Finding the Strength to Heal After Campus Unwanted Sexual Experiences: A Journey of Identity and Strength

by

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DEDICATION

This dissertation is dedicated to the survivors interviewed and surveyed through this project who trusted and inspired us with their stories of hurt, loss, and hope for a future without violence.

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ABSTRACT

There is a significant body of literature highlighting the impact of unwanted sexual experiences (USEs) on undergraduate health, disproportionately affecting female students compared to their male counterparts. Although we know much about the negative consequences of this concerning social and public health issue, we know little about survivor's healing needs and desires and what ultimately impacts their ability to recover and seek help after these sexually violent experiences. Therefore, the purpose of this dissertation is to better understand the retrospective and day-to-day healing processes of female undergraduate survivors of campus USEs as well as important influences of this phenomenon. Specific aims of this dissertation are four-fold including:

1. Evaluate the mediating role of trauma-related shame on the relationship between perceived peer rape myth acceptance and posttraumatic growth (PTG) in this population (N=174);
2. Evaluate the shared and independent variance contributions of mental health symptom and trauma history clusters on PTG (n=151);
3. Understand internal and socio-cultural influences of USE healing, as well as the nature of survivor healing goals, using narrative interviewing in a subset of our quantitative population (n=24); and
4. Understand the day-to-day USE healing process and goals, using a photo elicitation methodology focusing on healing and darker moments within survivors daily lives in a subset of our narrative interviewing population (n=17).

Results of this dissertation reveal that although trauma-related shame does not mediate the relationship between perceived peer rape myth acceptance and PTG, mental health symptoms and trauma history significantly contribute to 35.27% of PTG variance, with trauma history significantly impacting PTG scores beyond mental health symptoms alone. Additionally, our grounded theory analysis yields the Healing after Unwanted Sexual Experiences Model. In this model, the normalization of sexual aggression within one's social context is found to influence how one makes meaning of their USE, activating a cascade of emotions (shame, self-blame, fear, anger/frustration) and impacting their ability to integrate trauma into their identity. Through this model, we show that by externalizing one's trauma and integrating it into one's core identity, survivors of campus USE were able to pursue identified healing goals (i.e. reconstructing identity, cultivating worthiness, regaining trust, rebuilding worldview, and finding your voice). Finally, our photo elicitation analysis indicates that day-to-day healing functions on a continuum, impacted by darker moments (i.e. feelings of fear, anxiety, loneliness, guilt, anger, worthlessness) manifesting in overwhelm, disconnection, or vulnerability, as well as healing moments (i.e. rebuilding moments of self-care, self-love, connection, hope, peace, and freedom) influenced by self-reflection, authentic interactions, and resource utilization. Taken together, these results as a whole significantly contribute to our understanding of undergraduate USE healing, by creating a roadmap that can be used by survivors and service providers to better understand important influences and benchmarks in the day-to-day and grand healing process after campus USE. By acknowledging the great influence of the normalization of violence within American university culture and empowering survivors of campus USE to recognize their strengths and rise above this powerful socio-cultural silencer, we can begin to create a hopeful university environment that better supports survivor growth and healing needs.

Chapter I Introduction

Gender-based violence (GBV) is recognized as a major public health concern with profound consequences for survivors (World Health Organization, 2013). Specifically, there is a growing GBV-related epidemic on college campuses in the United States, as college-aged females (ages 18-24) have consistently had the highest rates of rape and sexual assault victimization when compared with females in other age groups (Krebs, Lindquist, Warner, Fischer, & Martin, 2007). This study will specifically focus on undergraduate unwanted sexual experiences (USEs) as they relate to posttraumatic growth (PTG) and trauma healing.

Gender-Based Violence Impact

In the United States, it is estimated that one in four women have been exposed to some form of GBV throughout their lifetime, threatening survivors' quality of life and overall wellbeing (Walsh, Keyes, Koenen, & Hasin, 2015). The physical and emotional distress caused by GBV (i.e. intimate partner violence, sexual violence, harassment, stalking) lasts well beyond the traumatic experience. For example, adverse social and psychological effects related to intimate partner violence, sexual assault, and child abuse have been well documented in scientific literature (e.g. posttraumatic stress disorder symptoms, substance use, suicidality, depression, eating disorders, and anxiety), impacting survivors' relationships with family, friends, and co-workers, as well as leading to health risk behaviors and high utilization of health care services (See Heise, Ellsberg, & Gottmoeller, 2002 for review). The injuries, fear, and stress associated with GBV (e.g. intimate partner abuse, sexual assault, child abuse) can additionally

result in chronic health problems such as chronic pain syndromes, gastrointestinal disorders, somatic complaints, and fibromyalgia as well as reproductive health issues such as unwanted pregnancy, sexually transmitted infections, gynecological disorders, pelvic inflammatory disease, and pregnancy complications (See Heise, Ellsberg, & Gottmoeller, 2002 for review). Unfortunately, many survivors do not disclose or seek help for their trauma experiences, creating barriers to their healing process (Fugate, Landis, Riordan, Naureckas, & Engel, 2005; Saint Arnault & O'Halloran, 2016). Suffering in silence can cause an increased symptom burden, further disconnecting the survivor from society and challenging their road to healing and recovery.

