)</td>
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<tr>
<td>16 Psychological Barriers to Responding to Sexual Aggression Instrument (Nurius et al., 2000; Appendix A17)</td>
<td>Extent to which one encountered psychological barriers during most recent sexual assault</td>
<td>Hypothesis 3</td>
<td>4 DVs, Continuous (Subscales: Self-consciousness, relationship preservation, injury exacerbation, alcohol concerns)</td>
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Table 3: continued

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<th>Type of Variable</th>
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<td>17 Social Reactions Adjunct Questionnaire</td>
<td>Characteristics of most recent disclosure of sexual assault, including nature of support source, latency to disclose, and distress during disclosure</td>
<td>Hypothesis 5a</td>
<td>DV, Continuous (Frequency of disclosure)</td>
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<tr>
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<td>Hypothesis 5b</td>
<td>DV, Categorical (Latencies to disclose)</td>
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<td>Hypothesis 5c</td>
<td>DV, Categorical (Distress during disclosure)</td>
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<td>Research Question 2</td>
<td>IV, Categorical (Disclosure/No disclosure to support source)</td>
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<tr>
<td>18 Social Reactions Questionnaire (SRQ; Ullman, 2000; Appendix A19)</td>
<td>Frequency of receipt of positive, negative, and mixed reactions to disclosure of most recent sexual assault</td>
<td>Hypothesis 5d</td>
<td>3 DVs, Continuous (Subscales: Positive, “UA,” and “TA” reactions to disclosure)</td>
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<td>19 Integrity Check Questions (Appendix A20)</td>
<td>Questions asked to ensure integrity of participant responses</td>
<td>Not applicable.</td>
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### Table 4

*Means and Standard Deviations of All Study Measures*

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<td>BYAACQ</td>
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<tr>
<td>DDSAQ</td>
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<td>SEM - Avoidance</td>
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<tr>
<td>SEM - Frequency</td>
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<td>SAS</td>
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<td>BDI-II</td>
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<td>SRQ – Unsupported Acknowledgment</td>
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<td>PBRSAI – Perpetrator concerns</td>
<td>3 - 15</td>
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<td>PBRSAI – Intoxication</td>
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<td>BRQ - Indirect</td>
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<td>BRQ – Direct</td>
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</table>
Note. SD = Standard deviation. SIAS – S = Social Interaction Anxiety Scale – Straightforward; BYAACQ = Brief Young Adult Alcohol Consequences Questionnaire; DDASAQ = Drinking Due to Social Anxiety Questionnaire; SEM = Social Engagement Measure; FSFI = Female Sexual Function Index; SAS = Sexual Aversion Scale; BDI – II = Beck Depression Inventory – II; IIP – SC = Inventory of Interpersonal Problems – Short Circumplex; SRQ = Social Reactions Questionnaire; PBRSAI = Psychological Barriers to Responding to Sexual Aggression Instrument; BRQ = Behavioral Response Questionnaire.
Table 5

**Bivariate Correlations between All Continuous Study Variables**

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<tr>
<td>15</td>
<td>PBRSAI – Intoxication</td>
<td>.41*</td>
<td>.40*</td>
<td>.36*</td>
<td>.25</td>
<td>.16</td>
<td>-.01</td>
<td>.38*</td>
<td>.20</td>
<td>.28</td>
<td>.33</td>
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<td>.18</td>
<td>.41*</td>
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<tr>
<td>16</td>
<td>PBRSAI – Physical concerns</td>
<td>.57**</td>
<td>-.08</td>
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<td>-.09</td>
<td>-.16</td>
<td>-.36*</td>
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<td>.46**</td>
<td>.51**</td>
<td>.06</td>
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<td>.28</td>
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<tr>
<td>17</td>
<td>BRQ - Indirect</td>
<td>.27</td>
<td>.15</td>
<td>.11</td>
<td>.09</td>
<td>.15</td>
<td>-.30</td>
<td>.45**</td>
<td>.45**</td>
<td>.37*</td>
<td>-.42</td>
<td>-.05</td>
<td>.22</td>
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<td>.39*</td>
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<td>21</td>
<td>34</td>
<td>33</td>
<td>34</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>BRQ – Direct</td>
<td>.36*</td>
<td>.05</td>
<td>.13</td>
<td>-.20</td>
<td>-.28</td>
<td>-.26</td>
<td>.39*</td>
<td>.41*</td>
<td>.45**</td>
<td>-.27</td>
<td>-.07</td>
<td>.39</td>
<td>-.11</td>
<td>.04</td>
<td>-.02</td>
<td>.53**</td>
<td>.17</td>
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<td>21</td>
<td>34</td>
<td>33</td>
<td>34</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: SIAS – S = Social Interaction Anxiety Scale – Straightforward; BYAACQ = Brief Young Adult Alcohol Consequences Questionnaire; DDSAQ = Drinking Due to Social Anxiety Questionnaire; SEM = Social Engagement Measure; FSFI = Female Sexual Function Index; SAS = Sexual Aversion Scale; BDI – II = Beck Depression Inventory – II; IIP – SC = Inventory of Interpersonal Problems – Short Circumplex; SRQ – TA = Social Reactions Questionnaire – Turning Against subscale; SRQ – UA = Social Reactions Questionnaire – Unsupported Acknowledgement subscale; SRQ – POS = Social Reactions Questionnaire – Positive reactions subscale; PBRSAI = Psychological Barriers to Responding to Sexual Aggression Instrument; BRQ = Behavioral Response Questionnaire. **Correlation is significant at the 0.01 level (2-tailed). *Correlation is significant at the 0.05 level (2-tailed).
Table 6

*Frequency Statistics of Adult Sexual Victimization*

<table>
<thead>
<tr>
<th>Variable</th>
<th>$n$</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult sexual victimization – Past year ($N = 203$)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-victim</td>
<td>161</td>
<td>79.3</td>
</tr>
<tr>
<td>Victim</td>
<td>42</td>
<td>20.7</td>
</tr>
<tr>
<td>Form of adult sexual victimization – Past year ($n = 42$)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unwanted sexual contact</td>
<td>33</td>
<td>16.3</td>
</tr>
<tr>
<td>Sexual coercion</td>
<td>21</td>
<td>10.3</td>
</tr>
<tr>
<td>Attempted rape</td>
<td>30</td>
<td>14.8</td>
</tr>
<tr>
<td>Completed rape</td>
<td>29</td>
<td>14.3</td>
</tr>
</tbody>
</table>

*Note.* Adult sexual assault categories are non-exclusive (i.e., women could endorse having experienced more than one type of assault).
Table 7

*Characteristics of Most Recent Past-Year Assault Event (n = 42)*

<table>
<thead>
<tr>
<th>Variable</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Relationship to perpetrator</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-romantic friend</td>
<td>8</td>
<td>19.0</td>
</tr>
<tr>
<td>Acquaintance</td>
<td>11</td>
<td>26.2</td>
</tr>
<tr>
<td>Stranger</td>
<td>1</td>
<td>2.4</td>
</tr>
<tr>
<td>Co-worker</td>
<td>1</td>
<td>2.4</td>
</tr>
<tr>
<td>Romantic partner</td>
<td>6</td>
<td>14.3</td>
</tr>
<tr>
<td>Spouse</td>
<td>1</td>
<td>2.4</td>
</tr>
<tr>
<td>Casual romantic acquaintance/first date</td>
<td>6</td>
<td>14.3</td>
</tr>
<tr>
<td>Relative(^a)</td>
<td>1</td>
<td>2.4</td>
</tr>
<tr>
<td>Missing</td>
<td>7</td>
<td>16.7</td>
</tr>
<tr>
<td><strong>Description of assault</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Miscommunication</td>
<td>24</td>
<td>57.1</td>
</tr>
<tr>
<td>Sexual assault</td>
<td>4</td>
<td>9.5</td>
</tr>
<tr>
<td>Attempted rape</td>
<td>1</td>
<td>2.4</td>
</tr>
<tr>
<td>Completed rape</td>
<td>4</td>
<td>9.5</td>
</tr>
<tr>
<td>Some other type of crime(^b)</td>
<td>2</td>
<td>4.8</td>
</tr>
<tr>
<td>Missing</td>
<td>7</td>
<td>16.7</td>
</tr>
<tr>
<td><strong>Degree of intoxication - Perpetrator</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not at all intoxicated</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>A little intoxicated</td>
<td>3</td>
<td>7.1</td>
</tr>
<tr>
<td>Moderately intoxicated</td>
<td>8</td>
<td>19.0</td>
</tr>
<tr>
<td>Quite intoxicated</td>
<td>6</td>
<td>14.3</td>
</tr>
<tr>
<td>Extremely intoxicated</td>
<td>3</td>
<td>7.1</td>
</tr>
<tr>
<td>Missing</td>
<td>22</td>
<td>52.4</td>
</tr>
<tr>
<td><strong>Degree of intoxication – Victim</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not at all intoxicated</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>A little intoxicated</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Moderately intoxicated</td>
<td>4</td>
<td>9.5</td>
</tr>
<tr>
<td>Quite intoxicated</td>
<td>10</td>
<td>23.8</td>
</tr>
<tr>
<td>Extremely intoxicated</td>
<td>8</td>
<td>19.0</td>
</tr>
<tr>
<td>Missing</td>
<td>20</td>
<td>47.6</td>
</tr>
</tbody>
</table>
The participant reported “Met him that night” when asked to specify the nature of relationship. One participant reported “Took advantage” when asked to specify the nature of the crime; no additional information was provided by the other participant who endorsed this category.

<table>
<thead>
<tr>
<th>Variable</th>
<th>(n)</th>
<th>Range</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Perpetrator age</td>
<td>35</td>
<td>17 – 29 years old</td>
<td>20.16</td>
<td>2.53</td>
</tr>
<tr>
<td>How well perpetrator was known the victim</td>
<td>35</td>
<td>1 – 7(^a)</td>
<td>3.86</td>
<td>2.10</td>
</tr>
<tr>
<td>Approximate number of drinks consumed at time of assault</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Perpetrator</td>
<td>17</td>
<td>1 – 20 drinks</td>
<td>8.18</td>
<td>5.14</td>
</tr>
<tr>
<td>Victim</td>
<td>22</td>
<td>4 – 13 drinks</td>
<td>7.02</td>
<td>2.64</td>
</tr>
</tbody>
</table>

Note. SD = Standard deviation. \(^a\)Did not know at all, 7 = Knew very well.
Table 8

Summary of Hierarchical Multiple Regression Analysis Examining the Prediction of Drinking-related Consequences (N = 203)

<table>
<thead>
<tr>
<th>Step</th>
<th>B</th>
<th>SE B</th>
<th>β</th>
<th>R²</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 1</td>
<td>ASA history</td>
<td>2.71</td>
<td>0.97</td>
<td>.20*</td>
</tr>
<tr>
<td>Step 2</td>
<td>ASA history</td>
<td>2.46</td>
<td>0.96</td>
<td>.18**</td>
</tr>
<tr>
<td></td>
<td>Social anxiety</td>
<td>0.07</td>
<td>0.03</td>
<td>.18*</td>
</tr>
<tr>
<td>Step 3</td>
<td>ASA history</td>
<td>3.11</td>
<td>1.75</td>
<td>.22</td>
</tr>
<tr>
<td></td>
<td>Social anxiety</td>
<td>0.07</td>
<td>0.03</td>
<td>.20**</td>
</tr>
<tr>
<td></td>
<td>Interaction</td>
<td>-0.03</td>
<td>0.07</td>
<td>-.06</td>
</tr>
</tbody>
</table>

Note. ASA = Adult sexual assault. Interaction = interaction term between social anxiety and ASA history. \( \Delta R^2 = .03 \) for Step 2 \( (p = .01) \), \( \Delta R^2 = .001 \) for Step 3 \( (p = .66) \). * \( p < .01 \). ** \( p < .05 \).
Table 9

Summary of Hierarchical Multiple Regression Analysis Examining the Prediction of Interpersonal Problems (N = 203)

<table>
<thead>
<tr>
<th>Step</th>
<th>Predictor</th>
<th>B</th>
<th>SE B</th>
<th>β</th>
<th>R²</th>
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<tbody>
<tr>
<td>1</td>
<td>ASA history</td>
<td>7.52</td>
<td>3.83</td>
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<td>.02</td>
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<tr>
<td>2</td>
<td>ASA history</td>
<td>4.50</td>
<td>3.17</td>
<td>.08</td>
<td>.34*</td>
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<tr>
<td></td>
<td>Social anxiety</td>
<td>0.82</td>
<td>0.08</td>
<td>.57*</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>ASA history</td>
<td>-9.27</td>
<td>5.67</td>
<td>-.17</td>
<td>.37*</td>
</tr>
<tr>
<td></td>
<td>Social anxiety</td>
<td>0.71</td>
<td>0.09</td>
<td>.49*</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Interaction</td>
<td>0.61</td>
<td>0.21</td>
<td>.32**</td>
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</tr>
</tbody>
</table>

Note. ASA = Adult sexual assault. Interaction = interaction term between social anxiety and ASA history. ΔR² = .32 for Step 2 (p < .001), ΔR² = .03 for Step 3 (p = .004). * p < .001. ** p < .01.
Figure 1. Plot of results from hierarchical multiple regression analysis conducted in the full sample of women (N = 203) examining the prediction of interpersonal problems from adult sexual assault history, social anxiety, and their interaction. IIP-SC = Inventory of Interpersonal Problems – Short Circumplex. ASA = Adult sexual assault.
Table 10

Summary of Hierarchical Multiple Regression Analysis Examining the Prediction of Sexual Aversion and Sexual Dysfunction (N = 203)

