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Women's Conceptualization of Their Unwanted Sexual Experiences: A Focus on Labeling, Time since Assault, Psychological Functioning and Risky Sexual Behavior

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By

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Abstract

Many women will experience rape. How a woman conceptualizes her rape experience may predict her psychological and sexual functioning post-rape. The time since assault may also impact labeling and post-assault functioning. The current study examined psychological functioning, sexual behavior and risky behavior among a sample of 721 college-age women from a large Midwestern university. Additional analyses focused on a sub-sample of 146 rape victims to examine the link between labeling and psychological distress, risky sexual behavior, and risky substance use. Labeling was assessed as a continuous variable, and was analyzed for each of the following label types: rape, sexual assault, and nonconsensual. Results suggested that characteristics of the assault, disclosure and social reactions, and attribution and blame predicted extent of labeling type. Labeling was associated with higher psychological distress, riskier sexual behavior and substance use. Meanwhile, more recent assaults were associated with higher risky sexual behavior, and decreased labeling. Implications for future research are discussed.

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Approximately 1 in 5 women is raped since the age of 14 (Fisher, Daigle, Cullen, & Turner, 2003; Kahn, Jackson, Kully, Badger, & Halvorsen, 2003; Peterson & Muehlenhard, 2004). Furthermore, although a large minority of women experience rape, only a few actually label their unwanted sexual experiences as rape. Research on labeling unwanted sexual experiences is mixed. Some studies indicate that as many as 60% of rape victims label their experience as rape (Littleton, Axsom, Breitkopf, & Berenson, 2006); however, other studies report that as many as 64% do not label their rape experiences as such even when it met legal definitions of rape (Bondurant, 2001). Accurately labeling an assault "rape" is critical. Without such a label, criminals may not be identified or punished, awareness of true prevalence rates may not be achieved, and victims may not receive the support or help that they deserve and that may be necessary for recovery. However, perhaps one of the most troubling aspects of women's failure to label unwanted sex as rape is that some critics contend that women who do not label should not be considered victims and prevalence estimates are subsequently inflated (Gilbert, 1997). Labeling appears to have both societal and personal implications.

Although there is extensive research documenting the deleterious effects of sexual assault and rape (Brener, McMahon, Warren, & Douglas, 1999; Briere, Elliott, Harris, & Cotman, 1995; Shapiro & Schwartz, 1997), fewer studies have examined whether labeling an event as rape (or failing to do so) has an impact on psychological functioning. The majority of research on labeling rape focuses on determinants of labeling (Bondurant, 2001; Kahn et al., 2003; McMullin & White, 2006), rather than the purported consequences of labeling in terms of current

functioning and risky behavior. However, of the few studies investigating the consequences of labeling (Kahn, et al., 2003; Harned, 2004; Littleton et al., 2006), most have not considered changes in functioning and behavior over time. It may be that psychological functioning and risky behavior patterns change over time, depending on whether or not victims label their unwanted sexual experiences as rape. Clearly, given the important implications of labeling in terms of victim social support and recovery, as well as the societal and political implications in terms of identifying "true" prevalence rates of sexual victimization, additional research is needed to identify intrapersonal as well as contextual factors that predict labeling as well as factors related to subsequent functioning in relation to the chosen label. Although numerous studies have examined some aspect of this issue, there are also some gaps in the research. More information is needed to determine whether women would prefer other labels to rape—for example, would a victim be more likely to accept the label of sexual assault versus rape? Related, it is not clear how women conceptualize unwanted experiences in terms the consensual nature of the act. Perhaps women are reticent to attach the rape label if they do not fully believe the activity was nonconsensual. Finally, more information is needed regarding the psychological and behavioral health outcomes associated with labeling (or failure to label) unwanted experiences. In essence, how critical is rape acknowledgment to the individual victim versus to the collective society? The goal of the present study is to examine questions that might contribute to closure of some of these identified gaps. However, it is first important to review the current knowledge literature on rape and labeling.

Impact of Rape and Sexual Assault

Rape and sexual assault, like other forms of trauma, have been found to impact victims' psychological functioning and risky behavior. Rape victims report higher levels of psychological

distress and poorer psychological well-being than nonvictims (McMullin & White, 2006). Rape victims are more depressed, more anxious, suffer from more intrusive experiences, defensive avoidance, dissociation, sexual concerns, impaired self-reference, and tension-reduction behavior (Briere, Elliott, Harris, & Cotman, 1995; Shapiro & Schwartz, 1997). In a sample of college women, Littleton et al. (2006) found that 25% of rape victims reported clinical levels of depression and 36% reported clinical levels of anxiety. In another study of college women (Green, Krupnick, Stockton, Goodman, Corcoran, & Petty, 2005), sexual assault was associated with high levels of dysfunctional sexual behavior, dangerous sexual behavior (i.e. sex without contraception with a partner just met), relatively high rates of pregnancy, abortion, and sexually transmitted infections (STI's). Clearly, rape has negative impacts on psychological and physical health outcomes.

Individuals who have been sexually assaulted, abused, or raped are likely to partake in risky behavior which can also result in negative health-related outcomes. There is some evidence that risky sexual behavior may increase following victimization. Deliramich and Gray (2008) found that in sexual assault victims, post-traumatic alcohol use predicted increases in post-traumatic sexual activity. Although it is not always clear whether this behavior occurs before or after the unwanted sexual experiences, such behavior may facilitate rape, negative outcomes after rape, or even revictimization. Trauma and sexual assault history has been found to be linked to risky sexual behaviors (Campbell, Self, & Ahrens, 2004; He, McCoy, Stevens, & Stark, 1998). Sexual assault victims perceive greater benefits and expect greater future involvement in risky sexual behaviors than nonvictims (Smith, Davis, & Fricker-Elhai, 2004). Given these expectations, it is not surprising that sexual assault victims have been found to engage in more risky sexual behavior (Brener, McMahon, Warren, & Douglas, 1999; Davis, Combs-Lane, &

Jackson, 2002; Green et al, 2005; Orcutt, Cooper, & Garcia, 2005; Shapiro & Schwartz, 1997; Smith, et al., 2004), engage in more frequent sex, and to have more sexual partners than nonvictims (Messman-Moore, Coates, Gaffey, & Johnson, 2008; Shapiro & Schwartz 1997). Rape victims are also more likely to have used drugs or alcohol the last time they had sexual intercourse, to have had sexual intercourse before the age of 15, and to have had multiple sexual partners during the past 3 months (Brener et al., 2006; McMullin & White, 2006). This risky sexual behavior can have serious implications for the physical and psychological health and well-being of victims after their assaults.

Labeling Unwanted Sexual Experiences

Although many women encounter unwanted sexual experiences, many do not label them as rape or sexual assault. Women who do not label their experiences that would meet legal definitions of rape as such have often been termed unacknowledged victims, nonlabelers, or minimizers in the research literature (Botta & Pingree, 1997; Harned, 2004; Kahn et al., 2003; Littleton et al., 2006; McMullin & White, 2006; Varia, Abidin, & Dass, 1996). Most research to date assesses labeling in terms of a yes/no dichotomy. However, some researchers have further divided victims labeling status by providing a "maybe" or "uncertain" option in response to questions asking whether or not they had ever been assaulted (Botta & Pingree, 1997). Other studies have provided a categorical list of options for victims to classify their unwanted sexual experiences with one label including such labels as "some other type of crime," "miscommunication," "bad sex," or "unsure" (Littleton, Axsom, & Grills-Taquechal, 2009). Such categorical options may not capture the women's conceptualization of the experience as a "sexual assault" or as a nonconsensual experience. The present study refers to victims who have not acknowledged their unwanted sexual experience as rape as "nonlabelers," women who do

label their unwanted sexual experience as rape as "labelers," and those that are uncertain as "ambivalent."

Although little research has investigated the differences in functioning and risky behavior between labeling groups, some research has focused on the variables and characteristics of the assault that may predict labeling. It seems that rape script factors contribute to labeling; the characteristics that have been found to predict labeling are consistent with traditional rape scripts. Peterson and Muehlenhard (2004) defined a rape script as "an individual's impression of what typically occurs during a rape" (p. 130). Stereotypic rape scripts commonly define rape very narrowly, involving unknown rapists who use weapons or force. Peterson and Muehlenhard (2004) also found that rape victims were less likely to label their experiences as rape when their rapes did not have characteristics that fit the stereotypic rape myths. Research has suggested that labelers' rape characteristics follow stranger rape script factors including violence, force, and less voluntary drinking and blame.

Research has found that labelers were more likely to have experienced assaults involving intimidation or force and to report physical injury (Bondurant, 2001; Kahn et al., 2003; McMullin & White, 2006). In a study of 123 college women, labelers were more likely to experience threat of force or force for attempted or completed vaginal intercourse while nonlabelers were more likely to experience physical force for anal or oral intercourse (Botta & Pingree, 1997). Nonlabelers have also been found to be less likely to use resistance or to have experienced victimization by another assailant or assailants (Bondurant, 2001; Littleton et al., 2006). Further, nonlabelers were more likely to report themselves and their assailants drinking heavily prior to the assault, greater assailant drug use, and more recent assaults (Kahn et al., 2003; Littleton et al., 2006). Labelers were more likely to blame the perpetrator, and less likely

to blame themselves or the situation (Botta & Pingree 1997; Kahn et al., 2003). Recent research has concentrated on whether the relationship with the assailant affects the labeling outcome. Labelers were not found to be more likely to be romantically involved with their assailant at the time of the assault (Bondurant, 2001; Littleton et al., 2006), or reported being less familiar with their assailants (Kahn et al., 2003). Clearly, the characteristics of the rape experience such as injury, violence, resistance, substance use, and reactions have been found to predict the labeling outcome.