Trauma Healing as it Relates to Gender-Based Violence

Despite the growing understanding of the impact of GBV-related experiences on health outcomes, very little research to our knowledge has focused on the trauma recovery processes of GBV survivors. The little research that has been done, particularly with survivors of sexual violence, has primarily focused on identifying factors associated with distress and/or adverse outcomes (Draucker, Martsolf, Ross, Cook, Stidham, & Mweemba, 2009). For example, in a qualitative meta-synthesis of 51 reports discussing healing after sexual violence, one limitation identified by the authors was that only 12 synthesized reports stated their purpose was to describe how individuals heal, adapt, or recover from sexual violence. Other reports included in the review focused on survivor's "lived experiences" more broadly without specifically asking the survivor about their healing goals and experiences, potentially missing important intricacies contributing to trauma healing. Reports that did discuss healing revealed the importance of relating to others, feeling safe, and re-evaluating the self as important benchmarks in their trauma recovery process (Draucker et al., 2009). Further understanding the trauma healing process after GBV-related sexual violence can help improve professional interactions with survivors by

encouraging clinicians to focus on survivor healing goals, rather than solely focusing on negative responses to USEs.

Sexual Violence and College Campuses

Sexual violence has been defined as "any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work" (World Health Organization, 2014). While both men and women experience sexual violence, women face disproportionately high rates, with nearly one in five women in the United States reporting an attempted or completed rape at some point in their lives compared to one in 71 men (Black et al., 2011). Relatedly, approximately one in twenty women in that same survey experienced sexual violence other than rape in the year prior, indicating the high prevalence of other USEs in this population. In 2015, more than 150,000 students from 27 universities participated in one of the largest studies ever on sexual assault and sexual misconduct. Results indicate that 23% of female undergraduate and graduate students across the 27 schools experienced some form of unwanted sexual contact - from kissing to touching to rape- carried out by force or threat (Cantor et al., 2015).

Recent political attention has been focused on female survivors of sexual assault on college campuses due to the high victimization rates of women in these settings. As a result, many national dialogue and policy efforts surrounding campus sexual assault (e.g. President Obama's 2014 *It's On Us* campaign, Title IX, SaVE Act, Jeanne Clery Act) have been created and implemented to target and prevent such occurrences from happening in our higher education institutions. Unfortunately, despite recent university efforts surrounding prevention of rape and other forms of sexual violence, the high incidence of these occurrences in the college campus setting have not decreased. This substantiates the need for further research on the infrastructure

that supports these crimes as well as how to support the growing number of survivors in our communities.

The Influence of the Unique College Campus Context

The high prevalence of sexual violence on college campuses has been attributed to circumstances unique to the college experience, including a growing conceptualization of a 'rape culture,' which has been defined as an environment in which sexual assault and date rape are tolerated as part of campus life (Burnett, Mattern, Herakova, Kahl, Tobola, & Bornsen, 2009). Other hypothesized risk factors include the presence of gender-segregated spaces (e.g. dorms, athletics, and fraternities) as well as the normalization of 'hook up' experiences, creating sexual expectations and norms that typically put heterosexual men in a position of power over their female peers (Boeringer, 1999; DeSantis, 2007; Foubert, Garner, & Thaxer, 2006; Garcia, Reiber, Massey, & Merriwether, 2012). In particular, parties that revolve around substance use, binge drinking, and hooking up, such as those hosted by fraternities and athletic teams, create environments that put women at an even greater risk for sexual victimization (e.g., Fink 2010; Mohler-Kuo, Dowdall, Koss, & Wetchler. 2004). This has been attributed to heightened levels of rape-prone attitudes, traditional gender beliefs, and perceived peer support of sexual aggression among individuals in these groups (Bleecker & Murnen 2005; Boyle & Walker, 2016; Humphrey & Kahn 2000; Murnen & Kohlman 2007).

Alcohol consumption frequently co-occurs with USEs both by perpetrators and victims (Abbey, McAuslan, & Ross, 1998; Harrington & Leitenberg 1994). One study found that 72% of college rape survivors reported that they were intoxicated at the time of their rape experience (Mohler-Kuo et al., 2004). Relatedly, researchers have found that approximately one-half of all sexual assaults are committed by men who have been drinking alcohol (Abbey, McAuslan, & Ross, 1998; Crowell & Burgess 1996). The high risk of assault victimization while intoxicated is

particularly concerning, because it has been estimated that 94% of college students perceive that alcohol or drugs are involved in typical hook up experiences (Paul & Hayes, 2002). These circumstances, among others, can cause women who have experienced USEs while under the influence to feel confusion or shame, disabling their help seeking and recovery. It is important to emphasize, however, that although substance use and participating in the college drinking culture may place a woman at increased risk of USEs, she is in no way responsible for the assault.

Shame Related to Sexual Violence

Negative emotions triggered by USEs can significantly shape how survivors feel about themselves and how they respond to their experiences. Of particular importance to this study, is the occurrence and influence of shame. In a recent study, 75% of women indicated that they felt ashamed about themselves following sexual assault (Vidal & Petrak, 2007). Additional studies have found that women who experience rape often feel dirty or disgusted afterwards, frequently blaming themselves for their assaults (Feiring & Taska, 2005; Pitts & Schwartz, 1997; Ullman, 1996). A 2010 study uncovered that for women, shame is sustained by the ideas that women are deserving, disgraced, or defamed by sexual victimization (Weiss, 2010). Relatedly, societal ideologies often hold women responsible for sexual victimization and differentiate "good girls" from those who get raped (Weiss, 2010). This is particularly problematic as women try to navigate their healing processes, as societal responses can enhance survivors' already high levels of shame, causing these women to remain invisible and hide themselves, creating barriers to their healing process (Feiring, Taska, & Lewis, 2002).