<table>
<thead>
<tr>
<th></th>
<th>B</th>
<th>SE B</th>
<th>β</th>
<th>R²</th>
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</thead>
<tbody>
<tr>
<td>Sexual aversion⁹</td>
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<tr>
<td><strong>Step 1</strong></td>
<td></td>
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</tr>
<tr>
<td>CSA history</td>
<td>5.98</td>
<td>2.79</td>
<td>.15**</td>
<td>.02**</td>
</tr>
<tr>
<td><strong>Step 2</strong></td>
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<td></td>
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<tr>
<td>CSA history</td>
<td>3.48</td>
<td>2.70</td>
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<td>.12*</td>
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<tr>
<td>ASA history</td>
<td>8.68</td>
<td>1.85</td>
<td>.32*</td>
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<tr>
<td><strong>Step 3</strong></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>CSA history</td>
<td>2.27</td>
<td>2.47</td>
<td>.06</td>
<td>.27*</td>
</tr>
<tr>
<td>ASA history</td>
<td>7.81</td>
<td>1.69</td>
<td>.29*</td>
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<tr>
<td>Social anxiety</td>
<td>0.28</td>
<td>0.04</td>
<td>.39*</td>
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<tr>
<td><strong>Step 4</strong></td>
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<tr>
<td>CSA history</td>
<td>2.39</td>
<td>2.40</td>
<td>.06</td>
<td>.32*</td>
</tr>
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<td>ASA history</td>
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<td>2.95</td>
<td>-.05</td>
<td></td>
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<tr>
<td>Social anxiety</td>
<td>0.20</td>
<td>0.05</td>
<td>.29*</td>
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</tr>
<tr>
<td>Interaction</td>
<td>0.40</td>
<td>0.11</td>
<td>.42*</td>
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<tr>
<td>Sexual dysfunction⁹</td>
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<td></td>
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</tr>
<tr>
<td><strong>Step 1</strong></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ASA history</td>
<td>0.47</td>
<td>1.68</td>
<td>.02</td>
<td>.00</td>
</tr>
<tr>
<td><strong>Step 2</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ASA history</td>
<td>1.04</td>
<td>1.64</td>
<td>.04</td>
<td>.06*</td>
</tr>
<tr>
<td>Social anxiety</td>
<td>-0.16</td>
<td>0.04</td>
<td>-.25*</td>
<td></td>
</tr>
<tr>
<td><strong>Step 3</strong></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ASA history</td>
<td>6.72</td>
<td>2.96</td>
<td>.28**</td>
<td>.08*</td>
</tr>
<tr>
<td>Social anxiety</td>
<td>-0.11</td>
<td>0.05</td>
<td>-.17**</td>
<td></td>
</tr>
<tr>
<td>Interaction</td>
<td>-0.25</td>
<td>0.11</td>
<td>-.30**</td>
<td></td>
</tr>
</tbody>
</table>

Note. ⁹ Regression analysis with sexual aversion as dependent variable. CSA = Childhood sexual assault. ASA = Adult sexual assault. Interaction = interaction term between social anxiety and ASA history. ΔR² = .10 for Step 2 (p < .001), ΔR² = .15 for Step 3 (p < .001), ΔR² = .05 for Step 3 (p = .001). ⁹ Regression analysis with sexual
dysfunction as dependent variable. ASA = Adult sexual assault. Interaction = interaction term between social anxiety and ASA history. $\Delta R^2 = .06$ for Step 2 ($p < .001$), $\Delta R^2 = .02$ for Step 3 ($p = .02$). * $p < .01$. ** $p < .05$. 
Figure 2. Plot of results from hierarchical multiple regression analysis conducted in the full sample of women \((N = 203)\) examining the prediction of sexual aversion from adult sexual assault history, social anxiety, and their interaction, controlling for childhood sexual assault history. SAS = Sexual Aversion Scale. ASA = Adult sexual assault.
Figure 3. Plot of results from hierarchical multiple regression analysis conducted in the full sample of women \((N = 203)\) examining the prediction of sexual dysfunction from adult sexual assault history, social anxiety, and their interaction. FSFI = Female Sexual Functioning Index. ASA = Adult sexual assault.
Appendix A1: Additional Psychometric Information for Study Measures

Social Interaction Anxiety Scale (SIAS; Mattick & Clarke, 1998; Appendix A2).

The SIAS is a 20-item, self-report measure that assesses fears of general social interactions using a five-point rating scale ranging from 0 (Not at all characteristic or true of me) to 4 (Extremely characteristic or true of me). Higher total scores indicate greater severity of social interaction anxiety. The SIAS has demonstrated strong convergent and discriminant validity as evidenced by significant and positive correlations with other, established measures of social anxiety ($r$s ranging from .66 to .81), and significantly stronger relationships with measures of social interaction anxiety than with measures assessing performance- or observation-based anxiety (Brown et al., 1997). Further, the SIAS has demonstrated high internal consistency (Cronbach’s $\alpha$s ranging from .86 - .94) across clinical, student, and community samples (Heimberg et al., 1993), and strong test-retest reliability in samples of SAD patients (all $r$s >.90, with time intervals ranging from 3 to 13 weeks; Mattick & Clarke, 1998). The SIAS has been found to adequately discriminate individuals diagnosed with SAD from individuals diagnosed with other anxiety disorders (including panic disorder with and without agoraphobia and simple phobia) and non-anxious controls (Heimberg, Mueller, Holt, Hope, & Liebowitz, 1993; Mattick & Clarke, 1998; Peters, 2000). The SIAS total score in the current study was calculated by summing only the 17 straightforwardly-worded SIAS items (i.e., SIAS – Straightforward; SIAS – S) provided that previous research has suggested that such a total score more validly assesses social interaction anxiety within student and clinical populations (Rodebaugh et al., 2011; Rodebaugh, Woods, & Heimberg, 2007). An
additional item was appended to the SIAS – S that inquired about when participants first noticed experiencing difficulty interacting with others. The internal consistency of the SIAS-S total score in the current sample was excellent, Cronbach’s α = .96.

The Brief Young Adult Alcohol Consequences Questionnaire – 30-day version (BYAACQ; Kahler, Hustad, Barnett, Strong, & Borsari, 2008; Read, Kahler, Strong, & Colder, 2006; Appendix A4). The BYAACQ is a brief version of the Young Adult Alcohol Consequences Questionnaire (YAACQ; Read et al., 2006), which assesses a broad range of alcohol-related consequences experienced by college students. The original YAACQ has robustly demonstrated strong psychometric properties, including internal consistency, reliability, and concurrent and predictive validity (see Read et al., 2006; Read, Merrill, Kahler, & Strong, 2007). The BYAACQ (past year version) has been found to correlate significantly with the full-length measure, $r = .95$ (Kahler, Strong, & Read, 2005). In addition, results from Rasch model analyses demonstrated the BYAACQ showed strong unidimensionality and additive properties, with higher scores indicating greater experience of negative alcohol-related consequences (Kahler et al., 2008). The 24-item BYAACQ asks participants to indicate whether or not they have experienced specific adverse alcohol-related consequences over the past month. Response items are rated dichotomously (i.e., yes/no); total scores indicate the total number of consequences the respondent has experienced over the past 30 days. The BYAACQ demonstrated strong internal consistency ($α = .84$) and test-retest reliability over a period of 6 weeks ($r = .70$) in an undergraduate sample (Kahler et al., 2008). Concurrent validity was established by significant and positive correlations between the BYAACQ and the
Alcohol Use Disorders Identification Test (AUDIT; Saunders, Aasland, Babor, de la Fuente, & Grant, 1993; \( r = .64 \)). The internal consistency of the BYAACQ total score in the current sample was excellent, Cronbach’s \( \alpha = .93 \).

**Drinking Due to Social Anxiety Questionnaire** (DDSAQ; Wagner, Stangier, Heidenreich, & Schneider, 2004; Appendix A5). The DDSAQ is a self-report measure that inquires about the use of alcohol to relieve social fears in various social situations over the past month. The measure consists of 28 items rated on a five-point rating scale, ranging from 0 (*Not at all characteristic or true of me*) to 4 (*Extremely characteristic or true of me*). Participants also indicated how often each situation occurred over the past thirty days. Items are summed to create a total score, with higher scores indicating greater use of alcohol to manage social anxiety symptoms. Construct validity of the DDSAQ was supported by positive and significant correlations between the DDSAQ and two measures of social interaction and performance anxiety (both \( r > .60 \)). Discriminant validity was demonstrated by a weak but significant correlation between the DDSAQ and a measure of depression, \( (r = .24) \). The unidimensional factorial validity of the scale was also supported by principal component analyses (Wagner et al., 2004). The internal consistency of the DDSAQ total score in the current sample was excellent, Cronbach’s \( \alpha = .95 \).

**Female Sexual Function Index** (FSFI; Rosen et al., 2000; Appendix A7). The FSFI is a 19-item measure that assesses six domains of female sexual functioning: desire, subjective arousal, lubrication, orgasm, satisfaction, and pain. Respondents were asked to answer items as they relate to their sexual experiences over the past month. Participants
responded to items using a five-point scale; items generally inquire about how often, and to what extent, participants experienced difficulties within each sexual functioning domain. The FSFI total score is calculated by summing subscale scores; each subscale is calculated by multiplying summed responses by a factor weight, with higher scores indicating fewer sexual functioning problems (Rosen et al., 2000). Provided that FSFI was utilized as a measure of sexual dysfunction in the current study, the total score was calculated using only the desire, subjective arousal, lubrication, orgasm, and pain subscales. When the FSFI was evaluated within a sample of female sexual arousal disorder patients and age-matched controls, the FSFI demonstrated high test-retest reliability ($r = .88$ over a period of two to four weeks; Rosen et al., 2000). Discriminant validity was demonstrated by the FSFI correlating only modestly with a measure of marital satisfaction. The internal consistency and discriminant validity of the FSFI has also been established within clinical samples consisting of women with orgasmic and hypoactive sexual desire disorders (Meston, 2003). The internal consistency of the FSFI total score in the current sample was excellent, Cronbach’s $\alpha = .98$.

**Sexual Aversion Scale** (SAS; Katz, Gipson, Kearl, & Kriskovich, 1989; Appendix A8). The SAS is a 30-item, self-report measure that assesses sexual anxiety and avoidance occurring over the past thirty days. Participants respond to each item using a four-point scale, ranging from 1 (*Not at all like me*) to 4 (*A lot like me*). The SAS is comprised of five subscales pertaining to sexual avoidance, sexual inadequacy, sexual anxiety and self-consciousness, fear of sexually transmitted infections (STIs), and experiences of childhood sexual abuse. A total score can be calculated by summing
responses to each item, with higher scores indicating greater sexual fears and avoidance. Items loading onto the fear of STIs and CSA experiences subscales were not utilized in the current study, provided that a) assessment of the fear of STIs was not relevant to current study aims, and b) CSA experiences were more comprehensively assessed by the CSVQ. The SAS has demonstrated a) temporal reliability over a 4-week period ($r = .86 - .89$; Katz, Gipson, & Turner, 1992; Katz et al., 1989), and b) concurrent validity, as evidenced by positive and significant correlations between SAS total scores and scores on measures of hypoactive sexual desire (Katz & Jardine, 1999) and fear/anxiety (Katz et al., 1992). The internal consistency of the SAS total score in the current sample was excellent, Cronbach’s $\alpha = .93$.

**Beck Depression Inventory – II** (BDI-II; Beck, Steer, & Brown, 1996; Appendix A13). The BDI-II is a 21-item, self-report measure of affective, cognitive, vegetative, and somatic symptoms of depression occurring over the past two weeks. Respondents rate the intensity of symptoms using a four-point scale ranging from 0 to 3, with higher total scores indicating higher levels of self-reported depression. The BDI-II has demonstrated excellent internal consistency in outpatient and undergraduate samples (both $\alpha$s > .92), as well as test-retest reliability ($r = .93$ over one week within an undergraduate sample; Beck et al., 1996). Using confirmatory factor analysis, a recent study also reported that BDI-II total scores index depression even when general negative affect is accounted for (Hill, Musso, Jones, Pella, & Gouvier, 2013). The BDI-II was administered to participants but was not utilized in analyses.

**The Inventory of Interpersonal Problems – Short Circumpex** (IIP-SC; Soldz,
Budman, Demby & Merry, 1995; Appendix A11). The IIP-SC is a self-report measure that assesses interpersonal problems as they relate to each of the eight octants of the interpersonal circumplex (i.e., interpersonal traits related to being domineering, vindictive, cold, socially avoidant, non-assertive, exploitable, overly nurturant, and intrusive). The IIP-SC is a shortened, 32-item version of the 64-item Inventory of Interpersonal Problems – Circumplex (IIP-C; Alden, Wiggins, & Pincus, 1990), items of which were extracted from the full-length, original IIP (Horowitz, Rosenberg, Bauer, Ureno, & Villasenor, 1988) that consisted of 127 items. The IIP-SC assesses behaviors a) that are difficult to do (e.g., “It is hard for me to trust other people”) and b) that one does too much (e.g., “I fight with other people too much”). Each item is rated using a five-point scale, with responses ranging from 0 (Not at all) to 4 (Extremely). Eight subscale scores can be calculated corresponding to each octant of the interpersonal circumplex; a total score can also be calculated, with higher scores indicating greater interpersonal problems. The psychometric profiles of both the IIP and IIP-C have been extensively researched and demonstrate strong reliability and validity; see Hughes & Barkham (2005) and Gurtman (1996) for reviews. Within clinical samples, the IIP-SC has demonstrated strong concurrent validity (as exhibited by strong and positive correlations between all IIP-C and IIP-SC subscales; all rs > .91), internal consistency (Cronbach’s αs = .88 - .89), and good test-retest reliability over a period of eight weeks (α = .83; Soldz et al., 1995). A recent psychometric evaluation of the IIP-SC using two undergraduate samples reported that the IIP-SC exhibited strong internal consistency (Cronbach’s α = .89), strong convergence between IIP-C and IIP-SC total scores (r = .98), and structural
validity (as indicated by a test of confirmatory model-fit indices for a structure consistent with circumplex assumptions; Hopwood, Pincus, DeMoor, & Koonce, 2008). The internal consistency of the IIP-SC total score in the current sample was excellent, Cronbach’s $\alpha = .94$.