Psychological Functioning & Labeling

Research on the differences in psychological functioning between labelers and nonlabelers has failed to yield consistent, clear pattern of findings. Many of these studies limit the investigation to women in dating relationships, in specific years in college study, or to date-rape victims only. Some research has found that labelers have less distress than nonlabelers. In a study of undergraduate college women, Botta and Pingree (1997) found that labelers report emotional problems interfering significantly less with work and social activities and feeling significantly better in terms of a list of happy versus down in the dumps items. Other research has found that labelers report greater psychological distress than nonlabelers (McMullin & White, 2006). Littleton and her colleagues (2006) found that both labelers and nonlabelers reported moderately severe levels of distress, with labelers reporting significantly more post-traumatic stress symptoms but not more symptoms of psychological distress. Kahn and his colleagues (2003) also found that labelers were more likely to have experienced extremely high negative affect after the experience. Still, other research suggests that there are no significant differences in psychological distress between labelers and nonlabelers. In a study of 1,744 college women, acknowledgment status was not a significant predictor of PTSD

symptomatology in a structural equation model (Littleton & Henderson, 2009). Melanie Harned (2004) investigated the differences in psychological functioning of nonlabelers and labelers and concluded that labeling is not a determinant of psychological outcomes. Six psychological outcomes were assessed: anxiety, depression, PTSD, body shape concern, and substance use. Harned concluded that it is the unwanted sexual experience, not the label, which is associated with negative outcomes. Further research is necessary to determine the differences in psychological functioning between labeling groups.

Risky Behavior

Little research has investigated the relationship between labeling, risky behavior and substance use. In a longitudinal study of 754 college women, nonlabelers reported significantly more alcohol use than nonvictims (McMullin & White, 2006). In another longitudinal study, Littleton and colleagues (2009) also found that unacknowledged victims reported more hazardous alcohol use at the first time point than acknowledged victims, but there were no significant differences in alcohol use at the 6-month follow-up period. If nonlabelers do not conceptualize their rape as a victimization experience, they may be less likely to change any behaviors that may place them at risk for victimization.

The majority of studies on labeling and its association with psychological functioning and risky behavior have not considered the impact of time on recovery and labeling. Research suggests that recovery from trauma is dependent on time (Gutner, Rizvi, Monson, & Resick, 2006). Findings reveal that victims of trauma generally experience a period of "natural" recovery in the first three months after the assault, after which longstanding psychological difficulties such as PTSD may become more entrenched. Labeling appears to be related to the passage of time as well. Melanie Harned (2005) found labeling to be a gradual process, with

only 35.2% of labelers labeling their experiences as sexual assault or abuse when it first occurred. Nonlabelers' assault experiences were significantly more likely to have occurred during the past year than labelers' assault experiences (Littleton et al., 1997). Research suggests that it takes time for women to label their unwanted sexual experiences. As victims recover over time, the likelihood of labeling increases. Thus, labeling is implied to be a step in the recovery process and improvement in psychological functioning.

Few studies have investigated the relationship between labeling and coping. Resick and Schnicke (1993) discussed the importance of labeling in relation to coping and integration of rape experiences when stating "Without a way to understand and categorize the experience, the strong emotions associated with sexual assaults are also left unprocessed" (p.11) and further described that "When information is not processed adequately…intrusive symptoms are associated with strong affective responses, which can then lead to escape and avoidance behavior" (pp. 11-13). Sexual assault victims may engage in avoidant coping strategies and maladaptive behavior to reduce distress related to their sexual assault. Cooper, Shapiro, and Powers (1998) found that coping is one form of motivation for sex and risky sexual behavior, reporting that compared to participants with low coping motives, high-coping motive participants had steeper increases in both risky practices and intercourse frequency. Rape victims have been found to engage in moderately frequent use of both avoidance and approach coping strategies in efforts to manage the assault (Littleton et al., 2006); however, only one study examined differences in coping styles based upon labeling. Littleton and colleagues (2006) found that labelers reported more reliance on avoidance strategies than nonlabelers, while the use of approach strategies was similar across groups. Labeling may be important to the coping process if failure to label is related to efforts to avoid thinking about or processing the unwanted sexual

experience. In contrast, victims of rape who have conceptualized their experiences as a victimization experience may turn to avoidance strategies when they have appraised the rape as overwhelming their coping resources (Littleton et al., 2009). More research is necessary to investigate the importance of acknowledgment of rape in the coping process.

Childhood Sexual Abuse

Several studies on sexual assault and rape have also investigated the impact of childhood sexual abuse (CSA) which may effect psychological functioning and risky sexual behavior differently than adult sexual abuse (ASA) alone. CSA has been found to be associated with subsequent revictimization (see Messman-Moore & Long, 2003, for a review). Smith and his colleagues (2004) found that individuals who reported any type of childhood abuse were 5.6 times more likely to report ASA. In a study of college women, Sanders and Moore (1999) found that date-rape victims reported higher levels of childhood maltreatment, including childhood sexual abuse, than nonvictims. Research indicates that various forms of psychological distress including dissociation, depression, and PTSD may act as a mediator of the association between childhood and adult sexual assault (Messman-Moore & Long, 2003; Messman-Moore, Ward, & Brown, 2009; Sanders & Moore, 1999). Victims of revictimization and ASA alone were found to have lifetime PTSD and higher levels of psychological distress (Kaltman, Krupnick, Stockton, Hooper, & Green, 2005). Revictimized women also reported a higher number of lifetime sexual partners than victims of ASA alone (Kaltman et al., 2005). Given that revictimization is associated with increased levels of distress both generally and in terms of psychological functioning, CSA will be assessed in the current study as a covariate in order to determine the impact of ASA on psychological distress and risky behavior.

Purpose of the Current Study

Research on the experience of rape has highlighted the negative impact of rape on psychological functioning on all victims, regardless of how they conceptualize the experience. However, research suggests that the majority of rape victims do not label their experience as rape. Rape experiences consistent with rape script stereotypes, such as those which involve injury and unknown perpetrators, have been associated with labeling in rape victims. How women conceptualize their unwanted sexual experiences may also predict their outcomes in terms of psychological and sexual functioning and risky behavior. Research findings have been inconsistent in determining whether differences exist for psychological distress between women who label their experience as rape and those who may conceptualize their rape experiences as something other than rape. Further, several different pathways of sexual behavior in rape victims have been identified post-assault. Some women engage in higher risky sexual behaviors post-assault, while others may decrease or remain constant in their risky sexual behaviors. The passage of time may also impact how women conceptualize their rape experiences, as well as their psychological and sexual functioning and engagement in risky sexual behavior. Women with more recent assaults may have psychological and sexual functioning patterns that are significantly different than women with older assault experiences. The current study was conducted to establish the predictors as well as explore the differences in outcomes of rape experiences depending on labeling.

Study Aims

There are two primary aims for the present study. First, we sought to replicate previous investigations regarding the deleterious impact of rape and sexual assault on psychological functioning and the association of victimization with risky behavior. Second, we aimed to

extend previous findings in the literature on the association between psychological functioning, risky behavior, time since assault and the labeling of unwanted sexual experiences. In order to examine the link between psychological distress, risky behavior and labeling, several aspects of labeling were studied in greater detail, including: a) outcomes associated with labeling an experience as rape, sexual assault, or nonconsensual; b) measurement of labeling on a continuum rather than a forced-choice dichotomous (yes/no) format, allowing for consideration of "ambivalence" in labeling (not sure); c) examining multiple types of rape including rape by intoxication rather than date or acquaintance rape only; and d) the impact of time since assault on labeling, psychological distress, and risky sexual behavior.

Hypotheses

Victimization & Psychological Functioning & Sexual Behavior. It was hypothesized that all rape victims, regardless of label, would have higher levels of psychological distress than nonvictims. Rape victims were predicted to score higher on measures of anxiety, depression, intrusive experiences, sexual concerns, dysfunctional sexual behavior, anxious arousal, defensive avoidance, dissociation. It was hypothesized that victims of rape, regardless of label, would engage in more frequent risky sexual behavior, alcohol use, and substance use.

Labeling & Psychological Functioning. Furthermore, the current study will investigate whether labeling is associated with psychological functioning. Three possible labels of unwanted sexual experiences, nonconsensual sex, sexual assault, and rape, will be examined. To assess any differences in functioning based upon labeling status, further analyses in the present study used a sub-sample of rape victims only, rather than including nonvictims.

The research linking labeling to psychological functioning and risky behavior is discrepant. A review of studies suggest two general patterns, that labeling is associated with

heightened distress among victims (Kahn, et al., 2003; Littleton, et al., 2006; McMullin & White, 2006) or that labeling is unrelated to psychological distress (Harned, 2004; Littleton & Henderson, 2009). However, it is possible that labeling also may be associated with healthy psychological functioning (Botta & Pingree, 1997) and recovery from the traumatic sequelae of rape (Resick & Schnicke, 1993). Given the mixed literature, we wanted to explore the relationship between labeling and functioning in terms of psychological distress and risky behavior. However, we did predict that labeling would be associated with time since assault, with those reporting more recent assaults being less likely to label.

Method

Participants

The current study focused on a group of 146 women who reported a history of rape, selected from an overall sample of 721 female university students. All participants were enrolled in an introductory psychology course and received course credit for their participation. The average age of the women was 18.76 years (SD = .98), with a range from 17 to 24 years. Most women (67.3%) were freshman in college. The majority (92%) had never been married. Most (91.8%) self-identified as Caucasian with the remaining 8.2% of other race or ethnicity. Of the 600 women who reported on family income, 56.5% reported an annual income of $100,000, whereas 20% reported an income of $200,000, with the remaining 23.5% reported other lower annual incomes.

Of the original sample, 721 women provided enough information so that rape status could be determined. Rape was defined as sexual intercourse due to threats of force, force, or incapacitation due to the victims' alcohol or drugs since the age of 14. Approximately 20% (n=149) of the women were victims of rape, while 79.8% were nonvictims. There were no

significant differences between victims and nonvictims on age, year in school, marital status, race/ethnicity, or family income. There was a marginally significance difference for family income (p = .052) with 31% of rape victims reporting family income of $200,000 or more, whereas only 17% of nonvictims reported a family income of $200,000.

Procedure

Participation consisted of completion of paper-and-pencil survey entitled "College Women's Beliefs about Interpersonal Relationships" in groups of about 5 to 20 women. The survey took approximately 50 to 90 minutes to complete and was presented as a study of women's health concerns. Participants received and signed consent forms prior to participation describing the study's purpose and aims. Participants were informed that their information would remain anonymous and that they were free to discontinue at any time without any penalty. Packets included the Trauma Symptom Inventory (TSI), Modified-Sexual Experiences Survey (MSES), Cognitive Appraisal of Risky Events- Revised (CARE-R), and the Life Experiences Survey (LES), as well as other measures not relevant to the current study. Following completion of the survey, participants received debriefing forms that included contact information for the study's administrators and counseling services. Study procedures were approved by the Miami University Internal Review Board.