Disclosure and Sexual Violence

Disclosure for sexual violence is alarmingly low, as data from the United States Bureau of Justice Statistics revealed that at least 80 percent of rapes and sexual assaults are not reported (Sinozich & Langton, 2014). A literature review synthesizing the barriers to seeking care after

sexual violence revealed the influencing factors of emotional states (e.g. shame, embarrassment, guilt, and self-blame), fear of external exposure (e.g. poor treatment by the justice system, not being believed, lack of confidentiality, going to trial, assailant retaliation or punishment, public exposure) and environmental factors (e.g. organizational barriers, rape myths; Munro, 2014). Of particular interest to this study, this synthesis noted that twelve studies cited perpetuation of rape myths and that ten studies cited shame, embarrassment, humiliation, or self-blame as factors in preventing sexual assault survivors from accessing care (for examples, see Sable, Danis, Mauzy, & Gallagher, 2006 and Tjaden & Thoennes, 2006). It is our belief that the internalization of sexual violence norms like rape myths can enhance one's trauma related shame, challenging survivor's road to healing and recovery.

Another aspect of the environment that may have bearing on survivor healing is the growing scientific literature studying the effect of rape myths on survivor wellbeing and adjustment (Moor, 2007; Peterson & Muehlenhard, 2004; Sheldon & Parent, 2002; Ullman & Najdowski, 2011). The term *rape myth* refers to stereotypical beliefs regarding sexual assault victims, sexual assault perpetrators, and the situational variables that distinguish sexual assault from consensual sex (Bannon, Brosi, & Foubert, 2013). These myths are used to transfer accountability from perpetrators to victims of rape (Edwards, Turchik, Dardis, Reynolds, & Gidycz, 2011; Frese, Moya, & Megías, 2004; Peterson & Muehlenhard, 2004). Commonly endorsed myths include "it only happens to 'certain' women," "she asked for it," and "rape is often falsely reported" (Burt, 1980; Franiuk, Seefelt, Cepress, & Vandello, 2008; Suarez & Gadalla, 2010).

The relationship between the acceptance of rape myths and self-blame in survivors of sexual violence has been well studied, indicating that due to the narrow cultural definition of rape, as well as often co-occurring alcohol use, many survivors blame themselves or mistakenly

believe that their experience is not severe enough to be reported (Bannon, Brosi, & Foubert, 2013; Iconis, 2008; Moor, 2007; Peterson, & Muehlenhard, 2004). Relatedly, the internal struggle between behaving as a "good girl" in society, while battling the cultural assumption that "bad girls" are the ones that have these unwanted sexual experiences, can cause a rift in understanding the meaning of violence and one's role within that violent event.

However, little is known about how the unique college campus context can positively or negatively impact the trauma healing process, with the majority of the literature focusing on service utilization and reporting. For example, one study revealed that women attending colleges with higher levels of sexual violence resources had better emotional health compared to those attending colleges with lower resource levels. This study, however, failed to mention the individual and socio-cultural factors that may have impacted the use of these resources (Eisenberg, Lust, Hannan, & Porta, 2016). For many students, the social environment of college campuses could play an integral role in their healing journey, creating either barriers or facilitators to this process. We hypothesize that some influences may include shame, fear of rejection and being ostracized and social milieu pressures that can inhibit disclosure and help-seeking. This can ultimately impact one's ability to process their trauma and as a result, heal from it. What is additionally unknown is how the availability of services, even if a survivor does not use them, might impact how she interprets the meaning of the violence experienced and her recovery from it.

Taken together, research in the societal context of rape myth culture, hook up expectations, alcohol use, and the unique social milieu indicates the increasing importance of better understanding social and cultural influences of USEs and how these elements influence survivor reactions and healing processes. By better articulating specific social-contextual barriers or facilitators to trauma recovery through survivor's voices, interventions can be targeted to

create a safer environment for survivors as they navigate the trauma healing process within this university social context.

A Focus on the Concept of Trauma Healing

The physical and emotional distress caused by USEs can have profound implications for survivors. On college campuses, the negative psychological outcomes related to sexual assault have been shown to impede academic success, contribute to higher substance use, correlate to higher transfer and college dropout rates, as well as negatively impact survivor relationships with family, friends, and co-workers (Department of Justice, 2014; Eisenberg, Lust, Hannan, & Porta, 2016; Sinozich & Langton, 2014). These negative health outcomes, among others, substantiate the need for research in the area of healing to improve campus support for survivors with the goal to mitigate the adverse emotional, social, and academic outcomes associated with USEs.

Little research has focused on the trauma healing processes for survivors of USEs, with most research primarily focusing on identifying factors associated with distress and adverse outcomes (Draucker et al., 2010). A growing body of literature, however, highlights the idea of posttraumatic growth (PTG). Posttraumatic growth is conceptualized as positive changes being attained by some individuals as a result of their survival of a highly stressful event (Tedeschi & Calhoun, 1996). The literature on PTG has encompassed a wide variety of traumatic experiences (e.g., natural disasters, community violence, medical diagnoses), highlighting the importance of three general domains: changes in the perception of the self, changes in the experience of relationships with others, and changes in one's general philosophy of life (Tedeschi & Calhoun, 1996). It has been proposed through the PTG literature, that positive posttraumatic changes occur through the process of making meaning out of a traumatic event and overcoming initially high levels of psychological distress (Tedeschi & Calhoun, 2004).

Despite progress looking at positive growth in trauma survivors, research in PTG has been generalized to all types of trauma, potentially missing the important nuances associated with interpersonal trauma such as sexual trauma specifically. For example, a study conducted by Shakespeare-Finch and Armstrong in 2010 revealed that sexual assault survivors had significantly higher PTSD levels and greater difficulties relating to others and appreciating life when compared to survivors of motor vehicle accidents and those in bereavement. The authors conclude that the direct threat to personal physical integrity and the fact that sexual assault is a trauma that is intentionally perpetrated by another person, may add another dimension to the trauma experience beyond that experienced in bereavement or motor vehicle accidents (Shakespeare-Finch & Armstrong, 2010). This highlights the need to look further into sexual trauma specifically, to identify pertinent barriers and facilitators to personal growth and healing.