**Child Sexual Victimization Questionnaire** (CSVQ; Finkelhor, 1979; Appendix A12). The CSVQ is a self-report questionnaire that consists of eight behaviorally-specific items used to assess sexual victimization experiences that occurred prior to the age of 14. Participants who endorsed having experienced an item were then asked additional questions about specifics of the victimization experience, such as relationship to, and age of, their perpetrator and perceived reason for the abuse. As has been done by previous researchers (e.g., Kelley, 2015), the wording of one follow-up question was modified from “what was the main reason you participated” to “what do you perceive to be the main reason this event occurred” so as to mitigate any implication that the victim was responsible for engaging in an unwanted sexual experience. Experiences were classified as childhood sexual abuse if the perpetrator was at least five years older than the victim, if the individual was coerced to engage in the sexual activity, and/or if the perpetrator was a caregiver or authority figure. The concurrent validity of the CSVQ was supported by the finding that 93% of a nationally representative sample of male college participants who reported CSA during an interview also endorsed experiencing CSA on the CSVQ (Risin & Koss, 1987). Child sexual victimization history was categorized dichotomously as history or no history of CSA (with CSA history including acts of sexual exhibition, fondling, and penetration).
Sexual Experiences Survey – Short Form Victimization (SES-SFV; Koss et al., 2007; Koss & Oros, 1982; Appendix A13). The SES-SFV is the revised version of the original Sexual Experiences Survey (SES; Koss & Oros, 1982) that assesses the nature and frequency of seven unwanted sexual experiences and five perpetration tactics used to compel unwanted sex. Participants responded to each item twice in order to indicate the number of times each form of victimization has occurred a) during the past year, and b) since the age of 14 (excluding the past year). A psychometric evaluation of the SES-SFV found the measure to exhibit excellent internal consistency in both an internet and in-person survey administrations (both $\alpha$s = .94), good test-retest reliability ($r$s = .71 and .77, over a period of two weeks, respectively), and good construct validity (as evidenced by significant and positive correlations with the original SES and other measures of trauma symptoms and sexual problems; Johnson, Murphy & Gidycz, in press). The SES-SFV was used in the current study to classify victimization history (i.e., categorized dichotomously as history or no history of ASA). Only women who met the criteria for having experienced sexual coercion, attempted rape, and rape within the past year were included in the victimization category.

Behavioral Response Questionnaire (BRQ; Nurius et al., 2000; Appendix A15). The BRQ is 25-item self-report questionnaire that assesses direct (i.e., assertive) and indirect (i.e., non-forceful) responses to sexual assault. Participants were asked to indicate how they reacted to their most recent unwanted sexual experience by responding to items using a five-point scale, ranging from 1 (Not at all like what I did) to 5 (Very like what I did). Responses to items loading onto each subscale (i.e., direct and indirect
responses to sexual assault) can be summed, providing a total score for each type of resistance tactic used. Higher subscale scores indicate that the response was more like what the participant did during the assault. The construct validity of the BRQ has been supported by the finding that direct resistance, as measured by the BRQ, was negatively correlated with psychological barriers to resistance (Norris, Nurius, & Dimeff, 1996; Stoner et al., 2007). In addition, previous research has found the indirect and direct responses to sexual aggression subscales to be uncorrelated ($r = .001$, $p = .99$), indicating that they represent different aspects of responses to sexual aggression (Macy, Nurius, & Norris, 2006). The internal consistencies of the direct and indirect subscales of the BRQ in the current sample were acceptable, Cronbach’s $\alpha = .70$ and .76, respectively.

**Alcohol Questionnaire** (Appendix A16). The alcohol questionnaire was designed to assess victim and perpetrator alcohol use at the time of the assault (Wilson, 2011). Items inquired about the number of alcoholic drinks that were consumed by participants (ranging from 1 – 2 drinks, to 5+ drinks), and how intoxicated the participant felt (ranging from *not at all intoxicated* to *very intoxicated*) at the time of the assault. Participants were also asked to report whether their perpetrator had consumed alcohol at the time of the assault, and if so, how many drinks had been consumed and how intoxicated he appeared to be.

**Psychological Barriers to Responding to Sexual Aggression Instrument** (PBRSAI; Nurius et al., 2000; Appendix A17). The PBRSAI is a 21-item, self-report measure that assesses the extent to which certain psychological factors impeded one’s ability to protect oneself during a sexual assault. Items are rated on a five-point scale,
ranging from 1 (Not at all significant) to 5 (Very significant). Due to a lack of consensus in previous literature regarding factor structure and composition (e.g., see Macy, Nurius, & Norris, 2007; Stoner et al., 2007; Turchik et al., 2007), an exploratory factor analysis using principal axis factoring (PAF) was conducted in order to identify the best-fitting PBRSAI factor structure for the current sample (See Appendix A for information regarding how the factor analysis was conducted). Results of the factor analysis revealed four subscales: self-consciousness (four items, $\alpha = .82$), concerns about preserving the relationship with the perpetrator (three items, $\alpha = .75$), concerns that alcohol impeded one’s ability to respond (three items; $\alpha = .94$), and concern for potentially exacerbating injury inflicted by the perpetrator (three items; $\alpha = .91$). Higher scores on each subscale reflect greater difficulty protecting oneself due to the relevant psychological barrier.

**Social Reactions Questionnaire** (SRQ; Ullman, 2000; Appendix A19). The SRQ is a self-report, 48-item instrument designed to measure social reactions to disclosure of sexual assault. Participants indicated how often they received different types of reactions from various support providers following disclosure of sexual assault on a five-point scale, ranging from 0 (never) to 4 (always). For the present study, participants were asked to respond to the SRQ in reference to responses received following disclosure of their most recent sexual assault; only participants who reported that they had disclosed their most recent unwanted sexual experience were administered the SRQ. A recent investigation conducted by Relyea and Ullman (2015) that utilized exploratory and confirmatory factor analyses demonstrated that a three-factor model fit the data: one, pertaining to positive social reactions (including emotional support and provision of
information/tangible aid), a second, pertaining to negative social reactions (e.g., “turning against” reactions, such as blaming or treating one differently), and a third, pertaining to mixed valenced items (e.g., “unsupportive acknowledgment” reactions, including egocentric and distracting reactions). Discriminant validity of these subscales was supported by the finding that each subscale was associated with different outcomes: participants who reported receiving “turned against” reactions endorsed greater levels of potentially harmful behavior/thinking, whereas those who received unsupportive acknowledgment reactions endorsed greater PTSD, depression, and maladaptive and adaptive coping. Further, positive social reactions were associated with increased social support, less depression, decreased self-blame, more sexual refusal assertiveness, and more positive coping (Relyea & Ullman, 2015). The internal consistencies of the SRQ subscales related to “positive,” “turning against,” and “unsupportive acknowledgment” reactions ranged from moderately acceptable to excellent, Cronbach’s αs = .93, .86, and .65, respectively.
Appendix A2: Demographics History Questionnaire (DHQ)

1. What is your current gender? (Check all that apply).
   a. Woman
   b. Transman
   c. Transwoman
   d. Genderqueer
   e. Additional category (Please specify)
   f. Decline to state

2. What sex were you assigned at birth?
   a. Male
   b. Female
   c. Decline to state

3. Were you born with an intersex condition?
   a. No
   b. Yes

4. What is your age?
   a. 18
   b. 19
   c. 20
   d. 21
   e. 22
   f. 23
   g. 24
   h. 25
   i. Other (Please specify)

5. What is your current year in school?
   a. Freshman
   b. Sophomore
   c. Junior
   d. Senior
   e. Graduate
   f. Other

6. What is your racial identity?
   a. American Indian or Alaskan Native
   b. Asian
   c. Black or African-American
   d. Native Hawaiian or Other Pacific Islander
7. What is your ethnicity?
   a. Hispanic or Latino
   b. Not Hispanic or Latino

8. In what religion were you raised?
   a. Catholic (Christian)
   b. Protestant (Christian)
   c. Jewish
   d. Nondenominational
   e. None/Atheist
   f. Muslim
   g. Other (Please specify)

9. Which one best describes your intimate relationships/sexual orientation?
   a. Exclusively heterosexual experiences
   b. Mostly heterosexual experiences
   c. More heterosexual than homosexual experiences
   d. Equal heterosexual and homosexual experiences
   e. More homosexual than heterosexual experiences
   f. Mostly homosexual experiences
   g. Exclusively homosexual experiences

10. Have you ever been to a therapist or counselor?
    a. No
    b. Yes
       i. If yes, reasons for seeing therapy (Write-in)

11. Approximately what is your parents’ combined yearly income?
    a. Unemployed or disabled
    b. Under $10,000
    c. $10,000-20,000
    d. $21,000-30,000
    e. $31,000-40,000
    f. $41,000-50,000
    g. $51,000-75,000
    h. $76,000-100,000
    i. $101,000-200,000
    j. Over $200,000
    k. I don’t know
12. In what type of household were you raised?
   a. Two parent (Mother and Father)
   b. Two parent (Mother and Mother)
   c. Two parent (Father and Father)
   d. Single Mother
   e. Single Father
   f. Mother and Step-father
   g. Father and Step-mother
   h. Grandparents
   i. Other relatives
   j. Foster parents
   k. Orphanage or group home
   l. Other (Write-in)

13. Which one best describes your relationship/sexual orientation?
   a. Heterosexual or straight
   b. Gay or lesbian
   c. Bisexual
   d. Asexual
   e. Pansexual
   f. Additional category (write-in)

14. During the past 12 months, have you had sex with:
   a. Only biological women
   b. Only biological men
   c. Both biological women and men
   d. Only transwomen
   e. Only transmen
   f. Both transwomen and transmen
   g. Biological men and women and transwomen and transmen
   h. Androgynous individuals/genderqueer individuals
   i. Non (asexual)

15. People are different in their sexual attraction to other people. Which best describes your feelings? Are you…
   a. Only attracted to biological women
   b. Mostly attracted to biological women
   c. Only attracted to biological men
   d. Mostly attracted to biological men
   e. Equally attracted to biological women and biological men
   f. Only attracted to transwomen
   g. Mostly attracted to transwomen
   h. Only attracted to transmen
i. Mostly attracted to transmen
j. Equally attracted to transwomen and transmen
k. Mostly attracted to androgynous individuals/genderqueer individuals
l. Only attracted to androgynous individuals/genderqueer individuals
m. Not sure
n. None (Asexual)
o. Additional category (write-in)

16. If you have dated previously, approximately how many dating relationships have you had? (write-in)

17. If you have dated previously, how old were you when you first began going on dates? (write-in)

18. Approximately how many consensual sexual partners have you had (including oral, anal and vaginal intercourse)? (write-in)

19. Are you currently involved in a dating/romantic/intimate relationship (of any degree of commitment, length etc.)?
   a. Yes
   b. No
      i. If yes:
         1. Are you currently involved in more than one relationship?
            a. Yes
            b. No
               i. If yes: If you are currently involved in more than one relationship, answer the following questions with regard to the relationship that is the most significant to you; if you are currently in one relationship answer the questions about this relationship.
               2. What best describes the status of your current relationship?
                  i. Married
                  ii. Civil union/domestic partnership
                  iii. Partnered in a monogamous relationship but not married, in a civil union, or domestic partnership.
                  iv. Partnered in an open relationship
                  3. How long have you been with your current partner? (Write-in)
Appendix A3: Social Interaction Anxiety Scale (SIAS)

For each statement, please select the appropriate numbered response on the scale provided to indicate the degree to which you feel the statement is characteristic of you. The rating scale is as follows:

<table>
<thead>
<tr>
<th>Rating</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Not at all characteristic or true of me</td>
</tr>
<tr>
<td>1</td>
<td>Slightly characteristic or true of me</td>
</tr>
<tr>
<td>2</td>
<td>Moderately characteristic/true of me</td>
</tr>
<tr>
<td>3</td>
<td>Very characteristic or true of me</td>
</tr>
<tr>
<td>4</td>
<td>Extremely characteristic or true of me</td>
</tr>
</tbody>
</table>

1. I get nervous if I have to speak with someone in authority (teacher, boss).
2. I have difficulty making eye contact with others.
3. I become tense if I have to talk about myself or my feelings.
4. I find it difficult mixing comfortably with the people I work with.
5. I find it easy to make friends of my own age.
6. I tense up if I meet an acquaintance in the street.
7. When mixing socially, I am uncomfortable.
8. I feel tense if I am alone with just one person.
9. I am at ease meeting people at parties, etc.
10. I have difficulty talking with other people.
11. I find it easy to think of things to talk about.
12. I worry about expressing myself in case I appear awkward.
13. I find it difficult to disagree with another’s point of view.
14. I have difficulty talking to attractive persons of the opposite sex.
15. I find myself worrying that I won’t know what to say in social situations.
16. I am nervous mixing with people that I don’t know well.
17. I feel I’ll say something embarrassing when talking.
18. When mixing in a group, I find myself worrying I will be ignored.
19. I am tense mixing in a group.
20. I am unsure whether to greet someone I know only slightly.
Follow-Up Item to the Social Interaction Anxiety Scale

Think about the responses you just provided in the previous questionnaire regarding your feelings about interacting socially with others. For the items that you indicated were at least moderately to extremely characteristic or true of you: when did you first notice that such feelings/experiences were characteristic or true of you?

a. Less than two months ago
b. Two to six months ago
c. Six months to one year ago
d. 1 – 2 years ago
e. 2 – 5 years ago
f. More than 5 years ago
**Appendix A4: Brief Young Adult Alcohol Consequences Questionnaire (BYAACQ)**