Measures

Unwanted Sexual Experiences. Sexual victimization in the form of rape was assessed with the Sexual Experiences Survey (SES), a commonly used self-report measure developed by Mary Koss and colleagues (Koss & Gidycz, 1985; Koss, Gidycz, & Wisiniewski, 1987; Koss & Oros, 1982) designed to identify experiences of multiple forms of sexual victimization since the age of 14. This measure was modified from the original 10-item SES to include 17 items

assessing specific sexual behaviors in greater detail (e.g., oral-genital contact), as well as information about alcohol-facilitated sexual victimization. The wording of questions regarding alcohol-facilitated victimization was patterned after modifications made by Muehlenhard, Powch, Phelps, and Giusti (1992). These changes are consistent with a methodology outlined by Messman-Moore and Long (2000). Additionally, participants were asked to include the number of occurrences of each experience, rather than simply yes or no as provided by the original Koss and Oros (1982) measure. Rape was defined as completed, unwanted oral-genital, vaginal, or anal penetration due to the woman's inability to consent or resist due to her level of intoxication (due to alcohol or drugs) or due to threats or use of physical force. Thus, a woman was coded for rape when she responded yes to a question asking whether she had had engaged in a sex act when she did not want to due to force, threat of force, or inability to give consent due to intoxication (e.g. have you had sexual intercourse when you didn't want to because a man threatened or used some degree of physical force (twisting your arm holding you down, etc.) to make you?).

After the initial items assessing the presence of rape, participants answered additional questions about their perceptions of their most distressing unwanted sexual experience. Additional questions were modeled after those used by Abbey et al. (2004) and examined specific aspects of the most severe unwanted experience, including age at time of assault, time since assault, identity of the perpetrator (e.g., current dating partner, friend or acquaintance, stranger, etc.), use of alcohol or drugs by the perpetrator and by the victim, method(s) of coercion, resistance strategies, level of injury, disclosure, and attributions of responsibility for the assault. To assess labeling, participants answered 6 items asking to what extent they considered their experience to be rape, sexual assault, and consensual on a scale of 1 (definitely

not) to 7 (definitely). The present study considered the items asking about the extent to which the participant considered what happened to be rape, sexual assault, or consensual. The consensual item was reverse-scored from 1-7 in order to create a variable of nonconsent. A categorical labeling variable was created by classifying women who responded 1-3 as nonlabelers, 4 as ambivalent, and 5-7 as labelers for each of the rape, sexual assault, and nonconsensual items.

Child Sexual Abuse. Childhood sexual abuse was assessed with a paper version of the Computer Assisted Maltreatment Inventory (CAMI; DiLillo et al., 2006; Nash, DiLillo, Messman-Moore, & Rinkol, 2002) which is a Web-based, self-report questionnaire designed to assess childhood maltreatment experiences. For purposes of the current study, only the child sexual abuse scale was used. Participants were asked to respond to a series of screener questions which, if answered affirmatively, were followed by a more detailed set of questions assessing CSA. Those who reported experiencing (before the age of 14) sexual touching, sexual kissing, or oral, anal, or vaginal intercourse with a family member, or a person who was five or more years older, were considered victims of CSA. Additionally, persons who reported experiencing any of these activities against their will, regardless of age difference or relationship to the perpetrator, were also classified at CSA victims. Voluntary sexual play with a similar age peer and voluntary sexual activities with a dating partner were not included as sexually abusive behavior.

Psychological Distress. To assess psychological distress, participants completed the Trauma Symptom Inventory (TSI; Briere et al., 1995). The TSI contains 10 clinical scales and three validity scales. The present study examined the clinical scales that are thought to represent common psychological distress responses to unwanted sexual experiences: Anxious Arousal (AA), Depression (DEP), Intrusive Experiences (IE), Defensive Avoidance (DA), Dissociation (DIS), Sexual Concerns (SC), and Dysfunctional Sexual Behavior (DSB). The TSI has

demonstrated reliability and validity in college samples (Briere et al., 1995). In the current sample, internal alpha reliability coefficients ranged from .83 for the anxious avoidance scale to .91 for the depression scale.

Risky Behavior. The Cognitive Appraisal of Risky Events- Revised (CARE-R) was administered to assess participant's frequency of engagement in risky sexual behavior, substance use, and alcohol use. The CARE (Fromme, Katz, & Rivet, 1997) is a 30-item survey that assesses participants' expected risk of, expected benefit of, and expected involvement in risky behaviors. Only actual frequency of engagement was considered in the present study for 3 categories: risky sexual behavior, heavy drinking, and drug use. The CARE-R Frequency of Involvement (CARE-R FOI) scales assess frequency of risky sexual behavior, alcohol use, and substance use. The CARE-R FOI survey contains 13 questions asking about participants' risky sexual behavior with regular partners and someone they just met or don't know well, leaving a social event with someone they didn't know well, illicit drug use, alcohol use, and driving or riding in a car with someone under the influence of alcohol. Participants answered on a 7-point scale of how often they had engaged in the given activity, ranging from 0 to 1, 2-4, 5-9, 10-20, 21-30, and 31 or more times over the past 6 months. For the current study, risky sexual behavior with a regular partner, or a partner they know well, is referred to as risky behavior with a "regular partner." Risky sexual behavior with an acquaintance or someone they just met or don't know well is referred to as risky behavior with "someone just met."

In addition, we assessed the total number of lifetime sexual partners using an unpublished measure. The Life Experiences Survey is a self-report measure which assesses basic demographic information (e.g., age, year in school, etc.), as well as information about consensual sexual behavior (Messman-Moore, 2004). This measure assessed the number of partners for

several types of consensual sexual behavior including giving oral-genital sex, receiving oral-genital sex, and vaginal or anal sexual intercourse. An example item is "Have you ever had sexual intercourse (vaginal or anal) when you wanted to (without force)?" with a dichotomous yes/no response. This question is followed by "With how many different partners?" in a free response format.

Results

Of the original 721 participants, 146 (20.2%) reported an experience consistent with our definition of rape: completed, unwanted oral-genital, vaginal, or anal penetration due to the woman's inability to consent or resist due to her level of intoxication (due to alcohol or drugs) or due to threats or use of physical force. Furthermore, 42 women (6.1%) reported experiences of CSA. We expected these two types of abuse to be associated based upon extensive literature on revictimization. Results of Chi-Square analyses did indicate a significant association between childhood sexual abuse (CSA) and rape since the age of 14, $\chi^2(1, N = 695) = 4.32$, $p < .05$. Of the victims of rape, 10% reported CSA, whereas 5.2% of nonvictims reported CSA.

Comparisons Based on Victimization History

Psychological Functioning

The first set of analyses aimed to replicate the previous literature on the deleterious impact of rape. A series of one-way ANOVA's were computed with rape (present/absent) and CSA (present/absent) as independent variables. The interaction of rape and CSA was also examined. See Table 1 for means and standard deviations. In terms of psychological functioning 6 dependent variables were examined: depression, anger, anxiety, dissociation, intrusive experiences, and defensive avoidance. A Bonferroni correction test was conducted for the 6

psychological distress variables, such that the alpha-level was adjusted to .01 for the TSI subscales.

There was a main effect for rape victim status on anxious arousal, $F(1, 673) = 22.44$, $p < .001$, partial eta-squared = .03; depression, $F(1, 669) = 6.91$, $p < .01$, partial eta-squared = .01; anger/irritability, $F(1, 671) = 8.16$, $p < .01$, partial eta-squared = .01; intrusive experiences, $F(1, 669) = 31.08$, $p < .001$, partial eta-squared = .05; defensive avoidance, $F(1, 664) = 26.58$, $p < .001$, partial eta-squared = .04; and dissociation, $F(1, 670) = 10.97$, $p = .001$, partial eta-squared = .02. Individuals who had experienced rape since the age of 14 had higher scores of anxious arousal, depression, anger/irritability, intrusive experiences, defensive avoidance, and dissociation, compared to those without a history of rape since the age of 14.

There was also a significant main effect for CSA victim status for the six TSI subscales of psychological distress, although the interaction of rape and CSA was not significant. There was a main effect for CSA victim status on anxious arousal, $F(1, 673) = 8.12$, $p < .01$, partial eta-squared = .01; depression, $F(1, 669) = 11.48$, $p = .001$, partial eta-squared = .02; anger/irritability, $F(1, 671) = 16.39$, $p < .001$, partial eta-squared = .02; intrusive experiences, $F(1, 669) = 24.50$, $p < .001$, partial eta-squared = .04; defensive avoidance, $F(1, 664) = 14.77$, $p < .001$, partial eta-squared = .02; and dissociation, $F(1, 670) = 17.96$, $p < .001$, partial eta-squared = .03. Individuals who had a history of CSA had higher scores of anxious arousal, depression, anger/irritability, intrusive experiences, defensive avoidance, and dissociation, compared to those without a history of CSA.

Sexual Behavior

In terms of sexual behavior 11 dependent variables were examined: sexual concerns, dysfunctional sexual behavior, sex, sex without protection against pregnancy sex without

protection against STDs, sex under the influence of alcohol, sex under the influence of drugs, and sex without a condom. Each of these sexual intercourse behaviors was examined for two different types of partners: regular and someone just met. A Bonferroni correction test was conducted for the 11 sexual behavior variables such that the alpha-level was adjusted to .005 for the analyses.