Scientific literature to date has primarily focused on the relationship between personal characteristics and traits (e.g., emotions, optimism, extraversion, and acceptance) and PTG (See Butler & Joseph, 2010 for review). However, there are limited studies to our knowledge that consider the important role one's socio-cultural context can play in influencing personal characteristics, traits, and subsequent growth after trauma. For example, a 2009 study of assault survivors found that lower levels of shame during one's interpersonal traumatic event led to higher subsequent growth (Kleim & Ehlers, 2009). This study failed to measure what might be causing that feeling of shame in the first place, however, as well as additional shame that can be caused by post assault interactions with service providers and others within survivors' social milieus. Ultimately, more research is needed to expand our knowledge of how one's social context can impact survivor shame and resulting growth, to enable the creation of interventions to adequately address shame and promote active healing engagement in this population.

The Present Dissertation

The purpose of this set of studies is to explore trauma healing among survivors of undergraduate USEs. Our research examines the complex relationships among contextual and individual barriers and facilitators to trauma healing through quantitative survey data, as well as through the utilization of narrative interviewing, a technique that may be a critical therapeutic gateway to facilitate trauma healing (Androff, 2012; Crossley, 2002; Saint Arnault, 2017). Additionally, to capture day-to-day healing more fully, we also utilized a photo elicitation methodology, a technique that can provide visual representation of healing that words alone may not be able to describe. Specific aims of this dissertation include:

1. Evaluate the mediating role of trauma-related shame on the relationship between perceived peer rape myth acceptance and posttraumatic growth in this population (N=174);
2. Evaluate the shared and independent variance contributions of mental health symptom and trauma history clusters on posttraumatic growth (n=151);
3. Understand internal and socio-cultural influences of USE healing, as well as the nature of survivor healing goals, using narrative interviewing in a subset of our quantitative population (n=24); and
4. Understand the day-to-day USE healing process and goals, using a photo elicitation methodology focusing on healing and darker moments within survivors daily lives in a subset of our narrative interviewing population (n=17).

Chapter II Mental Health Status and Trauma History as a Significant Predictor of Posttraumatic Growth

Introduction

Gender-based sexual violence on college campuses is a concerning social and public health issue, disproportionately affecting female university students compared to their male counterparts. In 2015, more than 150,000 students from 27 universities participated in one of the largest studies ever on sexual assault and sexual misconduct. Results indicated that among undergraduates, 23.1% of females, compared to 5.4% of males, reported experiencing rape or sexual assault through physical force, violence, or incapacitation (Cantor, Fisher, Chibnall, Townsend, Lee, Thomas, & Westat, 2015).

The physical and emotional distress caused by USEs (i.e. rape, intimate partner violence, sexual assault, unwanted sexual contact, harassment) and other forms of GBV can have profound implications for survivors. For example, adverse psychological effects related to intimate partner violence, sexual assault, and child abuse have been well documented in scientific literature (e.g. posttraumatic stress disorder symptoms, substance use, suicidality, depression, eating disorders, and anxiety), leading to health risk behaviors and high utilization of health care services (See Heise, Ellsberg, & Gottmoeller, 2002 for review). Relatedly, GBV has been associated with a host of chronic health problems such as chronic pain syndromes, gastrointestinal disorders, somatic complaints, fibromyalgia, gynecological disorders, pelvic inflammatory disease, and pregnancy complications, indicating the long-lasting impact violence can have on survivors (See Heise, Ellsberg, & Gottmoeller, 2002 for review). On college campuses specifically, the negative psychological outcomes related to gender-based sexual

violence can interfere with survivor's abilities to succeed academically, and have been associated with higher substance use behaviors, interpersonal problems, and higher college transfer and dropout rates (Department of Justice, 2014; Eisenberg, Lust, Hannan, & Porta, 2016; Sinozich & Langton, 2014). Taken together, the negative physical, emotional, and social health outcomes associated with gender-based sexual violence, substantiate the need for research around healing and growth to improve campus support for survivors. Therefore, the purpose of this study is to garner a better understanding of PTG among female survivors of undergraduate USEs by evaluating the mediating role of trauma-related shame on the relationship between perceived peer rape myth acceptance and PTG while also evaluating the shared and independent variance contributions of mental health symptoms and trauma history clusters on PTG. This research can point to places for intervention to mitigate the adverse emotional, social, and academic outcomes associated with USEs.

Sexual Violence Norms on College Campuses. Research on the pervasiveness of sexual violence on college campuses has focused on the beliefs about violence in the larger society, as well as the local culture of college life. As a result, studies are beginning to examine the impact these interacting sets of beliefs have on survivor wellbeing and adjustment (Moor, 2007; Peterson & Muehlenhard, 2004; Sheldon & Parent, 2002; Ullman & Najdowski, 2011). The term *rape myth* is often cited as a central cultural force, and the term refers to stereotypical beliefs regarding sexual assault victims, sexual assault perpetrators, and the situational variables that distinguish sexual assault from consensual sex (Bannon, Brosi, & Foubert, 2013). These myths are often used to transfer accountability from perpetrators to victims of rape (Edwards, Turchik, Dardis, Reynolds, & Gidycz, 2011; Frese, Moya, & Megías, 2004; Peterson & Muehlenhard, 2004). Commonly endorsed rape myths include "it only happens to 'certain' women," "she asked

for it," and "rape is often falsely reported" (Burt, 1980; Franiuk, Seefelt, Cepress, & Vandello, 2008; Suarez & Gadalla, 2010).