Below is a list of things that sometimes happen to people either during, or after they have been drinking alcohol. Next to each item below, please select either YES or NO to indicate whether that item describes something that has happened to you **IN THE PAST MONTH.** In the **past month...**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>While drinking, I have said or done embarrassing things.</td>
</tr>
<tr>
<td>2.</td>
<td>I have had a hangover (headache, sick stomach) the morning after I had been drinking.</td>
</tr>
<tr>
<td>3.</td>
<td>I have felt very sick to my stomach or thrown up after drinking.</td>
</tr>
<tr>
<td>4.</td>
<td>I often have ended up drinking on nights when I had planned not to drink.</td>
</tr>
<tr>
<td>5.</td>
<td>I have taken foolish risks when I have been drinking.</td>
</tr>
<tr>
<td>6.</td>
<td>I have passed out from drinking.</td>
</tr>
<tr>
<td>7.</td>
<td>I have found that I needed larger amounts of alcohol to feel any effect, or that I could no longer get high or drunk on the amount that used to get me high or drunk.</td>
</tr>
<tr>
<td>8.</td>
<td>When drinking, I have done impulsive things that I regretted later.</td>
</tr>
<tr>
<td>9.</td>
<td>I’ve not been able to remember large stretches of time while drinking heavily.</td>
</tr>
<tr>
<td>10.</td>
<td>I have driven a car when I knew I had too much to drink to drive safely.</td>
</tr>
<tr>
<td>11.</td>
<td>I have not gone to work or missed classes at school because of drinking, a hangover, or illness caused by drinking.</td>
</tr>
<tr>
<td>12.</td>
<td>My drinking has gotten me into sexual situations I later regretted.</td>
</tr>
<tr>
<td>13.</td>
<td>I have often found it difficult to limit how much I drink.</td>
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<tr>
<td>14.</td>
<td>I have become very rude, obnoxious or insulting after drinking.</td>
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<tr>
<td>15.</td>
<td>I have woken up in an unexpected place after heavy drinking.</td>
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<tr>
<td>16.</td>
<td>I have felt badly about myself because of my drinking.</td>
</tr>
<tr>
<td>17.</td>
<td>I have had less energy or felt tired because of my drinking.</td>
</tr>
<tr>
<td>18.</td>
<td>The quality of my work or schoolwork has suffered because of my drinking.</td>
</tr>
<tr>
<td>19.</td>
<td>I have spent too much time drinking.</td>
</tr>
<tr>
<td>20.</td>
<td>I have neglected my obligations to family, work, or school because of drinking.</td>
</tr>
<tr>
<td>21.</td>
<td>My drinking has created problems between myself and my boyfriend/girlfriend/spouse, parents, or other near relatives.</td>
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<tr>
<td>22.</td>
<td>I have been overweight because of drinking.</td>
</tr>
<tr>
<td>23.</td>
<td>My physical appearance has been harmed by my drinking.</td>
</tr>
<tr>
<td>24.</td>
<td>I have felt like I needed a drink after I’d gotten up (that is, before breakfast).</td>
</tr>
</tbody>
</table>
Appendix A5: Drinking Due to Social Anxiety Questionnaire (DDSAQ)

In the following, you will find a number of statements concerning emotions, thoughts and behaviors that may or may not occur in the context of alcohol use. Please read each of the following statements carefully and indicate how characteristic the statement was of you **during the last month** according to the scale.

<table>
<thead>
<tr>
<th>Situation</th>
<th>Not at all</th>
<th>Slightly</th>
<th>Moderately</th>
<th>Very</th>
<th>Extremely</th>
<th>How often occurred this situation in the last 30 days?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I felt safer when interacting with strangers after drinking alcohol</td>
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<tr>
<td>2. After drinking alcohol, I was less nervous when starting a conversation with a person I did not know well</td>
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<tr>
<td>3. I drank alcohol so I wouldn’t have to think about what impression I made on others</td>
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<tr>
<td>4. When I was in a diner or a restaurant, I drank alcohol to feel safer and less nervous</td>
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<tr>
<td>5. I drank to overcome my shyness</td>
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<tr>
<td>6. I drank alcohol to feel less self-conscious when I was the centre of attention</td>
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<tr>
<td>7. Drinking helped me to suppress feelings of inferiority</td>
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<tr>
<td>8. I drank alcohol so I could talk more freely and be more relaxed with other people</td>
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<tr>
<td>9. I drank alcohol in order to be less nervous during an exam</td>
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<tr>
<td>10. I drank alcohol to fight my fear of criticism and rejection by others</td>
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<td>11. When I had to talk to people in authority (teachers, superiors), I drank alcohol in order to be less nervous</td>
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<td>12. I drank alcohol so I would have less anxiety when speaking in public</td>
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<td>13. Alcohol helped me to be less self-conscious in social situations or</td>
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<td>whenever I was expected to be socially active</td>
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<td>14. I drank alcohol in order to self-medicate my fear of embarrassing myself in front of others</td>
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<td>15. I drank alcohol in order to be less tense in performance situations</td>
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<td>16. After drinking, I felt better able to express my opinions and convictions to others</td>
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<td>17. Alcohol helped me to be less tense and nervous whenever I had to eat with unfamiliar people</td>
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<td>18. When I was unable to avoid uncomfortable social situations, I sometimes drank alcohol in order to be less anxious</td>
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<td>19. Alcohol helped me to have less anxiety when talking to unfamiliar people</td>
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<td>20. I drank alcohol in order to feel less nervous and tense in group situations</td>
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<td>21. Drinking helped me to interact with others in a more relaxed way</td>
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<td>22. After drinking I was better able to share my feelings and thoughts with a person of the opposite sex</td>
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<td>23. I drank alcohol in order to feel less self-conscious or tense when speaking in public</td>
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<td>24. I was easier for me to approach an attractive person of the opposite sex after drinking alcohol</td>
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<td>25. I was better able to get to know people after drinking alcohol</td>
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<td>26. I drank alcohol to be less self-conscious or tense while giving a speech in front of an audience</td>
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<td>27. At parties or official social gatherings I drank alcohol in order to be more relaxed and less tense</td>
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<td>28. After drinking alcohol I was better able to hold my ground with authorities or people I was afraid of</td>
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**Appendix A6: Social Engagement Measure (SEM)**
Please answer the following questions about the frequency of your social engagements over the past year.

1. On average, how frequently over the past year have you attended a party (i.e., a social gathering with numerous people in attendance, held at such places as a friend’s house, a sorority/fraternity, or other venue)?
   a. Never
   b. Rarely
   c. Sometimes
   d. Often
   e. Very frequently

2. On average, what percentage of the time that you had an opportunity to attend a party over the past year did you actually attend?
   a. 0% - 20% of the time
   b. 21% - 40% of the time,
   c. 41% - 60% of the time,
   d. 61% - 80% of the time,
   e. 81% - 100% of the time

3. On average, how many times over the past year have you attended an informal social gathering (i.e., a social gathering with numerous people in attendance, such as a dinner party, hanging out at a friend’s place, attending a sporting event)?
   a. Never
   b. Rarely
   c. Sometimes
   d. Often
   e. Very frequently

4. On average, what percentage of the time that you had an opportunity to attend an informal social gathering over the past year did you actually attend?
   a. 0% - 20% of the time
   b. 21% - 40% of the time,
   c. 41% - 60% of the time,
   d. 61% - 80% of the time,
   e. 81% - 100% of the time

5. On average, how many times over the past year have you gone to a bar with friends/close acquaintances?
   a. Never
   b. Rarely
   c. Sometimes
   d. Often
   e. Very frequently
6. On average, what percentage of the time that you had an opportunity to go to a bar with friends/close acquaintances over the past year did you actually go?
   a. 0% - 20% of the time
   b. 21% - 40% of the time,
   c. 41% - 60% of the time,
   d. 61% - 80% of the time,
   e. 81% - 100% of the time

7. On average, how many times over the past year have you engaged in a one-on-one social activity with a friend/close acquaintance (such as going to dinner, seeing a movie, taking a walk)?
   a. Never
   b. Rarely
   c. Sometimes
   d. Often
   e. Very frequently

8. On average, on what percentage of the time that you had an opportunity to engage in a one-on-one social activity with a friend/close acquaintance over the past year did you actually engage in such activity?
   a. 0% - 20% of the time
   b. 21% - 40% of the time,
   c. 41% - 60% of the time,
   d. 61% - 80% of the time,
   e. 81% - 100% of the time

9. On average, how many times over the past year have you willingly met new people?
   a. Never
   b. Rarely
   c. Sometimes
   d. Often
   e. Very frequently

10. On average, on what percentage of the time that you had an opportunity to meet new people over the past year did you actually do so?
    a. 0% - 20% of the time
    b. 21% - 40% of the time,
    c. 41% - 60% of the time,
    d. 61% - 80% of the time,
    e. 81% - 100% of the time
11. On average, how many times over the past year have you engaged in a dating situation (e.g., gone on a date, or other similar activity)? If you are currently involved in a very serious and committed romantic relationship, please select “Not applicable.”
   a. Never
   b. Rarely
   c. Sometimes
   d. Often
   e. Very frequently
   f. Not applicable

12. On average, on what percentage of the time that you had an opportunity to engage in a dating situation over the past year did you actually engage in a dating situation?
   a. 0% - 20% of the time
   b. 21% - 40% of the time,
   c. 41% - 60% of the time,
   d. 61% - 80% of the time,
   e. 81% - 100% of the time

13. On average, how many times over the past year have you engaged in consensual sexual activity?
   a. Never
   b. Rarely
   c. Sometimes
   d. Often
   e. Very frequently

14. On average, on what percentage of the time that you had an opportunity to engage in consensual sexual activity over the past year did you actually do so?
   a. 0% - 20% of the time
   b. 21% - 40% of the time,
   c. 41% - 60% of the time,
   d. 61% - 80% of the time,
   e. 81% - 100% of the time
Appendix A7: Female Sexual Functioning Index (FSFI)

For each of the following items, select the response that best applies to you.

1. Over the past 4 weeks, how **often** did you feel sexual desire or interest?
   - A. Almost never or never
   - B. A few times (less than half the time)
   - C. Sometimes (about half the time)
   - D. Most times (more than half the time)
   - E. Almost always or always

2. Over the past 4 weeks, how would you describe your **level** (degree) of sexual desire or interest?
   - A. Very low or none at all
   - B. Low
   - C. Moderate
   - D. High
   - E. Very high

3. Over the past 4 weeks, how **often** did you feel sexually aroused (“turned on”) during sexual activity or intercourse?
   - A. Almost never or never
   - B. A few times (less than half the time)
   - C. Sometimes (about half the time)
   - D. Most times (more than half the time)
   - E. Almost always or always
   - F. No sexual activity

4. Over the past 4 weeks, how would you rate your **level** of sexual arousal (“turn on”) during sexual activity or intercourse?
   - A. Very low or none at all
   - B. Low
   - C. Moderate
   - D. High
   - E. Very high
   - F. No sexual activity

5. Over the past 4 weeks, how **confident** were you about becoming sexually aroused during sexual activity or intercourse?
   - A. Very low or no confidence
   - B. Low confidence
C. Moderate confidence
D. High confidence
E. Very high confidence
F. No sexual activity

6. Over the past 4 weeks, how often have you been satisfied with your arousal (excitement) during sexual activity or intercourse?
   A. Almost never or never
   B. A few times (less than half the time)
   C. Sometimes (about half the time)
   D. Most times (more than half the time)
   E. Almost always or always
   F. No sexual activity

7. Over the past 4 weeks, how often did you become lubricated (“wet”) during sexual activity or intercourse?
   A. Almost never or never
   B. A few times (less than half the time)
   C. Sometimes (about half the time)
   D. Most times (more than half the time)
   E. Almost always or always
   F. No sexual activity

8. Over the past 4 weeks, how difficult was it to become lubricated (“wet”) during sexual activity or intercourse?
   A. Not difficult
   B. Slightly difficult
   C. Difficult
   D. Very difficult
   E. Extremely difficult or impossible
   F. No sexual activity

9. Over the past 4 weeks, how often did you maintain your lubrication (“wetness”) until completion of sexual activity or intercourse?
   A. Almost never or never
   B. A few times (less than half the time)
   C. Sometimes (about half the time)
   D. Most times (more than half the time)
   E. Almost always or always
   F. No sexual activity
10. Over the past 4 weeks, how **difficult** was it to maintain your lubrication (“wetness”) until completion of sexual activity or intercourse?
   - A. Not difficult
   - B. Slightly difficult
   - C. Difficult
   - D. Very difficult
   - E. Extremely difficult or impossible
   - F. No sexual activity

11. Over the past 4 weeks, when you had sexual stimulation or intercourse, how **often** did you reach orgasm (climax)?
   - A. Almost never or never
   - B. A few times (less than half the time)
   - C. Sometimes (about half the time)
   - D. Most times (more than half the time)
   - E. Almost always or always
   - F. No sexual activity

12. Over the past 4 weeks, when you had sexual stimulation or intercourse, how **difficult** was it for you to reach orgasm (climax)?
   - A. Not difficult
   - B. Slightly difficult
   - C. Difficult
   - D. Very difficult
   - E. Extremely difficult or impossible
   - F. No sexual activity

13. Over the past 4 weeks, how **satisfied** were you with your ability to reach orgasm (climax) during sexual activity or intercourse?
   - A. Very dissatisfied
   - B. Moderately dissatisfied
   - C. About equally satisfied and dissatisfied
   - D. Moderately satisfied
   - E. Very Satisfied
   - F. No sexual activity

14. Over the past 4 weeks, how **satisfied** have you been with the amount of emotional closeness during sexual activity between you and your partner?
   - A. Very dissatisfied
   - B. Moderately dissatisfied
C. About equally satisfied and dissatisfied  
D. Moderately satisfied  
E. Very Satisfied  
F. No sexual activity  

15. Over the past 4 weeks, how **satisfied** have you been with your sexual relationship with your partner?  
   A. Very dissatisfied  
   B. Moderately dissatisfied  
   C. About equally satisfied and dissatisfied  
   D. Moderately satisfied  
   E. Very Satisfied  
   F. No sexual activity  

16. Over the past 4 weeks, how **satisfied** have you been with your overall sexual life?  
   A. Very dissatisfied  
   B. Moderately dissatisfied  
   C. About equally satisfied and dissatisfied  
   D. Moderately satisfied  
   E. Very Satisfied  
   F. No sexual activity  

17. Over the past 4 weeks, how **often** did you experience discomfort or pain during vaginal penetration?  
   A. Almost never or never  
   B. A few times (less than half the time)  
   C. Sometimes (about half the time)  
   D. Most times (more than half the time)  
   E. Almost always or always  
   F. Did not attempt intercourse  

18. Over the past 4 weeks, how **often** did you experience discomfort or pain following vaginal penetration?  
   A. Almost never or never  
   B. A few times (less than half the time)  
   C. Sometimes (about half the time)  
   D. Most times (more than half the time)  
   E. Almost always or always  
   F. Did not attempt intercourse  

19. Over the past 4 weeks, how would you rate your **level** (degree) of discomfort or pain during or following vaginal penetration?
A. Very low or none at all
B. Low
C. Moderate
D. High
E. Very high
F. Did not attempt intercourse
Appendix A8: Sexual Aversion Scale (SAS)

Please rate the following questions on a scale of 1 (not relating at all to you) to 4 (being very relatable to you) as they relate to you over the past four weeks.