There was a main effect for rape victim status on dysfunctional sexual behavior, $F(1, 668) = 66.47$, $p < .001$, partial eta-squared = .09; and sexual concerns, $F(1, 668) = 30.52$, $p < .001$, partial eta-squared = .04; having sex with someone just met, $F(1, 653) = 78.80$, $p < .001$, partial eta-squared = .12; having sex without protection against pregnancy with someone just met, $F(1, 653) = 33.51$, $p < .001$, partial eta-squared = .05; having sex without protection against pregnancy with a regular partner, $F(1, 661) = 9.32$, $p < .01$, partial eta-squared = .014; having sex without protection against STDs with someone just met, $F(1, 656) = 42.02$, $p < .001$, .06; having sex while under the influence of alcohol with someone just met, $F(1, 658)$, $p < .001$, partial eta-squared = .08; having sex while under the influence of alcohol with a regular partner, $F(1, 661) = 42.42$, $p < .001$, partial eta-squared = .06; having sex while under the influence of drugs with someone just met, $F(1, 657) = 36.49$, $p < .001$, partial eta-squared = .05; having sex without a condom with someone just met, $F(1, 657) = 36.91$, $p < .001$, partial eta-squared = .05; having sex without a condom with a regular partner, $F(1, 660) = 33.85$, $p < .001$, partial eta-squared = .05. There was a main effect for CSA victim status on dysfunctional sexual behavior, $F(1, 668) = 14.77$, $p < .001$, partial eta-squared = .02; sexual concerns, $F(1, 668) = 30.49$, $p < .001$, partial eta-squared = .04; having sex without protection against pregnancy with a regular partner, $F(1, 661)$, 28.43, $p < .001$, partial eta-squared = .04; having sex without a condom with a regular partner, $F(1, 660) = 18.07$, $p < .001$, partial eta-squared = .03. In all cases, individuals

who had a history of CSA reported higher rates of problem sexual behavior compared to those without a history of CSA.

There was a significant interaction of rape victim status and CSA victim status for having sex while under the influence of drugs with someone just met, $F(1, 657) = 9.36$, $p < .01$, partial eta-squared = .01. The effect of rape on sex while under the influence of drugs with someone just met varies as a factor of CSA. Women who were victims of both adult rape and CSA had the highest rates of having sex while under the influence of drugs with someone just met. See Figure 1 for a graphical representation.

Substance Use

Regarding risky substance use, 8 dependent variables were examined: leaving a social event with someone just met, marijuana use, drinking more than 5 drinks on one occasion, mixing drugs and alcohol, riding in a car with someone who has consumed alcohol, driving after one to two drinks, driving after three to four drinks, and driving after five or more drinks. A Bonferroni correction test was conducted for the 8 risky substance use variables such that the alpha-level was adjusted to .01 for the analyses.

There was a main effect for rape victim status on leaving a social event with someone just met, $F(1, 662) = 33.72$, $p < .001$, partial eta-squared = .05; marijuana use, $F(1, 657) = 17.88$, $p < .001$, partial eta-squared = .03; drinking more than 5 drinks on one occasion, $F(1, 668) = 45.14$, $p < .001$, partial eta-squared = .05; mixing drugs and alcohol, $F(1, 669) = 27.74$, $p < .001$, partial eta-squared = .04; riding in a car with someone who has consumed alcohol, $F(1, 669) = 26.87$, $p < .001$, partial eta-squared = .04; driving after one to two drinks, $F(1, 655) = 38.20$, $p < .001$, partial eta-squared = .06; driving after three to four drinks, $F(1, 650) = 27.83$, $p < .001$, partial eta-squared = .04; and driving after five or more drinks, $F(1, 649) = 12.81$, $p < .001$, partial eta-

squared = .02, although the main effect of CSA victim status and interaction of rape and CSA were insignificant. Individuals who had experienced rape since the age of 14 reported higher rates of all forms of risky behavior compared to those without a history of rape since the age of 14. The interaction of rape victim status and CSA victim status for leaving a social event with someone just met, was not significant after Bonferroni correction ($p < .01$), $F(1, 662) = 4.68$, $p < .05$, partial eta-squared = .007.

Summary. Compared to nonvictims, rape victims and CSA victims reported significantly higher levels of psychological distress, risky sexual behaviors and substance use. All differences remained significant after Bonferroni correction ($p < .01$). However, there was only one significant interaction of rape and CSA on these domains. This suggests that the impact of rape on these outcomes is not different for those women who have or have not experienced CSA (i.e., were revictimized).

Understanding Differences among Victimized Women

Labeling Frequencies

Labeling was assessed using a 7-point Likert scale of (ranging from "not at all" to "definitely") to assess the extent to which the participant considered the experience as rape, as sexual assault, and as nonconsensual sex (e.g. "to what extent did you consider the experience to be rape?"). Rape label was analyzed as a continuous variable and also as a categorical variable. The categorical labeling variable was created by classifying women who responded 1-3 as *nonlabelers*, 4 as *ambivalent*, and 5-7 as *labelers* for each of the rape, sexual assault, and nonconsensual questions. Using these categories, 25 (18.1%) of the women were labelers, 17 (12.3%) were ambivalent, and 96 (69.6%) were nonlabelers. See Table 2 for the frequencies and percentages of continuous rape, sexual assault, and nonconsensual label variables (1 through 7).

Predictors of Labeling

Bivariate correlations were computed to determine the relationship between assault-related variables and labeling for each type (i.e., rape, sexual assault, and nonconsensual). Thirteen variables were examined in three clusters: a) characteristics of the assault, b) disclosure and social reactions, and c) attribution and blame. Characteristics of the assault variables included: use of physical coercion, assault by non-intimate partner, victim physically resisted rape, physical injury or pain from rape, intoxication level of perpetrator, intoxication level of victim, and time since assault. Disclosure and social reactions variables included: victim disclosed rape to some else, negative reaction from others after victim disclosed, and others blamed the victim. Attribution and blame variables included: perpetrator blame by the victim, victim self-blame, and victim attributing the unwanted activity to "a failure to communicate." Table 3 presents correlations of assault-related variables and labeling. Extent of labeling rape was higher if the respondent reported assault by a non-intimate partner, presence of physical coercion, physical injury or pain, greater time since assault, negative reaction from others after victim disclosure, increased victim blame by others, and greater victim blame of the perpetrator. Extent of rape labeling was lower if the respondent reported attributing the unwanted experience to a failure to communicate. For sexual assault label, as use of physical coercion, physical injury or pain from rape, time since assault, victim disclosed the rape to someone else, negative reactions from others, others blamed the victim, and victim blamed to perpetrator increased, extent of labeling increased as well. Also for sexual assault label, as intoxication level of the perpetrator and failure to communicate increased, extent of labeling decreased. For nonconsensual label, as time since assault, victim disclosed rape to someone else, negative reactions from others after victim disclosed, and victim blamed the perpetrator increased, extent

of labeling increased as well. As failure to communicate increased, extent of labeling nonconsensual decreased.

Labeling & Current Functioning

The main purpose of the study was to examine the impact of labeling rape experiences on current psychological functioning, sexual behavior, and substance use. For the majority of analyses, labeling was analyzed as a continuous variable referred to as *labeling extent* for each labeling type: rape, sexual assault, and consensual.

Psychological and sexual functioning. A series of bivariate correlations were computed examining labeling extent (for rape, sexual assault, and consensual label) and psychological and sexual functioning. In terms of psychological functioning 8 dependent variables were examined: depression, anger, anxiety, dissociation, intrusive experiences, defensive avoidance, tension-reducing behavior, and impaired self-reference. In terms of sexual functioning 2 variables were examined: sexual concerns and dysfunctional sexual behavior. Table 4 presents the correlations of label and functioning variables. Several correlations were significant between rape label and psychological and sexual functioning variables. For depression, anger, intrusive experiences, defensive avoidance, and dysfunctional sexual behavior, as the extent of labeling rape increased, the degree of the psychological or sexual problems increased as well. All correlations were non-significant between sexual assault label and psychological and sexual functioning variables as well as between consensual label and psychological and sexual functioning variables.

Sexual Behavior. Bivariate correlations were also computed between labeling extent and frequency of sexual behavior within the past 6 months. Thirteen dependent variables were examined: leaving a social event with someone just met and the following variables were examined each for a regular partner and someone just met: sex, sex without protection against

pregnancy, sex without protection against STDs, sex under the influence of alcohol, sex under the influence of drugs, and sex without a condom. Each of these sexual behaviors was examined for two different types of partners: regular and someone just met. Table 5 presents correlations for labeling extent and sexual behavior variables. Several correlations were significant between rape label and sexual behavior variables. For sex with someone just met, sex under the influence of alcohol with someone just met, and sex under the influence of drug with someone just met, as the extent of labeling increased, the frequency of these sexual behaviors increased as well, All correlations were non-significant between sexual assault label and sexual behavior variables as well as between consensual label and sexual behavior variables.

In terms of *lifetime sexual behavior* 4 variables were examined: number of partners kissed, number of partners from who received oral sex, number of partners given oral sex, and number of sexual intercourse partners. Table 6 presents correlations for labeling extent and lifetime sexual behavior variables. For all lifetime sexual behaviors, as the number of partners increased, the extent of rape label increased.

Substance Use. Bivariate correlations were also computed on the relationship between labeling extent for rape, sexual assault, and consensual and substance use. In terms of substance use 3 variables were examined: marijuana use in the past six months, drinking more than 5 drinks on one occasion, and mixing drugs and alcohol in the past 6 months. All correlations were non-significant for labeling extent for rape and consensual,. The correlation of labeling extent for sexual assault and drinking more than five drinks on one occasion was significant $r(136) = -.178$, $p < .05$. A greater extent of labeling the experience as sexual assault as associated with a lesser frequency of drinking more than 5 drinks on one occasion.

Time Since Assault

Time since assault was assessed by asking the participants how long ago the unwanted sexual experience occurred. This variable was dichotomized into two levels: less than 6 months ago and greater than 6 months ago. Of the rape victims, 45 (30.8%) reported a rape experience that occurred within the past 6 months and 92 (63%) reported a rape experience that occurred more than 6 months ago. For all analyses, time since assault was analyzed as a dichotomous variable. A series of bivariate correlations were computed to examine the relationship between time since assault and study variables: psychological functioning, sexual functioning, and sexual behavior.

Psychological and sexual functioning. A bivariate correlation was computed to examine the relationship between time since assault and psychological functioning. In terms of psychological functioning 8 dependent variables were examined: depression, anger, anxiety, dissociation, intrusive experiences, and defensive avoidance. In terms of sexual functioning, two variables were examined: sexual concerns and dysfunctional sexual behavior. All bivariate correlations were non-significant for time since assault and psychological functioning. The correlation of time since assault and dysfunctional sexual behavior was significant $r(136) = .234$, $p < .01$. This positive correlation indicates that those whose assaults occurred more than 6 months ago endorsed a higher degree of dysfunctional sexual behavior.