The high prevalence of rape myth acceptance and sexual violence on college campuses has been attributed to circumstances unique to the college experience, including a growing conceptualization of a 'rape culture,' which has been defined as an environment in which sexual assault and date rape are tolerated as part of campus life (Burnett et al., 2009). For example, McMahon (2010) argues that college students, along with the larger society, typically consider women responsible for the sexual violence acted out against them (Boyle & Walker, 2016; Burnett et al., 2009; Fraser, 2015). Relatedly, Armstrong, Hamilton, and Sweeny (2006) found that gender roles within the social hierarchy at college parties contribute to women's degradation, with men typically having the ability to exercise control over most aspects of party and social situations (e.g., alcohol, theme, transportation), while often exhibiting peer support for disrespecting women. Ultimately, the hushed nature surrounding the communication of date rape and assault on college campuses, as well as the normality of these experiences within campus life, tend to perpetuate rape culture ideology as well as remove accountability from those who engage in these behaviors (Burnett et al, 2009; Giraldi & Monk-Turner, 2017). These findings were confirmed through a qualitative review of social media posts concerning rape culture on college campuses which found a variety of themes that support violence, or that silence the survivor, including "get over it," "just college fun," "lighten up," "not that serious," "this isn't rape," "women as sexual objects," and "they are just college kids" (Giraldi & Monk-Turner, 2017).

There is a small body of literature highlighting the influence of perceptions of rape myth acceptance within one's environment on survivor mental health and service utilization**.** For example, one 2009 study revealed that survivors of college sexual assault significantly

overestimate their peer's rape myth acceptance, and this overestimation predicted posttraumatic stress symptoms and the amount one disclosed about their unwanted sexual experience (Paul, Gray, Elhai, & Davis, 2009). The relationship between the acceptance of rape myths and self-blame in survivors of sexual violence has been well studied, indicating that due to the narrow cultural definition of rape, as well as often co-occurring alcohol use, many survivors blame themselves or mistakenly believe that their experience is not severe enough to be reported (Bannon, Brosi, & Foubert, 2013; Iconis, 2008; Moor, 2007; Peterson, & Muehlenhard, 2004). Relatedly, research is finding that self-blame and shame in survivors seems to be caused by internalization of the perceptions that only "bad girls" have USEs, either due to "risky behaviors" or due to not effectively protecting themselves (Burnett et al., 2009, Giraldi & Monk-Turner, 2017). This learned expectation, often heard from a very young age, can cause conflict in understanding the meaning of violence and one's role within the violent event, impacting one's feeling of shame and self-blame after USE's.

The Influence of Shame. Negative emotions triggered by USEs can significantly shape how survivors feel about themselves and how they respond to their experiences. Of importance to this study is the occurrence and influence of shame on trauma recovery. Shame is an emotion linked to a person's self-worth and identity (Weiss, 2010) commonly associated with powerlessness and feelings of disgrace, failure, and inadequacy (Buchbinder & Eisikovitz, 2003; Gilbert, 2002; Harelli & Parkinson, 2008). Shame is a frequently cited emotional consequence of sexual violence in females, with one study noting that 75% of female sexual assault survivors indicated that they felt ashamed about themselves following their assault (Vidal & Petrak, 2007). Additional studies have found that women who experience rape often feel "dirty" or "disgusted" afterwards, reporting self-blame and shame upon reflection of their traumatic experience (Feiring & Taska, 2005; La Bash & Papa, 2014; Ullman, 1996).

Shame has been argued to be socially constructed and culturally mediated (Weiss, 2010) with cultural narratives regarding gender, sexuality, and sexual crimes themselves contributing to the victim's own definitions of her situations as shameful. Shame has been found to be significantly related to traumatic stress symptoms and feelings of self-blame, hypothesized to be sustained by the ideas that women deserved the attack, and are disgraced or defamed by sexual victimization (Vidal & Petrak, 2007; Weiss, 2010). Relatedly, societal ideologies can influence one's view of themselves after sexual assault, as many people often hold women responsible for sexual victimization and differentiate "good girls" from those who get raped (Weiss, 2010). This is particularly problematic as women try to navigate their healing processes, because societal responses can increase survivors' already high levels of shame, creating barriers to recovery and growth (Feiring & Taska, 2005; Feiring, Taska, & Lewis, 2002).

Shame in sexual violence survivors has been found to occur most often in sociocentric societies (Kalra & Bhugra, 2013). In contrast, while America as a whole is most commonly considered an egocentric culture, the college campus environment can create an environmental "bubble" in which relations between people are at the core of individual identity, mimicking sociocentric ideals. An extensive body of literature has supported this, showing that peer beliefs and behaviors are key influences on student's beliefs, behaviors, and development (e.g., Astin, 1993; Astin 1998; Mutterperl & Sanderson, 2002). Additionally, student's values, beliefs, and aspirations have been hypothesized to be molded and changed in the direction of the dominant values, beliefs, and aspirations of other students (Astin, 1998). Because of this peer influence, and the idea that shame is socially and culturally constructed, we hypothesize that the perceived adherence of sexual violence myths amongst one's peers should impact one's resulting trauma-related shame and growth following a traumatic USE. This idea has been supported elsewhere, with one study of 64 undergraduates who had experienced sexual assault and 159 of their non-

assaulted peers finding that survivor's estimates of the rape myth acceptance of their peers was significantly correlated with posttraumatic stress symptom burden ($p<.01$), and this relationship had a medium effect size (Paul, Gray, Elhai, & Davis, 2009). It is our belief that the perceived beliefs of others in one's social environment are an important measure related to the normalization of violence in the college social environment (Sinko & Saint Arnault, in press). Because this normalization of violence within the peer culture can contribute to feelings of shame and disconnection between oneself and one's social world after a traumatic experience, we believe that peer acceptance of rape myths will directly impact trauma-related shame and resulting posttraumatic growth (Buchbinder & Eisikovitz, 2003; Gilbert, 2002; Harelli & Parkinson, 2008, Sinko & Saint Arnault, in press; Weiss, 2010).