1. I worry a lot about sex.

   1  2  3  4
   Not at all               A lot like me
     like me

2. I am afraid to engage in sexual intercourse with another person.

   1  2  3  4
   Not at all               A lot like me
     like me

3. I have avoided sexual relations recently because of my sexual fears.

   1  2  3  4
   Not at all               A lot like me
     like me

4. The AIDS scare has increased my fear about sex.

   1  2  3  4
   Not at all               A lot like me
     like me

5. I believe the risks associated with sex are greater than its rewards.

   1  2  3  4
   Not at all               A lot like me
     like me

6. I worry about being criticized because of my sexual behavior.

   1  2  3  4
   Not at all               A lot like me
     like me

7. I was sexually molested when I was a child.

   1  2  3  4
   Not at all               A lot like me
     like me

8. I try to avoid situations where I might get involved sexually.
1. Not at all  
2.  
3.  
4. A lot like me

9. I have strong sexual urges that I am unable to express.
1. Not at all  
2.  
3.  
4. A lot like me

10. I would like to feel more relaxed in sexual situations.
1. Not at all  
2.  
3.  
4. A lot like me

11. The thought of AIDS really scares me.
1. Not at all  
2.  
3.  
4. A lot like me

12. I have an abnormal fear of sex.
1. Not at all  
2.  
3.  
4. A lot like me

13. I have repeatedly avoided all or almost all genital sexual contact with a sexual partner.
1. Not at all  
2.  
3.  
4. A lot like me

14. I’m not afraid of kissing or petting but intercourse really scares me.
1. Not at all  
2.  
3.  
4. A lot like me

15. I worry a lot about catching a sexually transmitted disease.
1. Not at all  
2.  
3.  
4. A lot like me

16. I believe my attitudes about sex are abnormal.
1. Not at all  
2.  
3.  
4. A lot like me
17. When I was a child I was punished because of my sexual behavior.

1. Not at all
2. Like me
3. A lot like me

18. The way things are now, I would never engage in sexual intercourse.

1. Not at all
2. Like me
3. A lot like me

19. The thought of sex makes me nervous.

1. Not at all
2. Like me
3. A lot like me

20. I believe there is no such thing as “safe sex”.

1. Not at all
2. Like me
3. A lot like me

21. The thought of becoming pregnant scares me.

1. Not at all
2. Like me
3. A lot like me

22. My sex life has always been a source of dissatisfaction.

1. Not at all
2. Like me
3. A lot like me

23. I often wonder what other people think of me.

1. Not at all
2. Like me
3. A lot like me

24. I would become sexually active if I knew there was no such thing as a sexually transmitted disease.

1. Not at all
2. Like me
3. A lot like me

25. I am more afraid of sex now that I used to be.
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<th>2</th>
<th>3</th>
<th>4</th>
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<tr>
<td>26. I would like to feel less anxious about my sexual behavior</td>
<td>Not at all</td>
<td>2</td>
<td>3</td>
<td>A lot like me</td>
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<tr>
<td>27. I would go out of my way to avoid being alone with a member of the opposite sex</td>
<td>Not at all</td>
<td>2</td>
<td>3</td>
<td>A lot like me</td>
</tr>
<tr>
<td>28. Sex is a chronic source of frustration for me</td>
<td>Not at all</td>
<td>2</td>
<td>3</td>
<td>A lot like me</td>
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<tr>
<td>29. I feel sexually inadequate</td>
<td>Not at all</td>
<td>2</td>
<td>3</td>
<td>A lot like me</td>
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<tr>
<td>30. I would like to get help for a sexual problem</td>
<td>Not at all</td>
<td>2</td>
<td>3</td>
<td>A lot like me</td>
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Appendix A9: Diagnostic Questionnaire (DQ)

Please answer the following questions about your psychological and/or medical history.

1. Have you ever had any concerns about symptoms of attention-deficit hyperactivity disorder (ADHD)?
   a. Yes
   b. No

2. If Yes, have you ever received a diagnosis of ADHD?
   a. Yes
   b. No

3. Have you ever had any concerns about social anxiety symptoms?
   a. Yes
   b. No

4. If Yes, have you ever been given a diagnosis of social anxiety disorder?
   a. Yes
   b. No

5. Have you ever had any concerns about Diabetes (Type I or II)?
   a. Yes
   b. No

6. If Yes, have you ever been given a diagnosis of Type I or Type II diabetes?
   a. Yes
   b. No

7. Have you ever been concerned about having depressive symptoms?
   a. Yes
   b. No

8. If Yes, have you ever been given a diagnosis of depression?
   a. Yes
   b. No

9. Have you ever been concerned about having symptoms of posttraumatic stress disorder (PTSD)?
   a. Yes
   b. No

10. If Yes, have you ever been given a diagnosis of posttraumatic stress disorder (PTSD)?
11. Are you currently taking any medication for a psychological condition (e.g., anxiety, depression, ADHD)?
   a. Yes
   b. No

12. If Yes, what medication for a psychological condition are you currently taking?
   (Write-in)
Appendix A10: Beck Depression Inventory – II (BDI-II)

Due to the fact that the BDI-II is copyrighted, a copy of the instrument items was not included in the current document.
Appendix A11: Inventory of Interpersonal Problems – Short Circumplex (IIP-SC)

Due to the fact that the IIP-SC is copyrighted, a copy of the instrument items was not included in the current document. An example of IIP-SC items are provided below, as provided on the publisher’s webpage: (http://www.mindgarden.com/products/iip.htm).

**Item Example**

*Directions:* People have reported having the following problems in relating to other people. Please read the list below, and for each item, consider whether it has been a problem for you with respect to any significant person in your life. Then, using the following choices, circle the response that describes how distressing that problem has been for you.

<table>
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<tr>
<th>Not at all</th>
<th>A little bit</th>
<th>Moderately</th>
<th>Quite a bit</th>
<th>Extremely</th>
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<tr>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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The following are things you find hard to do with other people.

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<th>It is hard for me to:</th>
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<tr>
<td>Be firm when I need to be.</td>
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<tr>
<td>Understand another person’s point of view.</td>
</tr>
<tr>
<td>Take instructions from people who have authority over me.</td>
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The following are things that you do too much.

| I try to control other people too much                                            | 0 1 2 3 4 |
| I tell personal things to other people too much.                                 | 0 1 2 3 4 |
Appendix A12: Child Sexual Victimization Questionnaire (CSVQ)

Many people have sexual experiences as children, either with friends or with people older than themselves. The following questions ask about any experiences you may have had before the age of 14.

Questions about sexual intercourse mean penetration of the vagina, no matter how slight, by a man’s penis. Ejaculation is not required.

For each item, please select the appropriate response. Please read each item carefully.

c. Another person showed his/her sex organs to you.

A. No
B. Yes

If YES:
1a. Who was involved? (Circle one letter) [If more than one person was involved, who was the oldest person?]

A. I did not have this experience before age 14
B. Stranger
C. Older person you knew (neighbor, teacher, friend of your parents, etc.)
D. Friend of your brother or sister, or person about your age (not boyfriend)
E. Aunt, uncle, or grandparent
F. Brother, step-brother; sister, or step-sister
G. Step-father or step-mother
H. Father or mother
I. Boyfriend

1b. Approximately how much older than you was the other person? [If more than one person was involved, how much older was the oldest person?]

A. I did not have this experience before age 14
B. The person was younger than me or about my same age
C. The person was 1-4 years older than me
D. The person was 5-9 years older than me
E. The person was 10 or more years older than me

1c. What do you perceive to be the main reason this event occurred?

A. I did not have this experience before age 14
B. Curiosity, it felt good, it made me feel loved or secure
2. Someone older than you requested you to do something sexual.

A. No
B. Yes

If YES:
2a. Who was involved? (Circle one letter) [If more than one person was involved, who was the oldest person?]

A. I did not have this experience before age 14
B. Stranger
C. Older person you knew (neighbor, teacher, friend of your parents, etc.)
D. Friend of your brother or sister, or person about your age (not boyfriend)
E. Aunt, uncle, or grandparent
F. Brother, step-brother; sister, or step-sister
G. Step-father or step-mother
H. Father or mother
I. Boyfriend

2b. Approximately how much older than you was the other person? [If more than one person was involved, how much older was the oldest person?]

A. I did not have this experience before age 14
B. The person was younger than me or about my same age
C. The person was 1-4 years older than me
D. The person was 5-9 years older than me
E. The person was 10 or more years older than me

2c. What was the strategy used to request that you participate?

A. I did not have this experience before age 14
B. Curiosity, it felt good, it made me feel loved or secure
C. Other person used his/her authority
D. Other person gave me gifts, money, candy, etc.
E. Other person threatened to hurt or punish me
F. Other person used physical force
G. I did not willingly participate
3. You showed your sex organs to another person at his/her request.
   A. No
   B. Yes

If YES:

3a. Who was involved? (Circle one letter) [If more than one person was involved, who was the oldest person?]
   A. I did not have this experience before age 14
   B. Stranger
   C. Older person you knew (neighbor, teacher, friend of your parents, etc.)
   D. Friend of your brother or sister, or person about your age (not boyfriend)
   E. Aunt, uncle, or grandparent
   F. Brother, step-brother; sister, or step-sister
   G. Step-father or step-mother
   H. Father or mother
   I. Boyfriend

3b. Approximately how much older than you was the other person? [If more than one person was involved, how much older was the oldest person?]
   A. I did not have this experience before age 14
   B. The person was younger than me or about my same age
   C. The person was 1-4 years older than me
   D. The person was 5-9 years older than me
   E. The person was 10 or more years older than me

3c. What do you perceive to be the main reason this event occurred?
   A. I did not have this experience before age 14
   B. Curiosity, it felt good, it made me feel loved or secure
   C. Other person used his/her authority
   D. Other person gave me gifts, money, candy, etc.
   E. Other person threatened to hurt or punish me
   F. Other person used physical force

4. Another person fondled you in a sexual way.
   A. No
   B. Yes

If YES:
4a. Who was involved? (Circle one letter) [If more than one person was involved, who was the oldest person?]

A. I did not have this experience before age 14
B. Stranger
C. Older person you knew (neighbor, teacher, friend of your parents, etc.)
D. Friend of your brother or sister, or person about your age (not boyfriend)
E. Aunt, uncle, or grandparent
F. Brother, step-brother; sister, or step-sister
G. Step-father or step-mother
H. Father or mother
I. Boyfriend

4b. Approximately how much older than you was the other person? [If more than one person was involved, how much older was the oldest person?]

A. I did not have this experience before age 14
B. The person was younger than me or about my same age
C. The person was 1-4 years older than me
D. The person was 5-9 years older than me
E. The person was 10 or more years older than me

4c. What do you perceive to be the main reason this event occurred?

A. I did not have this experience before age 14
B. Curiosity, it felt good, it made me feel loved or secure
C. Other person used his/her authority
D. Other person gave me gifts, money, candy, etc.
E. Other person threatened to hurt or punish me
F. Other person used physical force

5. Another person touched or stroked your sex organs.

A. No
B. Yes

If YES:

5a. Who was involved? (Circle one letter) [If more than one person was involved, who was the oldest person?]

A. I did not have this experience before age 14
B. Stranger
C. Older person you knew (neighbor, teacher, friend of your parents, etc.)
D. Friend of your brother or sister, or person about your age (not boyfriend)
E. Aunt, uncle, or grandparent
F. Brother, step-brother; sister, or step-sister
G. Step-father or step-mother
H. Father or mother
I. Boyfriend

5b. Approximately how much older than you was the other person? [If more than one person was involved, how much older was the oldest person?]

A. I did not have this experience before age 14
B. The person was younger than me or about my same age
C. The person was 1-4 years older than me
D. The person was 5-9 years older than me
E. The person was 10 or more years older than me

5c. What do you perceive to be the main reason this event occurred?

A. I did not have this experience before age 14
B. Curiosity, it felt good, it made me feel loved or secure
C. Other person used his/her authority
D. Other person gave me gifts, money, candy, etc.
E. Other person threatened to hurt or punish me
F. Other person used physical force

6. You touched or stroked another person’s sex organs at his/her request.

A. No
B. Yes

If YES:

6a. Who was involved? (Circle one letter) [If more than one person was involved, who was the oldest person?]

A. I did not have this experience before age 14
B. Stranger
C. Older person you knew (neighbor, teacher, friend of your parents, etc.)
D. Friend of your brother or sister, or person about your age (not boyfriend)
E. Aunt, uncle, or grandparent
F. Brother, step-brother; sister, or step-sister
G. Step-father or step-mother
H. Father or mother
I. Boyfriend

6b. Approximately how much older than you was the other person?  [If more than one person was involved, how much older was the oldest person?]

   A. I did not have this experience before age 14
   B. The person was younger than me or about my same age
   C. The person was 1-4 years older than me
   D. The person was 5-9 years older than me
   E. The person was 10 or more years older than me

6c. What do you perceive to be the main reason this event occurred?