Sexual behavior. Bivariate correlations were computed to examine the relationship between time since assault and sexual behavior in the past 6 months. In terms of frequency of sexual behavior in the past 6 months, 13 dependent variables were examined including frequency of sexual behavior with a regular partner and someone just met. Table 5 presents correlations for time since assault and sexual behavior variables. Significant correlations were found between

time since assault and most risky sexual behaviors with a partner just met. Women with assaults that occurred less than six months ago reported higher frequencies of sexual intercourse with someone just met, sex without protection against pregnancy with someone just met, sex without protection against STD's with someone just met, sex under the influence of alcohol with someone just met, sex without a condom with someone just met, and leaving a social event with someone just met. In terms of lifetime sexual behavior, 4 variables were examined: number of lifetime partners kissed, number of lifetime partners from whom received oral sex, number of lifetime partners given oral sex, and number of lifetime sexual intercourse partners. All correlations between time since assault and lifetime sexual behaviors were non-significant.

Time by Label

A one-way ANOVA was computed with time since assault (less than 6 months ago/greater than 6 months ago) as independent variable and label as the dependent (continuous) variable. Time since assault predicted extent of rape label, $F(1, 134) = 3.95$, $p < .05$, sexual assault label, $F(1, 134) = 10.475$, $p < .01$, and nonconsensual sex label, $F(1, 132) = 10.546$, $p < .01$. Women with assaults that occurred more than 6 months ago had higher scores for labeling extent of rape, sexual assault, and nonconsensual sex.

Psychological Functioning & Behavior Predicting Rape Label

A step-wise regression analysis was computed with labeling extent as the dependent variable. Predictors included all variables significantly correlated with labeling at the bivariate level. Thus, the predictor variables included: sex with someone just met, sex under the influence of alcohol with someone just met, sex under the influence of drugs with someone just met, depression, anger, intrusive experiences, dysfunctional sexual behavior, and time since assault. In the final step, two predictors, time since assault and sex with someone just met, significantly

predicted rape label, adjusted $R^2 = .145$; $F(2, 125) = 11.641$, $p < .001$. Table 7 presents the regression model outcomes, including correlations.

Summary: Differences among Victimized Women

Examination of labeling frequencies suggests that most women do not acknowledge their experience as rape or sexual assault; however, the unwanted experiences are not labeled as consensual either. In terms of labeling predictors, for all labeling types extent of labeling was associated with older assaults, higher disclosure of rape to someone else, higher blaming of the perpetrator by the victim, and less attribution of unwanted activity due to failure to communicate.

Overall, a pattern of relationships between labeling and selected outcomes existed mostly in the case of rape label, and not in the case of sexual assault or nonconsensual label. In most cases, rape labeling was associated with high levels of psychological distress, more risky lifetime sexual behavior, and higher frequencies of risky behavior in the past 6 months with a partner just met. In addition, time since assault was examined in relation to all outcomes. In general, those who had a more recent assault (within the past 6 months) engaged in higher rates of risky sexual behavior with a partner just met. However, time since assault was not related to levels of psychological distress. In addition, the impact of time since assault on labeling was examined. When labeling was examined on a continuum, women who had been assaulted more than 6 months prior to the study endorsed greater levels of all labels: rape, sexual assault, and nonconsensual.

Discussion

This study examined how university women's labeling of their rape experience affects their psychological distress, sexual behavior, and substance use. Consistent with previous studies, approximately 20% of the women experienced forcible or substance-facilitated rape

since the age of 14 (Fisher et al., 2003; Kahn et al., 2003; Peterson & Muehlenhard, 2004). As expected, all rape victims, regardless of label, reported higher levels of psychological distress, more frequent risky sexual behavior with both partners just met and regular partners, and more frequent risky substance use than nonvictims. Rape victims reported higher levels of a variety of distress symptoms, including anxiety, depression, angry irritable affect, posttraumatic numbing and behavioral/cognitive avoidance, intrusive experiences (e.g. flashbacks, nightmares), and dissociation (e.g. depersonalization, psychic numbing). These results are consistent with previous literature indicating the negative impact of adult sexual victimization on mental health outcomes of women (Brener, et al., 1999; McMullin & White, 2002).

Labeling Rates and Predictors

Of the 20% of women who reported an experience that met the researchers' definition of rape, far fewer labeled the experience as such. When assessed on a continuum, 17% of participants labeled their experience as "rape," 33% labeled their experience as "sexual assault," and 9% labeled their experience as "consensual." Utilizing a continuous Likert scale to assess labeling afforded the opportunity for respondents to consider the "shades of grey" as they ponder a label for the unwanted experience. Despite this affordance, women in the current study did not endorse the rape label very frequently. However, labeling frequencies are similar to previous studies. Bondurant (2001) found that 36% of rape victims acknowledged that they had been raped. Littleton and her colleagues (2006) assessed whether or not 356 rape victims acknowledged their rape experience as victimization; of the 40% of women that acknowledged that they were victimized, 60% labeled the victimization as rape. One factor that may have contributed to the low levels of rape and sexual assault labeling in the current study were victimization characteristics. In the current study, the majority of women indicated that the

unwanted experience occurred due to her level of intoxication and inability to consent. Because this form of assault is not part of the stereotypic rape script, endorsement of rape label may have been lower.

Women were much more likely to describe their experience as nonconsensual rather than sexual assault and rape. This finding suggests that the participants were not confused regarding whether or not they construed the experience to be consensual; rather, they apparently had greater difficulty labeling such an experience as rape or sexual assault. Clearly women seem to be more comfortable conceptualizing their experience as nonconsensual sex. In essence, these women did not seem to misunderstand the questions assessing rape or sexual assault, but were quite unlikely to embrace the label of rape. It may be that the stigma and victim role that is associated with the term rape is different than sexual assault or nonconsensual sex and it may be more difficult to take the step in identifying a nonconsensual experience as sexual assault or rape. Peterson and Muehlenhard (2007) discussed a new model of wantedness, consenting to sex and their implications for definitions of rape. They concluded that in both the dominant models and the new proposed model, sexual experiences that are both unwanted and nonconsensual constitute rape. However, in the current study *all* rape victims reported their experiences to be *unwanted* sexual experiences. Interestingly, the majority (59.5%) of rape victims labeled their rape experiences as nonconsensual even though only 17% labeled it rape. These results suggest that there are significantly different meanings or connotations associated with different labels resulting from the same experience.

Our findings are also consistent with previous studies on the predictors of labeling (Bondurant, 2001; Botta & Pingree, 2002; Kahn et al., 2003; McMullin & White, 2006). Women who reported less recent assaults (6 or more months ago), physical pain or injury

following assault, unknown or "acquaintance" perpetrator (as opposed to an intimate partner), perpetrator alcohol use, more negative social reactions upon disclosure, less self-blame and higher perpetrator blame were more likely to label their unwanted sexual experience as rape. Of importance to note is that across labeling types (i.e., rape, sexual assault or nonconsensual), the strongest predictor of label endorsement was blaming the man. Similarly, Fisher, Daigle, Cullen, and Turner (2003) found that physical force, threat of force, victim's verbal resistance, and passage of time were all predictors of acknowledging rape. The characteristics of rape that predict labeling are consistent with Peterson and Muehlenhard's definition of stereotypical rape scripts including stranger perpetrator, force or threat of force, and injury.

Interestingly, women were more likely to label their experience as rape if they received more negative reactions to their initial disclosure (i.e., the *first* person they told) and were deemed more responsible for the incident. This highlights the importance of reactions to disclosure. If a woman feels self-blame following a rape experience, she is likely to remain silent (Pitts & Schwarz, 1997). However, women may not feel blame until they disclose the incident. More negative reactions and blaming the victim following rape disclosure may occur because of the stigma associated with rape in our culture. A victim may be blamed by others especially if she was drinking at the time of assault, and such blame may also serve to preserve a sense of safety and a just world. If the blame is shifted from perpetrator to victim, the survivor's right to be angry about what happened to her may be taken away. Awareness and educational programs should educate people on how to react to friends who have survived an unwanted sexual experience. Women who have supportive friends and family may be more likely to label, as well as be in a better situation to seek counseling or legal action.

Labeling and Functioning

The current study assessed the relationship between labeling and psychological and sexual functioning for three different types of label: rape, sexual assault, and nonconsensual sex. In general, for the rape label, as labeling increased psychological distress increased as well. Labeling the experience as rape was associated with higher levels of depression, anger, intrusive experiences, numbing and avoidance, and dysfunctional sexual behavior (i.e., indiscriminate or risky sexual behavior). In the current study, labeling an unwanted sexual experience as rape was associated with more PTSD-like symptomatology. These results are consistent with McMullin and White's (2006) findings that labelers had poorer psychological functioning than nonlabelers. The link between increased psychological distress and likelihood of labeling rape may be explained in several ways. High levels of distress may signal to a woman who was raped that the experience was "wrong" in some way or that it is more than "bad sex," therefore increasing the likelihood that she will label the unwanted experience as rape. However, it is also possible that a woman may label first, and because the label itself is stigmatized there is subsequently more distress. Other factors may also play a role in this relationship. For instance, assault characteristics that are associated with increased psychological distress may also influence likelihood of labeling (i.e., in the case of more violent rapes which involve more injury and victim resistance). Also, assaults that are more schematically similar to the stereotypical rape script as described by Peterson and Muehlenhard (2004) may also result in higher levels of psychological distress as well as labeling. Finally, in the current study, women who received negative reactions upon disclosure and who were blamed when they disclosed were more likely to label the experience rape. Research by Sarah Ullman (Ullman, Townsend, Filipas, &

Starzynski, 2007) suggests that poor social support and negative reactions to disclosure are significant predictors of distress in rape victims.

Resick and Schnicke (1993) described two possible pathways for survivors of interpersonal violence to manage the discrepancies between their traumatic experience and their belief systems prior to the experience. Survivors may minimize the experience and assimilate it with their prior belief system and not label experience as rape, or they may accommodate the experience and alter their prior belief system in line with their traumatic experience and label the experience as rape. Resick and Schnicke also posited that there might be a subgroup of individuals who overaccommodate, engaging in overgeneralized and far-reaching negative schematic beliefs about themselves and the world. They further suggested that overaccommodation may be related to less adequate social support. In fact, Littleton (2007) found that among rape victims, overaccommodators reported significantly more distress than accommodators and assimilators. In essence, although acknowledgement of rape is associated with recovery in the clinical literature, labeling an event as rape may not be healthy if it is associated with an extreme shift in beliefs about the self and world.