Posttraumatic Growth after Sexual Violence. A growing body of literature conceptualizes the idea of PTG, theorized as encompassing the positive changes in the perception of the self, changes in the experience of relationships with others, and changes in one's general philosophy of life that are attained as the result of a traumatic event (Tedeschi & Calhoun, 1996). Particularly important to the PTG literature is the idea of making meaning out of traumatic events, enabling survivors to overcome initially high levels of psychological distress (Tedeschi & Calhoun, 2004).

Posttraumatic growth has been studied in survivors of a variety of traumatic events (Tedeschi & Calhoun, 1996). However, despite progress in research that examines positive growth in trauma survivors in general, research on psychological growth after the experience of sexual violence in adult women is scarce (Ulloa, Guzman, Salazar, & Cala, 2016). A 2016 literature review of PTG studies of sexual violence survivors uncovered twelve quantitative studies in the scientific literature to date, with only half of them measuring the concept as described by Tedeschi and Calhoun, revealing an inconsistency in research designs, assessment,

and operational definitions of growth after trauma (Ulloa et al., 2016). This review pointed to the need for future research to identify relevant predictors in this population as well as how context can influence understanding of PTG (Ulloa et al., 2016).

Research about the relationship between PTG and psychological distress suggests that they co-occur, however, there has been much debate about whether one's level of psychological distress influences the tendency for growth in sexual violence survivors, or whether they are independent constructs (Ulloa et al., 2016). For example, two articles in Ulloa, Guzman, Salazar, & Cala's 2016 review proposed that for some individuals, the distress associated with sexual traumatic experiences could in fact act as a motivator for these individuals to grow (Frazier, Conlon, & Glaser, 2001; Thompson, 2000). Relatedly, Kleim & Ehlers (2009) found that low levels of shame during interpersonal trauma and high levels of posttraumatic stress and depression symptoms were correlated to heightened PTG scores in assault survivors. In opposition to these findings, Grubaugh & Resick (2007) concluded in their study on sexual assault survivors that PTG is not related to psychological distress at all. Taken together, these studies show a mixed relationship between PTG and distress, suggesting that more research is necessary in this area. Further clarity of the relationship between psychological distress and PTG is needed to create a better understanding of how one can achieve growth after trauma.

While the literature above focused on the presence of psychological distress, some literature has emphasized that rather, it is the centrality of the event to one's identity that serves as the stimulus for growth from it (Barton, Boals, & Knowels, 2013; Boals & Schuettler, 2011). Centrality of a traumatic event is defined as the degree to which an individual believes a negative event has become a core part of their identity (Boals, 2010). Centrality of event has been found to be a unique predictor of both posttraumatic distress and PTG, leading some to refer to the concept as a "double edged sword" for both debilitation and growth after trauma (Boals &

Schuettler, 2011; Groleau, Calhoun, Cann, & Tedeschi, 2013). This relationship has not yet been explored in survivors of campus sexual assault, however, and could prove to be a key variable when trying to understand one's trauma history due to the critical developmental stage many of our participants are in, forming both their personal and intimate identities as they heal from their traumatic experiences (Erikson, 1994). Because of this, we hypothesize that one's trauma history and the impact of their most traumatic USE will form a cluster which will significantly predict PTG over mental health symptoms alone.

The Current Study. Conflicting data on the relationship between mental health symptoms and PTG in sexual violence populations suggests a need for clarity about whether one's mental health influences their ability to achieve positive change after USEs. Relatedly, to our knowledge, no literature to date has explored the interrelationships among childhood trauma, sexual victimization history, and centrality of one's most traumatic sexual violence event to examine if these can add predictive variance to PTG beyond mental health symptoms alone. Finally, this research extends our previous qualitative findings that societal values and expectations, social responses to gender-based violence, and the normalization of violence influences survivor's internal processing (i.e., shame, self-blame) and resulting healing after gender-based violence, by quantitatively measuring relationships between internalization of perceived peer rape myth acceptance, trauma-related shame, and PTG (Sinko & Saint Arnault, in press; Sinko, Burns, O'Halloran, & Saint Arnault, 2019).

The aims of this study are:

1. Evaluate the mediating role of trauma-related shame on the relationship between perceived peer rape myth acceptance and PTG among a sample of female survivors of undergraduate USEs (n=174). We hypothesize that relationships between perceived peer

rape myth acceptance and PTG would be mediated or partially mediated by trauma-related shame.

2. Evaluate the shared and independent contributions of mental health symptoms and trauma history clusters on PTG among a sample of female survivors of undergraduate USEs (n=151). We hypothesize that the extent of one's childhood trauma, sexual victimization history, and centrality of one's most serious sexual violence event (trauma history cluster), would add significant predictive variance as a whole, beyond mental health symptoms, to PTG in female survivors of undergraduate USEs.

Methods

Design. This study used an observational cross sectional design. Eligibility for this study included self-identifying as female, self-identifying as having had an USE as an undergraduate college student, and being currently or previously enrolled in an undergraduate program. Exclusion criteria included graduating from one's undergraduate program over five years ago, those who had an USE during a time before or after their undergraduate career, and those who self-identified as any gender other than female.

Measures. Demographic and Participant Background Questionnaire consisted of five-items to gather information regarding the participants' age, ethnicity, educational-level, gender-identity, and sexual orientation for the purpose of describing the sample.