   A. I did not have this experience before age 14
   B. Curiosity, it felt good, it made me feel loved or secure
   C. Other person used his/her authority
   D. Other person gave me gifts, money, candy, etc.
   E. Other person threatened to hurt or punish me
   F. Other person used physical force

7. Another person attempted intercourse (Got on top of you, attempted to insert penis but penetration did not occur).

   A. No
   B. Yes

If YES:

7a. Who was involved?  (Circle one letter)  [If more than one person was involved, who was the oldest person?]

   A. I did not have this experience before age 14
   B. Stranger
   C. Older person you knew (neighbor, teacher, friend of your parents, etc.)
   D. Friend of your brother or sister, or person about your age (not boyfriend)
   E. Aunt, uncle, or grandparent
   F. Brother, step-brother; sister, or step-sister
   G. Step-father or step-mother
   H. Father or mother
   I. Boyfriend

7b. Approximately how much older than you was the other person?  [If more than one person was involved, how much older was the oldest person?]
A. I did not have this experience before age 14
B. The person was younger than me or about my same age
C. The person was 1-4 years older than me
D. The person was 5-9 years older than me
E. The person was 10 or more years older than me

7c. What was the strategy used to request that you participate?

A. I did not have this experience before age 14
B. Curiosity, it felt good, it made me feel loved or secure
C. Other person used his/her authority
D. Other person gave me gifts, money, candy, etc.
E. Other person threatened to hurt or punish me
F. Other person used physical force

8. Another person had intercourse (oral, vaginal or anal) with you, (any amount of penetration — ejaculation is not necessary).

A. No
B. Yes

If YES:

8a. Who was involved? (Circle one letter) [If more than one person was involved, who was the oldest person?]

A. I did not have this experience before age 14
B. Stranger
C. Older person you knew (neighbor, teacher, friend of your parents, etc.)
D. Friend of your brother or sister, or person about you age (not boyfriend)
E. Aunt, uncle, or grandparent
F. Brother, step-brother; sister, or step-sister
G. Step-father or step-mother
H. Father or mother
I. Boyfriend

8b. Approximately how much older than you was the other person? [If more than one person was involved, how much older was the oldest person?]}

A. I did not have this experience before age 14
B. The person was younger than me or about my same age
C. The person was 1-4 years older than me
D. The person was 5-9 years older than me
E. The person was 10 or more years older than me
8c. What do you perceive to be the main reason this event occurred?

A. I did not have this experience before age 14
B. Curiosity, it felt good, it made me feel loved or secure
C. Other person used his/her authority
D. Other person gave me gifts, money, candy, etc.
E. Other person threatened to hurt or punish me
F. Other person used physical force
Appendix A13: Sexual Experiences Survey – Short Form Victimization (SES-SFV)

The following questions concern sexual experiences that you may have had that were unwanted. We know that these are personal questions, so we do not ask your name or other identifying information. Your information is completely confidential. We hope that this helps you to feel comfortable answering each question honestly. Please indicate the number of times each experience has happened to you. If several experiences occurred on the same occasion—for example, if one night someone told you some lies and had sex with you when you were drunk, you would select both options a and c. The past 12 months refers to the past year going back from today. Since age 14 refers to your life starting on your 14th birthday and stopping one year ago from today.

<table>
<thead>
<tr>
<th>Sexual Experiences</th>
<th>How many times in the past 12 Months?</th>
<th>How many times since age 14?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Someone fondled, kissed, or rubbed up against the private areas of my body (lips, breast/chest, crotch or butt) or removed some of my clothes without my consent <em>(but did not attempt sexual penetration)</em> by:</td>
<td>0 1 2 3+</td>
<td>0 1 2 3+</td>
</tr>
<tr>
<td>a. Telling lies, threatening to end the relationship, making promises I knew were untrue, or continually verbally pressuring me after I said I didn’t want to.</td>
<td>□ □ □ □</td>
<td>□ □ □ □</td>
</tr>
<tr>
<td>b. Showing displeasure, criticizing my sexuality or attractiveness, getting angry but not using physical force, after I said I didn’t want to.</td>
<td>□ □ □ □</td>
<td>□ □ □ □</td>
</tr>
<tr>
<td>c. Taking advantage of me when I was too drunk or out of it to stop what was happening.</td>
<td>□ □ □ □</td>
<td>□ □ □ □</td>
</tr>
<tr>
<td>d. Threatening to physically harm me or someone close to me.</td>
<td>□ □ □ □</td>
<td>□ □ □ □</td>
</tr>
<tr>
<td>e. Using force, for example holding me down with their body weight, pinning my arms, or having a weapon.</td>
<td>□ □ □ □</td>
<td>□ □ □ □</td>
</tr>
<tr>
<td>2. Someone had oral sex with me or made me have oral sex with them without my consent by:</td>
<td>0 1 2 3+</td>
<td>0 1 2 3+</td>
</tr>
<tr>
<td>a. Telling lies, threatening to end the relationship, making promises I knew were untrue, or continually verbally pressuring me after I said I didn’t want to.</td>
<td>□ □ □ □</td>
<td>□ □ □ □</td>
</tr>
<tr>
<td></td>
<td>b. Showing displeasure, criticizing my sexuality or attractiveness, getting angry but not using physical force, after I said I didn’t want to.</td>
<td>□ □ □ □ □ □ □ □</td>
</tr>
<tr>
<td>---</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>--------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>c. Taking advantage of me when I was too drunk or out of it to stop what was happening.</td>
<td>□ □ □ □ □ □ □ □</td>
</tr>
<tr>
<td></td>
<td>d. Threatening to physically harm me or someone close to me.</td>
<td>□ □ □ □ □ □ □ □</td>
</tr>
<tr>
<td></td>
<td>e. Using force, for example holding me down with their body weight, pinning my arms, or having a weapon.</td>
<td>□ □ □ □ □ □ □ □</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3.</th>
<th>A man put his penis into my vagina, or someone inserted fingers or objects without my consent by:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>a. Telling lies, threatening to end the relationship, threatening to spread rumors about me, making promises I knew were untrue, or continually verbally pressuring me after I said I didn’t want to.</td>
</tr>
<tr>
<td></td>
<td>□ □ □ □ □ □ □ □</td>
</tr>
<tr>
<td></td>
<td>b. Showing displeasure, criticizing my sexuality or attractiveness, getting angry but not using physical force, after I said I didn’t want to.</td>
</tr>
<tr>
<td></td>
<td>c. Taking advantage of me when I was too drunk or out of it to stop what was happening.</td>
</tr>
<tr>
<td></td>
<td>d. Threatening to physically harm me or someone close to me.</td>
</tr>
<tr>
<td></td>
<td>e. Using force, for example holding me down with their body weight, pinning my arms, or having a weapon.</td>
</tr>
</tbody>
</table>

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<thead>
<tr>
<th>4.</th>
<th>A man put his penis into my butt, or someone inserted fingers or objects without my consent by:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>a. Telling lies, threatening to end the relationship, threatening to spread rumors about me, making promises I knew were untrue, or continually verbally pressuring me after I said I didn’t want to.</td>
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<td></td>
<td>□ □ □ □ □ □ □ □</td>
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<tr>
<td></td>
<td>b. Showing displeasure, criticizing my sexuality or attractiveness, getting angry but not using physical force, after I said I didn’t want to.</td>
</tr>
<tr>
<td></td>
<td>c. Taking advantage of me when I was too drunk or out of it to stop what was happening.</td>
</tr>
<tr>
<td></td>
<td>d. Threatening to physically harm me or someone close to me.</td>
</tr>
</tbody>
</table>
5. **Even though it did not happen, someone tried to have oral sex with me, or make me have oral sex with them without my consent by:**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th>3+</th>
<th></th>
<th>1</th>
<th>2</th>
<th>3+</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Telling lies, threatening to end the relationship, threatening to spread rumors about me, making promises I knew were untrue, or continually verbally pressuring me after I said I didn’t want to.</td>
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<tr>
<td>b. Showing displeasure, criticizing my sexuality or attractiveness, getting angry but not using physical force, after I said I didn’t want to.</td>
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<td></td>
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<tr>
<td>c. Taking advantage of me when I was too drunk or out of it to stop what was happening.</td>
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<td></td>
<td></td>
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<tr>
<td>d. Threatening to physically harm me or someone close to me.</td>
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<td></td>
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<tr>
<td>e. Using force, for example holding me down with their body weight, pinning my arms, or having a weapon.</td>
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</table>

6. **Even though it did not happen, a man tried to put his penis into my vagina, or someone tried to stick in fingers or objects without my consent by:**

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<tr>
<th></th>
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<th></th>
<th>3+</th>
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<th>1</th>
<th>2</th>
<th>3+</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Telling lies, threatening to end the relationship, threatening to spread rumors about me, making promises I knew were untrue, or continually verbally pressuring me after I said I didn’t want to.</td>
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</tr>
<tr>
<td>b. Showing displeasure, criticizing my sexuality or attractiveness, getting angry but not using physical force, after I said I didn’t want to.</td>
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<tr>
<td>c. Taking advantage of me when I was too drunk or out of it to stop what was happening.</td>
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<td></td>
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<tr>
<td>d. Threatening to physically harm me or someone close to me.</td>
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<tr>
<td>e. Using force, for example holding me down with their body weight, pinning my arms, or having a weapon.</td>
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</table>

7. **Even though it did not happen, a man tried to put his penis into my butt, or**

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<th>3+</th>
<th></th>
<th>1</th>
<th>2</th>
<th>3+</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Telling lies, threatening to end the relationship, threatening to spread rumors about me, making promises I knew were untrue, or continually verbally pressuring me after I said I didn’t want to.</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>b. Showing displeasure, criticizing my sexuality or attractiveness, getting angry but not using physical force, after I said I didn’t want to.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Taking advantage of me when I was too drunk or out of it to stop what was happening.</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>d. Threatening to physically harm me or someone close to me.</td>
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<td></td>
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<tr>
<td>e. Using force, for example holding me down with their body weight, pinning my arms, or having a weapon.</td>
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</tr>
</tbody>
</table>
someone tried to stick in objects or fingers without my consent by:

<p>| | | | | | | | |</p>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Telling lies, threatening to end the relationship, threatening to spread rumors about me, making promises I knew were untrue, or continually verbally pressuring me after I said I didn’t want to.</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>b. Showing displeasure, criticizing my sexuality or attractiveness, getting angry but not using physical force, after I said I didn’t want to.</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>c. Taking advantage of me when I was too drunk or out of it to stop what was happening.</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>d. Threatening to physically harm me or someone close to me.</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>e. Using force, for example holding me down with their body weight, pinning my arms, or having a weapon.</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

8. Did any of the experiences described in this survey happen to you one or more times?  Yes □  No □

9. Did you mark a 1, 2, or 3+ for any of the above items in this questionnaire (i.e., the SES-SFV)? Yes □  No □
Appendix A14: Characteristics of Sexual Victimization Scale (CSVS)

To be filled out by participants who marked 1, 2, or 3+ for any of the above items in the SES-SFV.

Please answer the following item in reference to your most recent unwanted sexual experience.

d. How long ago did this incident occur?

A. Less than two months ago
B. Two to six months ago
C. Six months to one year ago
D. 1 – 2 years ago
E. 2 – 5 years ago
F. More than 5 years ago

2. Was there more than one person who did this to you during the most recent incident?

A. Yes
B. No

e. What was the gender of the person or persons who did them to you?

I reported no experiences □
Female only □
Male only □
Transgender □
Both females and males □

f. How old was the person who did this to you?

(Write-in) ___________ years old
___________ I do not know

5. What was your relation to the person(s) who did this to you? (Choose the most applicable option)

A. Non-romantic friend
B. Acquaintance
C. Stranger
C. Co-worker
D. Romantic partner
E. Spouse
F. Casual romantic acquaintance/first date
G. Relative__________(please specify)

6. Please rate how well you knew the person who did this to you.

1 2 3 4 5 6 7
Did not know at all Knew very well

7. How would you best describe what happened to you?

A. Miscommunication
B. Sexual Assault
C. Attempted Rape
D. Completed Rape
E. Some other type of crime
F. Other ________________________________(please specify)

8. Since this incident occurred, have you engaged in any sexual activity?

A. Yes
B. No
C. Not applicable
Appendix A15: Behavioral Response Questionnaire (BRQ)

Think about the most recent incident that occurred. What was your reaction? Women may respond in a variety of ways to many different situations. Feel free to endorse more than one response, that is, endorse any response you may have used during the incident by using the scale below.

<table>
<thead>
<tr>
<th>Question</th>
<th>Not at all like what I did</th>
<th>A little like what I did</th>
<th>Fairly like what I did</th>
<th>Quite like what I did</th>
<th>Very like what I did</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I acted unresponsive, and didn’t say anything to him.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2. I jokingly tried to tell him that he was coming on too strong.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>3. I made an excuse (which may or may not be true) for why I didn’t want to have sex.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>4. I nicely tried to tell him that I didn’t want to have sex.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>5. I apologetically told him that I didn’t wan’ to have sex (i.e., assumed responsibility for giving him the wrong impression).</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>6. I tried to discuss with him how uncomfortable he was making me feel.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>7. I tried to make him do things that I’m comfortable with like kissing or hugging but not sex.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>8. I told him that I liked him (or found him attractive) but that I was not ready for this.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>9. I told him clearly and directly that I wanted to him to stop.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
10. Gave him alcohol or drugs to make him pass out, to stall him, or to make him less able to bother me.

11. Felt too intoxicated to be able to think or act clearly.

12. Fainted or passed out from the effects of alcohol or drugs.

13. Pushed him away.

14. Started tearing up or crying.

15. Raised my voice and used stronger language (for example, "Hey, LISTEN! I really mean it.").

16. Clearly rejected or insulted him (for example, "You jerk, you're acting like an adolescent.").

17. Found a way to attract attention and help like yelling "Fire!"

18. Ran out of the room, or attempted to run out of the room.

19. Yelled or screamed loud enough for someone nearby to hear me.

20. Faked the arrival of others (i.e., I know my roommate is coming home now).

21. Told him I wouldn't like him or wouldn't go out with him anymore if he tried to force me.

22. Threatened him (i.e., said I would tell mutual)
friends about his behavior).

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23. Threatened that I would tell a campus official, police or a security person about his behavior.