Labeling and Risky Sexual Behavior

One focus of the current study was on the relationship between labeling and sexual behavior. In the current study, labeling the experience as rape was associated with having more lifetime sexual partners, including a higher number of partners kissed, partners received oral sex, partners given oral sex, and sexual intercourse partners. It may be that women who are more sexually experienced are better able to recognize abnormal sexual experiences that deviate from the sexual script such as sexual assault and rape, and subsequently are more likely to label their experience as rape.

The link between labeling and frequency of risky sexual behavior was also examined. The current study examined the relationship between labeling and risky sexual behavior in the past 6 months for all three label types (i.e., rape, sexual assault, and nonconsensual). For the rape label, as labeling increased, frequency of engagement in several risky sexual behaviors also increased. Labeling the experience as rape was associated with more frequent engagement in sex with someone just met, sex under the influence of alcohol with someone just met, and sex under the influence of drugs with someone just met. Campbell, Sefl, and Ahrens (2004) found that there are three patterns of sexual health risk behaviors post-assault: high risk, moderate risk, and low risk. These researchers found that women in the high risk group reported substantial increases from pre- to post-rape in their frequency of sexual activity, number of sexual partners, infrequency of condom use, and frequency of alcohol and/or drug use during sex. In the current study, these patterns of behavior are similar to those women who were more likely to label. This risky sexual behavior may be accounted for by poor risk perception in women who have labeled their recent assaults as rape. This could be an outcome of the higher psychological distress experienced by those victims who are more likely to label. Future studies may benefit from a longitudinal analysis in the change of frequency and expectations of risky sexual behavior between different labeling groups from pre- to post-rape. Further, research suggests that poor support after rape may be related to self-blame and avoidance coping thus resulting in risky behavior (Ullman et al. 2007). In the current study, as women who are more likely to label conceptualize their experience as rape, they may be using sex as a maladaptive coping strategy. Future studies may benefit from further assessing the relationships between disclosure, labeling, coping, and risky behavior.

Most research has focused on issues pertaining to labeling an experience as "rape." In the current study, the impact of other labels, such as sexual assault and nonconsensual, were also examined. Interestingly, labeling the experience as sexual assault or nonconsensual was not associated with psychological distress or with risky sexual behavior. These results further indicate that the rape label may be associated with a greater stigma and suggest that it might be less distressing to label a rape experience as nonconsensual or as sexual assault. These results highlight the importance of asking multiple questions about unwanted or nonconsensual sexual experiences including behavioral questions to determine victimization history.

Time Since Assault

Time since assault was investigated in the present study as a dichotomous variable: less than 6 months ago and greater than 6 months ago. Operationalized in this manner, time since assault was not related to psychological distress. These non-significant results may be a result of the dichotomous format. Due to the sample size and study design, it was not feasible to analyze differences in time since assault at more than two different time points. Based on the distribution of responses, we chose to dichotomize this variable as greater than or less than 6 months post-assault. However, other groupings may be more informative clinically. For instance, the PTSD recovery literature indicates that victims' symptoms drop significantly at three months (Resick & Schnicke, 1993). Future studies may assess the aspect of time since assault at different time points, including three months since assault.

The relationship between time since assault and sexual functioning and risky sexual behavior in the past six months was also examined. Victimized women with assaults that occurred less than six months ago engaged in more frequently in risky sexual behaviors. Time since assault was negatively related to dysfunctional sexual behavior, sex with someone just met,

sex without protection against pregnancy with someone just met, sex without protection against STD's with someone just met, sex under the influence of alcohol with someone just met, sex without a condom with someone just met, and leaving a social event with someone just met. It may be that initially after the assault women are in the midst of processing their experiences and engage in more risky sexual behavior as a maladaptive coping strategy. Deliramich and Gray (2008) found that the majority of sexual assault survivors in their sample of 57 women increased in sexual activity post-assault. As time goes on, women may be able to process their experiences and engage in healthier coping strategies. In support of this interpretation, time since assault was not associated with lifetime sexual behaviors (e.g. number of sexual intercourse partners).

The relationship between time since assault and labeling was also examined in the current study. When labeling was analyzed continuously, women who had been assaulted more than 6 months prior to the study endorsed greater levels of all labels: rape, sexual assault, and nonconsensual. These results suggest that it takes time to process a rape experience and to be able to label the experience as rape and are consistent with previous findings where victims with less recent assaults were more likely to acknowledge them as rape (Littleton et al., 2006). Indeed, Melanie Harned's (2005) findings suggested that labeling generally appears to be a gradual process with only 35.2% of labelers conceptualizing their assaults as rape at the time that they occurred. When labeling was examined as a categorical variable, there were no differences between label groups based on time since assault. However, given that analyses of the continuous labeling variable were significant, future studies may benefit from examining labeling from a more dimensional perspective, either as a continuous variable, or by examining multiple categories including an option for "unsure," in order to assess the impact of time since assault on labeling. It may be that disclosure and reactions to disclosure after the first six months

post-assault impacts how a victim perceives the experience. Future studies should continue to examine the relationship between disclosure and labeling, ideally with prospective designs that allow researchers to examine change over time. How a victim labels an experience might frame her disclosure; women who have labeled their experience as rape may describe their experiences differently during disclosure than women who have not labeled their experience as rape. Further, women who might be unsure of how to label their experience may depend on another's reactions to disclosure.

Overall, when considered separately, the pattern of findings pertaining to labeling and outcomes as well as time since assault and outcomes is fairly clear. Labeling was associated with increased levels of psychological distress and risky behavior. However, when also considering time since assault the relationships appear much more complex. For instance, frequency of risky sexual behavior was associated with labeling and a more recent assault; however, labeling was associated with less recent assault. This seemingly contradictory pattern may suggest the presence of moderation, in which the relationship between labeling and risky sexual behavior differs as a function of time. Valentiner, Foa, Riggs, and Gershuny (1996) found that most victims of sexual assault recover to varying degrees within the first three months following their assault. Perhaps analyzing the time since assault variable at three-month intervals would reveal different results given that PTSD symptoms typically decrease considerably without intervention in this time frame (Resick & Schnicke, 1993). Unfortunately, the current sample was not large enough to statistically examine interactions or to consider time since assault at a 3-month interval. Future studies should analyze the impact of the passage of time in a prospective design to better understand the differences in patterns of psychological and sexual outcomes between women who label their experiences differently.

Future Studies/Limitations

The present study utilized a college sample from a Midwestern public university that was homogenous in terms of participant age, race, socioeconomic status, and education. Additional studies are needed to examine similar questions among more diverse populations. Future research in a community sample may be desirable, particularly to increase the range of sexual experiences, as well as psychological distress levels. More heterogeneous or clinical samples may reveal greater differences among victims in PTSD and other symptoms and future studies should investigate specific PTSD symptoms or include measures of a wider range of symptomatology. Also, in the current study participants were asked to self-report retrospectively on their experiences. The study is further limited by an overreliance on self-report measures. Significant relationships found may have occurred in part due to common method shared variance. To address this, future studies may include information from multiple sources, such as diagnostic interviews, or use other methodologies to increase likelihood of accurate recall (i.e., prospective, self-report diary methods).

There was also a possible confounding variable of time. Participants were asked to report on psychological and sexual functioning and behavior within the past six months. Given that the dichotomous variable of time since assault was also divided at six months, it is possible that the risky behavior reported here actually preceded or facilitated the rape experience. Women who engage in more sexual behavior may put themselves at higher risk for encountering an unwanted sexual experience. Future studies should attempt to measure time since assault at different intervals given previous research on the process of natural recovery from trauma (Valentiner et al., 1996). A longitudinal/prospective study with finer gradations in time may indicate the most crucial turning points in functioning as well as clarify the causal direction of the relationship

between rape and risky sexual behavior. Thus, it is important to consider the current correlational results with caution. Directions of these relationships cannot be determined with a cross-sectional, retrospective design.

Future Research and Conclusions

Findings from the present study suggest that future research should carefully consider the terminology used in investigating women's sexual experiences. As many women have difficulty labeling their unwanted sexual experiences, researchers should avoid questions such as "Have you been raped?" and include less definitive labels of unwanted sexual experiences, including a behavior-specific assessment such as the Sexual Experiences Survey (Koss & Gidycz, 1985). Furthermore, future studies should not limit labeling unwanted sexual experiences as rape; the results here suggest that including other labels for the experience, such as sexual assault and non-consensual, as well as utilizing a continuum may be useful. Further, the current study asked women whether they had engaged in certain experiences "when they didn't *want* to." Given that the participants were asked behavioral questions in terms of wantedness (e.g. "Have you ever experienced sexual intercourse when you didn't want to due to force?"), these findings may be explained by the conflicting aspects of wanting and consent. Peterson and Muehlenhard (2007) found that it is possible to consent to unwanted sex and to not consent to wanted sex. Thus, given that unwantedness does not necessarily imply nonconsent and vice versa, the current study may not have identified victimizations that occurred when women may have wanted to engage in sexual behavior but still did not give consent. Future research should examine these issues in more detail. However, Peterson and Muehlenhard did find that labelers reported less wantedness and had felt the activity was less consensual.

Although limitations do exist within the current study, these exploratory results emphasize the complexity of understanding and labeling rape experiences and their impact on psychological and sexual health. The current study highlighted the negative impact of rape on psychological functioning and risky behavior for all victims. Furthermore, labeling was associated with poorer psychological outcomes and more risky sexual behavior. Researchers and clinicians should consider and be sensitive to the ambiguous and complex conceptualizations that women may hold of their rape experiences. Given the impact of time on risky sexual behavior, immediate intervention following sexual behavior may help victims of rape process their experience and encourage healthier coping strategies to reduce risky sexual behavior. Continued research in the areas of labeling, the passage of time, and risky behavior will aid in understanding the complex impact of rape and the development of effective interventions.