Mental Health Symptoms consisted of posttraumatic stress disorder, depression, anxiety, and somatic symptoms. *Posttraumatic Stress Disorder symptoms* were assessed with the PTSD Checklist for the DSM V (PCL-5; Weathers, Litz, Palmieri, Marx, & Schnurr, 2013). Response options are on a 5-point Likert scale (anchors: 0 = 'not at all', 4 = 'extremely'). A total symptom severity score was obtained by summing participants' responses to the 20 items. A score of 33 is the current clinical cut-point score as recommended by The National Center for

PTSD (Weathers, Litz, Palmieri, Marx, & Schnurr, 2013). The PCL-5 has excellent psychometric properties (e.g., test-retest reliability, internal consistency, convergent and discriminant validity; Blevins, Weathers, Davis, Witte, & Domino, 2015). Cronbach's alpha for the present study was 0.95. *Depression Symptoms* were measured by the Patient Health Questionaire-8 (PHQ-8; Kroenke, Strine, Spitzer, Williams, Berry, & Mokdad, 2009). The PHQ-8 is an eight-item, self-administered scale that is based on DSM-IV diagnostic criteria, identical to the PHQ-9 without the suicide item. Each item is scored on a four-point scale with responses ranging from not at all to nearly every day. A PHQ-8 score of 10 or more has been found to have 88% sensitivity and 88% specificity for diagnosis of major depression based on clinical interview (Kroenke, Strine, Spitzer, Williams, Berry, & Mokdad, 2009). Superior criterion validity of the PHQ-8 compared to other established self-report questionnaires was confirmed with respect to the diagnoses of "major depressive disorder" and "other depressive disorders" made by a standard interview in assessing psychiatric disorders (Löwe, et al., 2004). Cronbach's alpha for the present study was 0.87. *Anxiety Symptoms* were measured by the Generalized Anxiety Disorder-7 (Spitzer, Kroenke, Williams, & Löwe, 2006). The response options of the GAD- 7 items are identical to the PHQ-8 and range from 0 to 21, with scores of ≥5, ≥10 and ≥15 representing mild, moderate and severe anxiety symptom levels, respectively (Spitzer, Kroenke, Williams, & Löwe, 2006). Good internal consistency and test–retest reliability as well as convergent, construct, criterion, procedural and factorial validity was found for the diagnosis of Generalized Anxiety Disorder (Kroenke, Spitzer, Williams, Monahan, & Lowe, 2007; Spitzer, Kroenke, Williams, & Löwe, 2006). The GAD-7 also has good sensitivity and specificity for the three other anxiety disorders that most often present clinically in primary care — panic disorder, social anxiety disorder, and posttraumatic stress disorder (Kroenke, Spitzer, Williams, Monahan, & Lowe, 2007). Cronbach's alpha for the present study was 0.90. *Somatic Symptoms*

were measured by the Patient Health Questionaire-15 (PHQ-15; Kroenke, Spitzer, & Williams, 2002). The PHQ-15 is a 15-item scale consisting of 15 somatic symptoms, including 10 of the diagnostic symptoms of DSM-IV somatization disorder. The PHQ-15 scores somatic symptoms as 0 (not bothered at all), 1 (bothered a little), or 2 (bothered a lot). A total sum of ≥15 indicates high somatic symptom severity based on data from primary care settings (Kroenke, Spitzer, & Williams, 2002). The PHQ-15 has high internal reliability and convergent and discriminant validity (PHQ-15; Kroenke, Spitzer, & Williams, 2002). Cronbach's alpha for the present study was 0.79.

Trauma History consisted of one's history of childhood trauma, and undergraduate sexual violence victimization. *Childhood trauma* was measured by the Adverse Childhood Experiences Questionnaire (ACE; Felitti, Anda, Nordenberg, Williamson, Spitz, Edwards, & Marks, 1998). The ACE consists of 10 items inquiring about different adverse childhood experiences including abuse, neglect, mental illness or substance abuse by family members, and family dysfunction. This has been shown to be reliable and has been validated in prior research (Edwards, Holden, Felitti, & Anda, 2003; Chapman, Whitfield, Felitti, Dube, Edwards, & Anda, 2004). Cronbach's alpha for the present study was 0.76. *Undergraduate Sexual Violence Victimization History* was assessed by asking about the number of unwanted sexual contact experiences using behaviorally specific questions (e.g. *During your time as an undergraduate, how many times has someone had sexual contact with you when you didn't want to?*) and unwanted sexual intercourse experiences (e.g *During your time as an undergraduate, how many times has someone had sexual intercourse with you when you didn't want to?*) occurring throughout the participant's undergraduate careers (Walsh, Keyes, Koenen, & Hasin, 2015). Participants answered on a five-point Likert scale consisting of 0 - "never," 1 - "1-2 times," 2 - "3-5 times", 3 - "6-9 times", and 4 - "ten or more times" for both questions. Participants were

able to choose "do not want to say" if desired which was treated as missing data. *Impact of Trauma* was assessed in reference to one's most distressing USE by the Centrality of Events Scale- Short Form (Berntsen & Rubin, 2006). This scale has been utilized to measure the integration of trauma into one's identity, consisting of questions pertaining to trauma as a reference point for everyday memories, trauma as a turning point in one's life story, and trauma as a key component of one's personal identity. The short form is a 7-item scale that has been shown to be reliable and valid in trauma populations (α=.88). Cronbach's alpha in the present study was 0.93.