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24. Became physically defensive (for examples, hitting, kicking, scratching).

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25. Suggested that I had a weapon (for example, mace, or a sharp object).

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<tbody>
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</table>
Appendix A16: Alcohol Questionnaire (AQ)

Please answer the following questions about your alcohol use as it pertains to your most recent experience of unwanted sexual activity.

1. Were you under the influence of alcohol at the time of this incident?
   a. Not applicable/did not use any alcohol
   b. I do not know/do not remember
   c. Yes

2. IF YES on 1, approximately how many standard alcoholic drinks had you consumed at the time of the incident? (1 standard drink = 4 oz. glass of wine, 12 oz. beer, 1 oz. hard liquor, 1 straight/mixed drink, 1 pitcher = 6 drinks) (write in)

3. IF YES on 1, approximately how intoxicated did you feel at the time of the incident?
   a. Not at all intoxicated
   b. A little intoxicated
   c. Moderately intoxicated
   d. Quite intoxicated
   e. Extremely intoxicated

4. Was the man who initiated the unwanted sexual behavior under the influence of alcohol at the time of the incident, to your knowledge?
   a. Not applicable/did not use any alcohol
   b. I do not know/do not remember
   c. Yes

5. IF YES on 4, approximately how many alcoholic drinks had he consumed at the time of the incident? (1 standard drink = 4 oz. glass of wine, 12 oz. beer, 1 oz. hard liquor, 1 straight/mixed drink, 1 pitcher = 6 drinks) (write in)

6. IF YES on 4, approximately how intoxicated did he appear at the time of the incident?
   a. Not at all intoxicated
   b. A little intoxicated
   c. Moderately intoxicated
   d. Quite intoxicated
   e. Extremely intoxicated

7. Were you under the influence of any drugs at the time of the incident?
   a. Not applicable/did not use any drugs
   b. I do not know/do not remember
   c. Yes
8. If yes, which drugs did you use? (Circle all that apply)
   a. Not applicable/did not use any drugs
   b. I do not know/do not remember
   c. Marijuana
   d. Cocaine
   e. other (specify)

9. Was the man who initiated the unwanted sexual behavior under the influence of drugs at the time of the incident, to your knowledge?
   a. Not applicable/did not use any drugs
   b. I do not know/do not remember
   c. Yes

10. If yes, which drugs did he use?
    a. Not applicable/did not use any drugs
    b. I do not know/do not remember
    c. Marijuana
    d. Cocaine
    e. other (specify)
Appendix A17: Psychological Barriers to Responding to Sexual Aggression

Instrument (PBRSAI)

Think about the most recent incident, and consider: to what extent would the following factors make it difficult for you to protect yourself or control the situation? Select the number that best represents your answer using the scale below. People respond in many different ways, so please try to remember yourself in that situation and indicate all the ways you may have responded to an unwanted sexual activity.

<table>
<thead>
<tr>
<th>Not At All Significant</th>
<th>Slightly Significant</th>
<th>Moderately Significant</th>
<th>Quite Significant</th>
<th>Very Much Significant</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

1. I hesitated, fearing that I was not understanding his intentions.
2. I didn’t want him to think I am uptight or a “prude.”
3. I didn’t want to overreact and make a big deal out of nothing
4. I didn’t want him to laugh at me.
5. I didn’t want to create a scene in front of him
6. I liked him and didn’t want to ruin things for the future.
7. I didn’t want to embarrass myself by screaming out loud.
8. I didn’t want to scream because others might hear and suspect something.
9. I didn’t want to let other people know what was happening because I didn’t want to get a reputation for being “loose.”
10. I was embarrassed to get up and run out of the room.
11. I wouldn’t want to get a reputation as a “tease.”
12. I was afraid of being physically hurt if I didn’t go along with it.
13. I didn’t want to hurt his feelings.
14. I didn’t want him to get mad at me.
15. Because of his strength, I felt that I had no choice but to go along with him.
16. I was so intoxicated or too high to think through a plan to get out of the situation.
17. I was intoxicated or high, I lacked the physical strength and coordination to get away from him.
18. I felt that since I got myself into this situation I must deal with the consequences.
19. My mind went blank making it hard to figure out what to do.
20. I didn’t expect anyone to help me even if I screamed.
21. I was too intoxicated or too high to see it coming.
Appendix A18: Social Reactions Adjunct Questionnaire (SRAQ)

Please answer the following questions as they relate to your most recent unwanted sexual experience.

1. Have you told another person about your most recent unwanted sexual experience?
   a. Yes
   b. No

If YES to 1:

2. About how long after the experience did you first tell someone about it?
   a. immediately after
   b. days after
   c. weeks after
   d. months after
   e. a year after
   f. more than a year after

3. To what extent did you describe what actually happened during your most recent disclosure?
   a. I said what happened briefly, but didn’t discuss it further
   b. I said what happened and talked about it a little
   c. I said what happened and talked about it but only in a general way
   d. I said what happened and talked about it in detail

4. When thinking about the most recent time that you experienced unwanted sexual activity, did you tell any of the following people about it (indicate as many as apply):
   a. Romantic partner(s)
      i. If so, how many?
   b. Close friend(s)
      i. If so, how many?
   c. Casual friend(s)
      i. If so, how many?
   d. Acquaintance(s)
      i. If so, how many?
   e. Coworker(s)
      i. If so, how many?
   f. Family member(s) (including parents, siblings, and other relatives)
      i. If so, how many?
   g. Legal personnel (including police officers or prosecutors)
      i. If so, how many?
h. Counselor(s) (including therapists, crisis advocates, social service agency staff, or religious personnel)
   i. If so, how many?
   i. Medical personnel (including doctors or nurses)
   i. If so, how many?

5. For each person that is selected above: how difficult/distressing was it for you to tell this person about what happened to you?

   a. Not difficult/distressing at all
   b. Slightly difficult/distressing
   c. Moderately difficult/distressing
   d. Very difficult/distressing
   e. Extremely difficult/distressing

6. In general, how difficult/distressing was it for you to tell other(s) about what happened to you?

   a. Not difficult/distressing at all
   b. Slightly difficult/distressing
   c. Moderately difficult/distressing
   d. Very difficult/distressing
   e. Extremely difficult/distressing
Appendix A19: Social Reactions Questionnaire (SRQ)

The following is a list of behaviors that other people responding to a person with this experience often show. Please indicate how often you experienced each of the listed responses from other people after you told another person(s) about your most recent unwanted sexual experience.

<p>| | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Never</td>
<td>rarely</td>
<td>sometimes</td>
<td>frequently</td>
<td>always</td>
</tr>
</tbody>
</table>

___ 1. Told you it was not your fault
___ 2. Pulled away from you
___ 3. Wanted to seek revenge on the perpetrator
___ 4. Told others about your experience without your permission
___ 5. Distracted you with other things
___ 6. Comforted you by telling you it would be all right or by holding you
___ 7. Told you he/she felt sorry for you
___ 8. Helped you get medical care
___ 9. Told you that you were not to blame
___ 10. Treated you differently in some way than before you told him/her that made you uncomfortable
___ 11. Tried to take control of what you did/decisions you made
___ 12. Focused on his/her own needs and neglected yours
___ 13. Told you to go on with your life
___ 14. Held you or told you that you are loved
___ 15. Reassured you that you are a good person
___ 16. Encouraged you to seek counseling
___ 17. Told you that you were to blame or shameful because of this experience
___ 18. Avoided talking to you or spending time with you
___ 19. Made decisions or did things for you
___ 20. Said he/she feels personally wronged by your experience
___ 21. Told you to stop thinking about it
___ 22. Listened to your feelings
___ 23. Saw your side of things and did not make judgments
___ 24. Helped you get information of any kind about coping with the experience
___ 25. Told you that you could have done more to prevent this experience from occurring
___ 26. Acted as if you were damaged goods or somehow different now
___ 27. Treated you as if you were a child or somehow incompetent
___ 28. Expressed so much anger at the perpetrator that you had to calm him/her down
___ 29. Told you to stop talking about it
___ 30. Showed understanding of your experience
31. Reframed the experience as a clear case of victimization
32. Took you to the police
33. Told you that you were irresponsible or not cautious enough
34. Minimized the importance or seriousness of your experience
35. Said he/she knew how you felt when he/she really did not
36. Has been so upset that he/she needed reassurance from you
37. Tried to discourage you from talking about the experience
38. Shared his/her own experience with you
39. Was able to really accept your account of your experience
40. Spent time with you
41. Told you that you did not do anything wrong
42. Made a joke or sarcastic comment about this type of experience
43. Made you feel like you didn’t know how to take care of yourself
44. Said he/she feels you’re tainted by this experience
45. Encouraged you to keep the experience a secret
46. Seemed to understand how you were feeling
47. Believed your account of what happened
48. Provided information and discussed options
Appendix A20: Integrity Check Questions

1. Please select the response “blue” from the following options:
   a. Red
   b. Green
   c. Blue
   d. Yellow

2. Answer this question with “somewhat disagree”
   a. Agree
   b. Agree completely
   c. Disagree
   d. Somewhat Disagree

3. Are you a student at Ohio University?
   a. Yes
   b. No
Appendix B1: Results of the Factor Analysis of the Psychological Barriers to Responding to Sexual Aggression Instrument

Due to the need to explore underlying theoretical constructs, a factor analysis using principal axis factoring (PAF) was identified as the most appropriate exploratory factor analytic statistical procedure with which to reduce PBRSAI (Nurius et al., 2000) scale dimensions. A factor analysis using PAF with Varimax (orthogonal) rotation of the 21 items from the PBRSAI was conducted. An examination of the Kaiser-Meyer-Olking (KMO) measure of sampling adequacy suggested that the sample was factorable (KMO = .79, Bartlett’s test of sphericity $\chi^2(210) = 1107.81, p < .001$). The factor analysis, conducted with initial extraction criteria based on a cut-off of eigenvalues greater than 1.0, identified a five-factor solution that explained 67.36% of the total variance. Visual examination of the scree plot confirmed a five-factor solution. However, item selection conventions require a minimum of three significant item loadings per factor for factor retention (Raubenheimer, 2004); provided that only two items loaded onto one of the five identified factors, a subsequent factor analysis extracting four fixed factors was conducted. Visual inspection of the scree plot supported retention of four factors. Results of the factor analysis revealed that the four factors explained 62.96% of the total variance. Following, the rotated factor matrix was examined to determine factor loadings. Recommendations regarding the minimum threshold for validity of factor loadings (e.g., a factor loading higher than .60 on the parent factor and a loading less than .40 on the foreign factor) established by Chin, Gopal, and Salisbury (1997) and van der Heijden (2004) were followed. Based upon this inclusion/exclusion criteria, the
following scale items were retained: four items on Factor 1 (i.e., referred to as the self-consciousness subscale; items 7, 9, 10, and 11) three items on Factor 2 (i.e., referred to as concern about preserving the relationship with the perpetrator subscale; items 2, 3, and 13), three items on Factor 3 (i.e., referred to as the concern that alcohol impeded one’s ability to respond subscale; items 16, 17, and 21), and three items on Factor 4 (i.e., referred to as the concern for potentially exacerbating injury inflicted by the perpetrator subscale; items 12, 15, and 20). Appendix B2 displays factor loadings after rotation of the four-factor solution as well as the total variance explained by each factor.
Appendix B2: Factor Loadings of the Psychological Barriers to Responding to Sexual Aggression Instrument Items from Fixed Four-Factor Factor Analysis Using Principal Axis Factoring with Varimax Rotation

<table>
<thead>
<tr>
<th>Item</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I hesitated, fearing that I was not understanding his intentions.</td>
<td>.445</td>
<td>.194</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. I didn’t want him to think I am uptight or a “prude.”</td>
<td>.329</td>
<td>.716</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. I didn’t want to overreact and make a big deal out of nothing</td>
<td>.283</td>
<td>.732</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. I didn’t want him to laugh at me.</td>
<td>.630</td>
<td>.539</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. I didn’t want to create a scene in front of him</td>
<td>.463</td>
<td>.672</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. I liked him and didn’t want to ruin things for the future.</td>
<td>.299</td>
<td>.379</td>
<td>.177</td>
<td></td>
</tr>
<tr>
<td>7. I didn’t want to embarrass myself by screaming out loud.</td>
<td>.685</td>
<td>.247</td>
<td>.369</td>
<td></td>
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<tr>
<td>8. I didn’t want to scream because others might hear and suspect</td>
<td>.551</td>
<td>.185</td>
<td>.423</td>
<td></td>
</tr>
<tr>
<td>9. I didn’t want to let other people know what was happening because I didn’t want to get a reputation for being “loose.”</td>
<td>.653</td>
<td>.267</td>
<td>.209</td>
<td></td>
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<tr>
<td>10. I was embarrassed to get up and run out of the room.</td>
<td>.857</td>
<td>.288</td>
<td>.212</td>
<td>.230</td>
</tr>
<tr>
<td>11. I wouldn’t want to get a reputation as a “tease.”</td>
<td>.797</td>
<td>.271</td>
<td></td>
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</tr>
<tr>
<td>12. I was afraid of being physically hurt if I didn’t go along with it</td>
<td>.169</td>
<td>.125</td>
<td>.653</td>
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<tr>
<td>13. I didn’t want to hurt his feelings.</td>
<td></td>
<td>.602</td>
<td>.163</td>
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<tr>
<td>14. I didn’t want him to get mad at me.</td>
<td>.274</td>
<td>.607</td>
<td>.505</td>
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<tr>
<td>15. Because of his strength, I felt that I had no choice but to go along with him.</td>
<td>.177</td>
<td></td>
<td></td>
<td>.849</td>
</tr>
<tr>
<td>16. I was so intoxicated or too high to think through a plan to get out of the situation.</td>
<td></td>
<td></td>
<td></td>
<td>.988</td>
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<tr>
<td>17. I was intoxicated or high, I lacked the physical strength and coordination to get away from him.</td>
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<td></td>
<td></td>
<td>.866</td>
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<tr>
<td>18. I felt that since I got myself into this situation I must deal with the consequences.</td>
<td>.378</td>
<td>.578</td>
<td>.245</td>
<td>.222</td>
</tr>
<tr>
<td>19. My mind went blank making it hard to figure out what to do.</td>
<td>.321</td>
<td>.300</td>
<td>.496</td>
<td>.411</td>
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<tr>
<td>20. I didn’t expect anyone to help me even if I screamed.</td>
<td>.167</td>
<td></td>
<td></td>
<td>.786</td>
</tr>
<tr>
<td>21. I was too intoxicated or too high to see it coming.</td>
<td></td>
<td>.106</td>
<td>.881</td>
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Percentage of variance explained

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<tr>
<th>Factor</th>
<th>Percentage of variance explained</th>
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<tbody>
<tr>
<td>1</td>
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</tr>
<tr>
<td>2</td>
<td>12.43</td>
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<tr>
<td>3</td>
<td>9.01</td>
</tr>
<tr>
<td>4</td>
<td>4.95</td>
</tr>
</tbody>
</table>

Note. Bolded value indicates that item was retained on respective factor. Coefficients below .10 were repressed.
Appendix C1: Ohio University Consent Form

Title of Research: Women’s Social Experiences

Researcher: Alison Reilly Menatti, M.S.
Faculty Supervisor: Christine Gidycz, Ph.D.