References

Abbey, A., Zawacki, T., Buck, P. O., Clinton, A. M., & McAuslan, P. (2004). Sexual assault and alcohol consumption: What do we know about their relationship and what types of research are still needed? *Aggression and Violent Behavior, 9 (3),* 271 – 303.

Bondurant, B. (2001). University women's acknowledgement of rape. Individual, situational, and social factors. *Violence against Women*, 7(3), 294-314.

Botta, R. A., & Pingree, E. (1997). Interpersonal communication and rape: Women acknowledge their assaults. *Journal of Health Communication*. Vol. 2, 197-212.

Brener N. D., McMahon, P. M., Warren, C. W., & Douglas, K. A. (1999). Forced sexual intercourse and associated health-risk behaviors among female college students in the United States. *Journal of Consulting and Clinical Psychology*, 67. No 2, 252-259.

Briere, J., Elliott, D. M., Harris, K., & Cotman A. (1995) Trauma Symptom Inventory: Psychometrics and association with childhood and adult victimization in clinical samples. *Journal of Interpersonal Violence*. Vol. 10 No. 4, Dec 1995, 387-401.

Campbell, R., Sefl, T., & Ahrens, C. E. (2004). The impact of rape on women's sexual health risk behaviors. *Health Psychology*. Vol. 23, No. 1, 67-74.

Cooper, M. L., Shapiro, C. M., Powers, A. M. (1998). Motivations for sex and risky sexual behavior among adolescents and young adults: A functional perspective. *Journal of Personality and Social Psychology, 75* No 6, 1528-1558.

Deliramich, A. N., & Gray, M. J. (2008). Changes in women's sexual behavior following sexual assault. *Behavior Modification*. Vol. 32(5), 611-621.

Davis J. L., Combs-Lane, A. M., Jackson, T. L. (2002). Risky behaviors associated with interpersonal victimization comparison based on type, number, and characteristics of assault incidents. *Journal of Interpersonal Violence*, 17 No 6, June 611-629.

DiLillo, D., Fortier, M. A., Hayes, S. A., Trask, E., Perry, A. R., Messman-Moore, T. L., Fauchier, A., & Nash, C. (2006). Retrospective assessment of childhood sexual and physical abuse: A comparison of scaled and behaviorally specific approaches. *Assessment, 13,* 297-312.

Fisher, B. S., Daigle, L. E., Cullen, F. T., Turner, M. G. (2003). Acknowledging sexual victimization as rape: Results from a national-level study. *Justice Quarterly*, 20, 3, Sept., 535-571.

Gilbert, N. (1997). Advocacy research and social policy. *Crime and Justice: Crime and Justice-A Review of Research*. Vol. 22,101-148.

Green, B. L., Krupnick, J. L., Stockton, P., Goodman, L., Corcoran, C., & Petty, R. (2005). Effects of adolescent trauma exposure on risky behavior in college women. *Psychiatry: Interpersonal and Biological Processes.* Vol. 68(4)2005 p.363-378

Gutner, C. A., Rizvi, S. L., Monson, C. M., & Resick, P. A. (2006). Changes in coping strategies, relationship to the perpetrator, and posttraumatic distress in female crime victims. *Journal of Traumatic Stress*. Vol. 19(6), 813-823.

Fromme, K., Katz, E. C., & Rivet, K. (1997). Outcome expectancies and risk-taking behavior. *Cognitive Therapy and Research.* Vol. 21(4), 421-442.

Harned, M. S. (2005). Understanding women's labeling of unwanted sexual experiences with dating partners: A qualitative analysis. *Violence Against Women*, 11, No 3, March, 374-413.

Harned, M.S. (2004). Does it Matter what you Call it? The Relationship between Labeling Unwanted Sexual Experiences and Distress. *Journal of Consulting and Clinical Psychology*, 72(6), 1090-1099.

He, H.; McCoy, H. V., Stevens, S. J., & Stark, M. J. (1998). Violence and HIV sexual risk behaviors among female sex partners of male drug users. *Women & Health*. Vol. 27(1-2), 161-175.

Kahn, A. S., Jackson, J., Kully, C., Badger, K., & Halvorsen, J. (2003). Calling it rape: Differences in experiences of women who do or do not label their sexual assault as rape. *Psychology of Women Quarterly, 27*, 233-242.

Kaltman, S., Krupnick, J., Stockton, P., Hooper, L., & Green, B. L. (2005). Psychological impact of types of sexual trauma among college women. *Journal of Traumatic Stress*, 18 (5), Oct, 547-555.

Koss, M. P. & Gidycz, C. A. (1985). Sexual Experiences Survey: Reliability and validity. *Journal of Consulting and Clinical Psychology, 53,* 422-423.

Koss, M. P. & Oros, C. J. (1982). Sexual Experiences Survey: a research instrument investigating sexual aggression and victimization. *Journal of Consulting and Clinical Psychology, 50,* 455-457.

Koss, M. P., Gidycz, C. A., & Wisiniewski, N. (1987). The scope of rape: Incidence and prevalence of sexual aggression and victimization in a national sample of higher education students. *Journal of Consulting and Clinical Psychology*, 55, 162-170.

Littleton, H. (2007). An evaluation of the coping patterns of rape victims: Integrations with a schema-based information-processing model. *Violence Against Women*. Vol. 13(8), 789-801.

Littleton, H. L., & Axsom, D. (2003). Rape and seduction scripts of university students: Implications for rape attributions and unacknowledged rape. *Sex Roles*, Vol. 49 (9/10).

Littleton, H. L., Axsom, D., Breitkopf, C. R., & Berenson, A. (2006). Rape acknowledgement and postassault experiences: How acknowledgement status relates to disclosure, coping, worldview, and reactions received from others. *Violence and Victims*, Vol. 21(6), 761-778.

Littleton, H., Axsom, D., & Grills-Taquechal, A. (2009). Sexual assault victim's acknowledgement status and revictimization risk. *Psychology of Women Quarterly*. Vol. 33.

Littleton, H., & Henderson, C. E. (2009). If she is not a victim, does that mean she was not traumatized? Evaluation of predictors of PTSD symptomatology among college rape victims. *Violence Against Women.* Vol. 14(2), 148-167.

McMullin, D., & White, J. W. (2006). Long-term effects of labeling a rape experience. *Psychology of Women Quarterly, 30*, 96-105.

Messman-Moore, T. L. (2004). *Life Experiences Survey*. Unpublished measure. Miami University, Oxford Ohio.

Messman-Moore, T. L., & Brown, A. L. (2004). Child maltreatment and perceived family environment as risk factors for adult rape: Is child sexual abuse the most salient experience? *Child Abuse & Neglect* Vol. 28(10) p.1019-1034

Messman-Moore, T.L., Coates, A.A., Gaffey, K.J., & Johnson, C.F. (2008). Sexuality, substance use and susceptibility to victimization: Risk for rape and sexual coercion in a prospective study of college women. *Journal of Interpersonal Violence, 23, 1730-1746*.

Messman-Moore, T. L., Long, P. J. (2003). The role of childhood sexual abuse sequelae in the sexual revictimization of women: An empirical review and theoretical reformulation. *Clinical Psychology Review*, 23(4), 537-571.

Messman-Moore, T. L., Ward, R. M. & Brown, A. L. (2009). Substance use and PTSD symptoms impact the likelihood of rape and revictimization in college women. *Journal of Interpersonal Violence, 24,* 499-521.

Muehlenhard, C. L., Powch, I. G., Phelps, J.L., and Giusti , L. M. (1992). Definitions of rape: Scientific and political implications. *Journal of Social Issues*, Vol. 48, 23-44.

Nash, C. L., DiLillo, D., Messman-Moore, T. L. & Rinkol, S. (2002, November). *The Computer Assisted Maltreatment Inventory (CAMI): An Investigation of Test-Retest Reliability and Criterion Validity.* Paper presented at the 36th annual meeting of the Association for the Advancement of Behavior Therapy, Reno, Nevada.

Orcutt, H. K., Cooper, M. L., & Garcia M. (2005) Use of sexual intercourse to reduce negative affect as a prospective mediator of sexual revictimization. *Journal of Traumatic Stress*, 18(6), 729-739.

Peterson, Z. D., & Muehlenhard, C. L. (2004). Was it rape? The function of women's rape myth acceptance and definitions of sex in labeling their own experiences. *Sex Roles, 51 (3/4),* 129 – 144.

Peterson, Z. D., & Muehlenhard, C. L. (2007). Conceptualizing the "wantedness" of women's consensual and nonconsensual sexual experiences: Implications for how women label their experiences with rape. *Journal of Sex Research*. Vol. 44(1), 72-88.

Pitts, V. L., & Schwarz, M.D. (1993). Promoting self-blame in hidden rape cases. *Humanity & Society.* Vol. 17, 383-398.

Resick, P. A., & Schnicke, M. K. (1993). Cognitive processing therapy for rape victims: A treatment manual. *Interpersonal violence: The practice series*, Vol. 4. Sage Publications.

Sanders, B. & Moore, D. L. (1999). Childhood maltreatment and date rape. *Journal of Interpersonal Violence,* 14, No 2 Feb, 115-124.

Shapiro, B. L., & Schwartz J. C. (1997). Date rape: Its relationship to trauma symptoms and sexual self-esteem. *Journal of Interpersonal Violence.* Vol. 12 No. 3 June 1997. 407-419.

Smith D. W., Davis, J. L., & Fricker-Elhai, A. E. (2004). How does trauma beget trauma? Cognitions about risk in women with abuse histories. *Child Maltreatment, 9(3) 292-303.*

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

Valentiner, D. P., Foa, E. B., Riggs, D. S., & Gershuny, B. S. (1996). Coping strategies and posttraumatic stress disorder in female victims of sexual and nonsexual assault. *Journal of Abnormal Psychology.* Vol 105(3) p.455-458.

Van Berlo, W., & Ensink, B. (2000). Problems with sexuality after sexual assault*. Annual Review of Sex Research*. 11, 235-257.

Van Bruggen, L. K., Runtz, M. G., & Kadlec, H. (2006). Sexual revictimization: The role of sexual self-esteem and dysfunctional sexual behaviors. *Child Maltreatment*, Vol. 11(2), May, 131-145.

Varia, R., Abidin, R. R., & Dass, P. (1996). Perceptions of abuse: Effects on adult psychological and social adjustment. *Child Abuse & Neglect, 20 (6), 511-526*

Table 1. Psychological Functioning, Sexual Behavior and Risky Behavior by Victimization

	Rape	No Rape	CSA	No CSA
	Mean (SD)	Mean (SD)	Mean (SD)	Mean (SD)
Psychological Functioning				
Depression	7.78 (5.73)	6.31 (4.97)	9.33 (6.67)	6.41 (4.99)
Anger/Irritability	9.24 (5.76)	7.55 (5.39)	11.33 (7.34)	7.64 (5.28)
Anxious Arousal	9.51 (4.62)	7.28 (4.58)	9.90 (5.95)	7.55 (4.54)
Intrusive Experiences	7.87 (5.94)	5.01 (4.68)	9.48 (6.41)	5.29 (4.85)
Defensive Avoidance	10.04 (5.72)	6.92 (5.76)	11.28 (6.52)	7.27 (5.75)
Dissociation	8.09 (5.19)	6.34 (4.82)	9.93 (7.54)	6.45 (4.64)

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Table 1 continued

Sexual Behavior & Functioning	Rape Mean (SD)	No Rape Mean (SD)	CSA Mean (SD)	No CSA Mean (SD)
Dysfunctional Sexual Behavior	6.75 (5.47)	3.33 (3.76)	6.74 (6.77)	3.80 (4.08)
Sexual Concerns	6.47 (5.26)	3.77 (4.53)	8.44 (7.87)	4.02 (4.39)
Sex with someone just met	0.59 (0.96)	0.10 (0.39)	0.29 (0.60)	0.19 (0.58)
Sex without protection-pregnancy-just met	0.19 (0.52)	0.02 (0.20)	0.07 (0.35)	0.06 (0.29)
Sex without protection-pregnancy-regular partner	0.91 (1.61)	0.47 (1.23)	1.62 (2.24)	0.48 (1.20)
Sex without protection-STDs-just met	0.33 (0.76)	0.48 (0.31)	0.15 (0.48)	0.10 (0.44)
Sex without condoms-just met	0.28 (0.69)	0.05 (0.27)	0.17 (0.44)	0.09 (0.39)
Sex without condoms-regular partner	2.04 (2.24)	0.94 (1.74)	2.43 (2.34)	1.06 (1.83)
Sex under the influence of alcohol-just met	0.52 (0.96)	0.10 (0.41)	0.26 (0.59)	0.17 (0.58)
Sex under the influence of alcohol-regular partner	1.74 (1.74)	0.81 (1.36)	1.27 (1.55)	0.97 (1.48)
Sex under the influence of drugs-just met	0.20 (0.53)	0.02 (0.20)	0.15 (0.48)	0.05 (0.29)

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Table 1 continued

Risky Behavior & Substance Use	Rape Mean (SD)	No Rape Mean (SD)	CSA Mean (SD)	No CSA Mean (SD)
Left a social event with someone just met	0.91 (1.06)	0.43 (0.78)	0.45 (0.74)	0.53 (0.87)
Binge Drinking (5 or more)	3.56 (1.76)	2.27 (2.02)	2.14 (1.77)	2.54 (2.05)
Marijuana Use	1.13 (1.67)	0.57 (1.21)	0.85 (1.57)	0.66 (1.31)
Mixing Drugs & Alcohol	1.11 (1.64)	0.46 (1.13)	0.79 (1.63)	0.57 (1.24)
Riding in car with intoxicated driver	1.65 (1.49)	0.96 (1.29)	1.29 (1.49)	1.07 (1.35)
Driving under the influence 1-2 drinks	1.31 (1.48)	0.59 (1.06)	0.90 (1.34)	0.71 (1.17)
Driving under the influence 3-4 drinks	0.75 (1.30)	0.27 (0.78)	0.46 (1.00)	0.35 (0.92)
Driving under the influence 5 or more drinks	0.69 (0.94)	0.11 (0.42)	0.30 (0.69)	0.19 (0.75)

Table 2. Frequencies of Labeling

	Label Type		
	Rape (n = 138)	Sexual Assault (n = 138)	Consensual (n = 136)
1 (Definitely Not Rape)	30.4% (42)	18.1% (25)	33.1% (45)
2	25.4% (35)	22.5% (31)	25.7% (35)
2.5	0% (0)	0% (0)	0.7% (1)
3	13.8% (19)	11.6% (16)	17.6% (24)
4	12.3% (17)	14.5% (20)	14.0% (19)
5	8.7% (12)	10.1% (14)	3.7% (5)
6	5.8% (8)	11.6% (16)	2.9% (4)
7 (Definitely Was Rape)	3.6% 5	11.6% 16	2.2% (3)

Note. Actual number included below reported percentages.

Table 3. Predictors of Labeling.

	Label		
	Rape	Sexual Assault	Consensual
Assault by non-intimate partner	.173*	.041^{ns}	-.121^{ns}
Use of physical coercion	.255**	.216*	-.146^{ns}
Victim physically resisted rape	.085^{ns}	.078^{ns}	-.105^{ns}
Physical injury or pain from rape	.432**	.291**	-.143^{ns}
Intoxication level of perpetrator	-.122^{ns}	-.197*	.125^{ns}
Intoxication level of victim	.106^{ns}	-.061^{ns}	-.031^{ns}
Time since assault	.169*	.269**	-.272**
Victim disclosed rape to some else	.061^{ns}	.197*	-.264**
Negative reaction from others	.211*	.196*	-.177*
Others blamed the victim	.192*	.239**	-.152^{ns}
Victim blamed self	-.074^{ns}	-.141^{ns}	.056^{ns}
Victim blamed perpetrator	.352**	.466**	-.444**
Failure to communicate	-.301**	-.301**	.218*

* $p < .05$, ** $p < .01$, ***$p < .001$

Table 4. Correlations of Labeling Extent and Psychological and Sexual Functioning

	Label Type		
	Extent Considered Rape	Extent Considered Sexual Assault	Extent Considered Consensual
Depression	.174*	.113	-.070
Anger	.186*	.113	-.039
Anxiety	.031	.052	.048
Dissociation	.047	.106	.022
Intrusive experiences	.194*	.111	-.046
Defensive avoidance	.196*	.116	-.032
Sexual concerns	.109	.030	.148
Dysfunctional sexual behavior	.182*	.003	.114

* $p < .05$, ** $p < .01$, ***$p < .001$

Table 5. Rape Label and Time Since Assault as Correlates of Risky Sexual Behavior

	Extent Considered Rape	*Extent Considered Sexual Assault*	*Extent Considered Consensual*	*Time Since Assault*
Sex (regular partner)	.080	-.003	.008	.102
Sex (someone just met)	.268**	.075	-.043	-.216*
Sex without protection against pregnancy (regular)	.035	-.079	.036	.030
Sex without protection against pregnancy (just met)	.167	.014	.009	-.172*
Sex without protection against STD's (regular)	-.006	-.067	-.033	.069
Sex without protection against STD's (just met)	.146	-.008	.014	-.232**
Sex under influence of alcohol (regular)	.089	-.005	-.025	.046
Sex under influence of alcohol (just met)	.258**	.069	-.033	-.198*
Sex under influence of drugs (regular)	.122	.034	.072	-.047
Sex under influence of drugs (just met)	.277**	.157	-.026	-.102
Sex without condom (regular)	.112	.037	-.066	.110
Sex without condom (just met)	.145	-.012	.087	-.195*
Left social event with someone just met	.007	-.049	.081	-.274**

* $p < .05$, ** $p < .01$, ***$p < .001$

Table 6. Correlations of Labeling Extent and Lifetime Sexual Behaviors

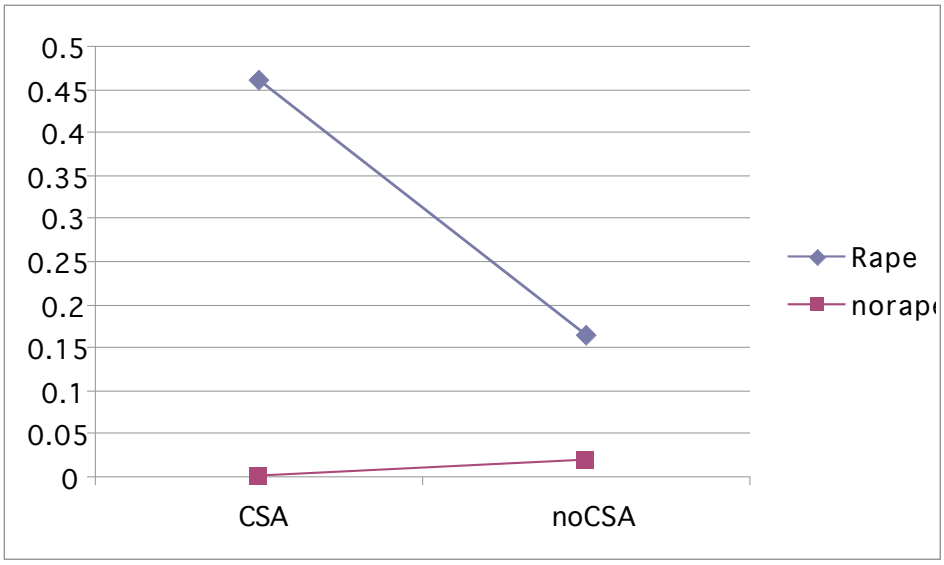
	Label		
	Extent considered rape	Extent considered sexual assault	Extent considered consensual
Number partners kissed	.229**	.140	-.192*
Number partners received oral sex	.287**	.201*	.008
Number partners given oral sex	.290**	.123	-.031
Number partners intercourse	.332**	.121	-.152

* $p < .05$, ** $p < .01$, ***$p < .001$

Table 7. Step-Wise Regression Predicting Rape Labeling Extent

Predictors	B	SE	Beta	*t*	Correlations		
					Zero-order	Partial	Part
Step 1							
Sex with someone just met	.601	.163	.314	3.68**	.314	.314	.314
Step 2							
Sex with someone just met	.700	.162	.366	4.33***	.314	.364	.358
Time since assault	.920	.309	.252	2.977**	.176	.259	.246

Figure 1. Rape Victim and CSA Victim Status Interaction for Having Sex While Under the Influence of Drugs with Someone Just Met



Appendix