You are being asked to participate in research. For you to be able to decide whether you want to participate in this project, you should understand what the project is about, as well as the possible risks and benefits in order to make an informed decision. This process is known as informed consent. This form describes the purpose, procedures, possible benefits, and risks. It also explains how your personal information will be used and protected. This will allow your participation in this study. If you wish to have a copy of this consent document to take with you, you should print it.

Explanation of Study

This is a one-session study. The purpose of this study is to better understand social, sexual, and psychological health experiences of college women.

If you agree to participate in this study, you will be asked to fill out an Internet survey which includes questions about your current and past social, sexual, and psychological experiences; questions may ask about upsetting, unwanted, or negative experiences that may have occurred recently or in childhood. Many of the questions about recent and childhood sexual experiences are very explicit. You should not participate in this study if you feel that you may not be comfortable answering questions about personal and sexual information. Following these surveys, you will be provided debriefing information regarding the study and referral sources.

Your participation in the study will last approximately one and a half hours. If you elect to participate in this study, the online survey must be completed in one sitting.

Risks and Discomforts

Risks or discomforts that you might experience include emotional discomfort or distress. You may skip any questions that you do not want to answer, may stop participating at any time, and may withdraw from the research at any time.

In addition, if you are concerned about the study materials used or questions asked and wish to speak with a professional, or if you would like more information or reading material on this topic, please contact one of the following resources:
Ohio University Counseling and Psychological Services: 740-593-1616
Hudson Health Center, 3rd Floor
2 Health Center Drive
Athens, Ohio 45701

OU Survivor Advocate Program 740-597-7233
Office in McKee House, 44 University Terrace
Hours: Mon-Thurs 8 a.m. - 8 p.m.; Fri: 8 am – 5 pm
On-Call available 24 hours/7 days a week
E-mail: survivor.advocacy@ohio.edu

OU Counselor-in-Residence: 740-593-0769
http://www.ohio.edu/counseling/Counselor-in-Residence.cfm
Walk-ins Sunday through Friday in Jefferson Hall, Room 122 from 5 – 10 pm

Benefits

Individually, you may benefit from participation in this study by having the opportunity to learn about how the scientific method is applied to psychological research. Furthermore, information obtained from participation in this study is important to both science and society, in that its findings will inform future research and help various health professionals be better able to provide help and support to students with upsetting social or unwanted sexual experiences.

Confidentiality and Records
Your study information will be collected anonymously, meaning that your name will not in any way be linked to the confidential information that you share. Additionally all data will be stored safely in a locked laboratory. For maximum confidentiality, please clear your browser history and close the browser before leaving the computer.

Additionally, while every effort will be made to keep your study-related information confidential, there may be circumstances where this information must be shared with:
* Federal agencies, for example the Office of Human Research Protections, whose responsibility is to protect human subjects in research;
* Representatives of Ohio University (OU), including the Institutional Review Board, a committee that oversees the research at OU;

Compensation
As compensation for your time/effort, you will receive 1.5 course credits for your participation in the study.

Contact Information
If you have any questions regarding this study, please contact:
If you have any questions regarding your rights as a research participant, please contact Chris Hayhow, Director of Research Compliance, Ohio University, (740) 593-0664 or hayhow@ohio.edu.

By agreeing to participate in this study, you are agreeing that:

- you have read this consent form (or it has been read to you) and have been given the opportunity to ask questions and have them answered
- you have been informed of potential risks and they have been explained to your satisfaction.
- you understand Ohio University has no funds set aside for any injuries you might receive as a result of participating in this study
- you are 18 years of age or older
- your participation in this research is completely voluntary
- you may leave the study at any time. If you decide to stop participating in the study, there will be no penalty to you and you will not lose any benefits to which you are otherwise entitled.
Appendix C2: Ohio University Debriefing Form

Thank you for your participation in this research project. This study was designed to examine social, sexual, and psychological health experiences. To accomplish this goal, you were asked questions about personal life events, including psychological, social, and sexual experiences and related information that may pertain to you.

The information provided by these questionnaires will help psychology researchers and clinicians learn more about college students’ sexual experiences, including those sexual experiences that were unwanted. This information will also help psychologists to research important social issues in the future. The results of studies such as this one will help to inform the development of intervention and prevention programming related to unwanted sexual experiences.

As a reminder, all of your questionnaire responses will remain anonymous. If you have any further questions regarding the nature of this study, or would like to request details of the results, please feel free to contact one of the following:

Alison Reilly Menatti, M.S. 056 Porter Hall (740-593-1088) ar377209@ohio.edu
Christine A. Gidycz, Ph.D. 231 Porter Hall (740-593-1092) gidycz@ohio.edu

In addition, if you are concerned about the study materials used or questions asked and wish to speak to a professional, or if you would like more information or reading material on this topic, please contact one of the following resources:

Ohio University Counseling and Psychological Services: (740) 593-1616
Ohio University Psychology and Social Work Clinic (740) 593-0902
My Sister’s Place Battered Women’s Shelter (740) 593-3402
Sexual Assault Survivor Advocacy Program (740) 589-5562
OU Counselor-in-Residence (740) 593-0769

Thank you again for your participation.
Appendix D: Results of Statistical Analyses Conducted for Research Question 2

Results of *t*-tests Comparing Social Anxiety Symptoms across Women who Did and Did Not Disclose to Various Support Sources

<table>
<thead>
<tr>
<th>Disclosure source</th>
<th>Results of <em>t</em>-tests</th>
<th>Cohen’s <em>d</em></th>
</tr>
</thead>
<tbody>
<tr>
<td>Romantic partner</td>
<td><em>t</em>(20) = -1.98, <em>p</em> = .06</td>
<td>0.88</td>
</tr>
<tr>
<td>Close friend(s)</td>
<td><em>t</em>(20) = 1.89, <em>p</em> = .07</td>
<td>1.18</td>
</tr>
<tr>
<td>Casual friend(s)</td>
<td><em>t</em>(20) = -0.34, <em>p</em> = .74</td>
<td>0.15</td>
</tr>
<tr>
<td>Acquaintance(s)</td>
<td><em>t</em>(20) = -0.57, <em>p</em> = .58</td>
<td>0.42</td>
</tr>
<tr>
<td>Family member(s)</td>
<td><em>t</em>(20) = 1.33, <em>p</em> = .20</td>
<td>0.64</td>
</tr>
<tr>
<td>Legal personnel</td>
<td><em>t</em>(20) = 1.15, <em>p</em> = .26</td>
<td>0.86</td>
</tr>
<tr>
<td>Counselor(s)</td>
<td><em>t</em>(20) = 2.21, <em>p</em> = .04<em>α</em></td>
<td>1.64</td>
</tr>
<tr>
<td>Medical personnel</td>
<td><em>t</em>(20) = -0.64, <em>p</em> = .53</td>
<td>0.66</td>
</tr>
</tbody>
</table>

*Note.* *α* = .006 per the Bonferroni-Holm alpha correction. All reported results are non-significant.
Means and Standard Deviations of Social Anxiety Total Scores within Sexual Assault Disclosure Group

<table>
<thead>
<tr>
<th>Disclosure source</th>
<th>n</th>
<th>Mean SIAS - s (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Romantic partner</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disclosed</td>
<td>8</td>
<td>15.63 (10.42)</td>
</tr>
<tr>
<td>Did not disclose</td>
<td>14</td>
<td>27.29 (14.65)</td>
</tr>
<tr>
<td>Close friend(s)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disclosed</td>
<td>19</td>
<td>20.89 (13.65)</td>
</tr>
<tr>
<td>Did not disclose</td>
<td>3</td>
<td>36.67 (11.06)</td>
</tr>
<tr>
<td>Casual friend(s)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disclosed</td>
<td>9</td>
<td>21.78 (18.28)</td>
</tr>
<tr>
<td>Did not disclose</td>
<td>13</td>
<td>23.92 (11.34)</td>
</tr>
<tr>
<td>Acquaintance(s)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disclosed</td>
<td>2</td>
<td>17.50 (4.95)</td>
</tr>
<tr>
<td>Did not disclose</td>
<td>20</td>
<td>23.60 (14.78)</td>
</tr>
<tr>
<td>Coworker(s)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disclosed</td>
<td>0</td>
<td>-</td>
</tr>
<tr>
<td>Did not disclose</td>
<td>22</td>
<td>23.05 (14.21)</td>
</tr>
<tr>
<td>Family member(s)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disclosed</td>
<td>6</td>
<td>29.50 (17.10)</td>
</tr>
<tr>
<td>Did not disclose</td>
<td>16</td>
<td>20.63 (12.74)</td>
</tr>
<tr>
<td>Legal personnel</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disclosed</td>
<td>2</td>
<td>34.00 (24.04)</td>
</tr>
<tr>
<td>Did not disclose</td>
<td>20</td>
<td>21.95 (13.38)</td>
</tr>
<tr>
<td>Counselor(s)</td>
<td></td>
<td></td>
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<tr>
<td>Disclosed</td>
<td>2</td>
<td>42.50 (12.02)</td>
</tr>
<tr>
<td>Did not disclose</td>
<td>20</td>
<td>21.10 (13.11)</td>
</tr>
<tr>
<td>Medical personnel</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disclosed</td>
<td>1</td>
<td>14.00 (-)</td>
</tr>
<tr>
<td>Did not disclose</td>
<td>21</td>
<td>23.48 (14.41)</td>
</tr>
</tbody>
</table>

*Note.* SIAS = Social Interaction Anxiety Scale - Straightforward. SD = Standard deviation.
All analyses included only women who experienced victimization within the past year. Given that a) the overarching objective of the current research entailed evaluation of the relationship between social anxiety symptomology and sexual victimization experiences, and b) participants responded to items inquiring about their current social anxiety symptoms, examination of correlates of victimization experienced over the past year only (as opposed to victimization experienced since age 14) made greater theoretical sense.

Forty-six participants were removed from the original sample for the following reasons: failure to correctly answer at least one of three integrity check inquiries embedded within survey (n = 7); failure to respond to any survey item (n = 5); and failure to respond to items on the Sexual Experiences Survey – Short Form Victimization (n = 20), which categorizes assault history. In addition, women who reported victimization histories consisting of sexual contact only (n = 14) were removed from the sample due to the fact that only women reporting ASA histories consisting of coercion, attempted rape, or rape were categorized as victims.

It is important to note that the directionality of all reported mediation paths cannot be conclusively determined provided that all study measures were completed at one time-point, which precluded the ability to establish the causal priority of one variable in the model in relation to another. Accordingly, the results of all reported mediation analyses should be interpreted cautiously and within the context of this limitation.

The Bonferroni-Holm correction for multiple comparisons method (Holm, 1979) entails the following: if $H_1 \ldots, H_m$ is a family of hypotheses with corresponding $p$-values $P_1 \ldots, P_m$, the $p$-values $P_1 \ldots, P_m$ and associated hypotheses are ordered from the lowest to highest obtained values. The significance of the lowest obtained $p$-value is first evaluated by comparing $p$ to $\alpha/m$, where $m$ is the total number of comparisons. If $p > \alpha/m$, the procedure is stopped and all null hypotheses fail to be rejected. If $p < \alpha/m$, the null hypothesis is rejected. Following, the significance of the next lowest obtained $p$-value is evaluated by comparing $p$ to $\alpha/(m - 1)$. The procedure is continued in this fashion until a given $p$-value fails to reach statistical significance. Please reference Holm (1979) for further information regarding how to utilize this method.

CSA history served as a covariate in this analysis due to the finding that CSA status was significantly related to the outcome variables (see Descriptive and Preliminary Analyses section).

Of note, higher scores on the measure of sexual dysfunction (i.e., the FSFI) indicate fewer sexual functioning problems.

Higher scores on the sexual aversion measure indicated greater sexual aversion, whereas higher scores on the sexual functioning measure indicated better sexual functioning. Given this difference in scoring, although social anxiety was positively related to sexual aversion and negatively related to sexual functioning, the effect of the relationship between social anxiety and each outcome, respectively, was the same (i.e., social anxiety was positively associated with worse sexual functioning problems). Accordingly, the absolute values of the correlation coefficients were utilized in the
Fisher’s $r$-to-$z$ test in order to reveal differences in the strengths of the relationship between social anxiety and each measure of sexual functioning problems.

The finding that there were no significant differences in the levels of interpersonal functioning across women with and without past-year ASA histories is likely attributable to the disordinal nature of the significant interaction between social anxiety and sexual victimization on interpersonal functioning.

The finding that there were no significant differences in the levels of sexual dysfunction across women with and without past-year ASA histories is likely attributable to the disordinal nature of the significant interaction between social anxiety and sexual victimization on sexual functioning.