Mediation Variables consisted of perceived rape myth acceptance, trauma-related shame, and posttraumatic growth. *Perceived Peer Rape Myth Acceptance* was the predictor of our mediation model, assessed using a modified version of the Subtle Rape Myths Scale based on the Illinois Rape Myth Acceptance Scale (IRMA; Payne, Lonsway, & Fitzgerald, 1999; McMahon & Farmer, 2011). Participants were asked to answer this 22-item scale in reference to the degree to which they believed the average student at their undergraduate university would agree with the listed subtle rape myth statement. Responses were scored on a five-point Likert scale ranging from 1 "strongly agree" to 5 "strongly disagree. McMahon & Farmer (2011) updated this measure based on focus group data and a survey to capture subtle rape myths, showing good reliability and validity when psychometrically tested (McMahon & Farmer, 2011). Cronbach's alpha for the present study was 0.97. *Trauma-related Shame* was the proposed mediator, evaluated by the Trauma Related Shame Inventory (Øktedalen, Hagtvet, Hoffart, Langkaas, & Smucker, 2014*).* This scale is a 24-item version of internal- and external-referenced shame used in this study in reference to one's most distressing undergraduate USE. Responses were scored on a four-point Likert scale from 0 "not true of me" to 3 "completely true of me." This scale has demonstrated reliablility and validity with multivariate

generalizability analyses revealing strong positive correlations among the components of shame to include condemnation and affective-behavioral components for internal- and external-referenced shame (Øktedalen, Hagtvet, Hoffart, Langkaas, & Smucker, 2014). Cronbach's alpha for the present study was 0.96. *Posttraumatic growth* was our proposed outcome measure, measured by the Posttraumatic Growth Inventory (PTGI), a 21-item self-report instrument used for assessing psychological growth following a traumatic event (Tedeschi & Calhoun, 1996). The PTGI includes factors of New Possibilities (e.g., "Established a new path for my life"), Relating to Others (e.g., "A sense of closeness with others"), Personal Strength (e.g., "Knowing I can handle difficulties"), Spiritual Change (e.g., "I have a stronger religious faith"), and Appreciation for Life ("Appreciating each day"). Participants of this study were asked to indicate the degree to which this change occurred in their life for each statement since their *most distressing* or *traumatic* USE as an undergraduate. Scores on the PTGI range from 1 to 126, with higher scores reflecting greater perceived growth. Items on the PTGI range from 1 ("I did not experience this change as a result of my crisis") to 6 ("I experienced this change to a very great degree as a result of my crisis"). Tedeschi and Calhoun 1996 reported a Cronbach's alpha of 0.90 for the global score. Cronbach's alphas for the five factor scores ranged from 0.67-0.85. The global test-retest reliability over a 2-month period was 0.71 (Tedeschi & Calhoun, 1996). Cronbach's alpha for the present study was 0.90.

Procedures. This study was approved by the University of Michigan Health Sciences and Behavioral Sciences IRB (HUM00144780). Study participants were invited to enroll in this study through a listserv email sent out by a Southeastern Michigan university sexual assault center to their student volunteers, ally subscribers, and alumni group. Participants were also recruited by a health research portal through a Southeastern Michigan university health system, designed to connect individuals who have utilized their health care system's services to identify

potential research opportunities. Interested participants were informed that participation would be voluntary and anonymous and that they would receive a $10 gift card upon completion of the survey if they provided a mailing address on a separate survey, not linked to their data. Participants then completed a survey containing a variety of self-report questionnaires. Participation time was approximately 30 minutes for the total 83 items. The survey was sent out through the university sexual assault center in two waves, one in May 2018 at the end of the winter academic year as well as one in July 2018 at the end of the spring academic year to attempt to gather both "early responders" and "late responders," who may possibly differ in where they were in their healing process.

Statistical Analysis. Stata statistical software (v15.1) was used for all statistical tests (StataCorp, 2017); all p-values were set at .05. Scale scores were calculated for outcome and predictor measures as directed in the literature. Some scale scores required transformations prior to hypothesis testing to correct for statistical assumptions; specific details are provided below. Nine participants stopped completing the survey after the demographic information and were thus dropped from our analysis sample. Most of our subjects completed all items per scale (83%); however, a small percentage of subjects skipped one or more individual questions that would be necessary to calculate scale scores (2%). Any subject who answered less than 80% of the questions for any given scale was considered "missing" and their data did not inform our analyses (n=22). For subjects who skipped one or more questions per scale-score, but <80% of the items per scale-score, we used mean substitution of the available within-scale items when calculating their total scale-score.

We performed two types of statistical analyses to address the main research hypotheses. First, a three-step statistical approach delineated by Baron and Kenny (1986) was used to examine the mediating effects of trauma-related shame on the relationship between perceived

peer rape myth acceptance and PTG (See Figure 1). Consistent with Baron and Kenny, we tested for mediation by regressing trauma-related shame on rape myth acceptance scale scores (Figure 1, path a), and by regressing PTG on trauma-related shame scores and perceived peer myth acceptance (Figure 1, paths b and c'). Trauma-related shame would be shown to be a fully mediating variable in our study if the regression coefficients for paths a and b (Figure 1) were significant, but the direct path between rape myth acceptance and PTG, path c', were non-significant. Trauma-related shame would be revealed as a partially mediating variable if all three paths were significant (Figure 1). Non-mediation would be revealed if paths a or b were not significant.

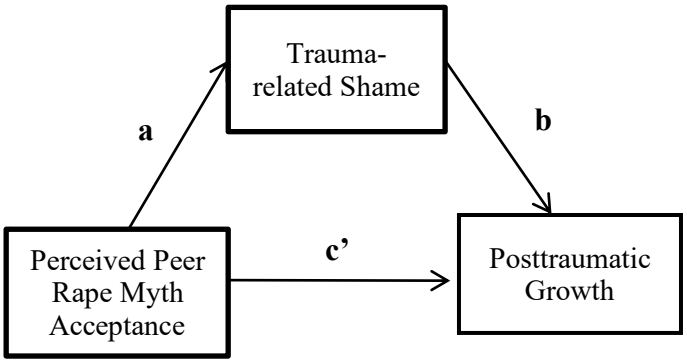

Figure 1: Proposed Mediation Pathways

For our second aim of evaluating the independent and shared variance contributions of mental health symptoms and trauma history on PTG, we regressed PTG on these predictors using block OLS (hierarchical) regression with squared semi-partial correlation coefficients ($_sr^2$; See Figure 2). More specifically, three blocks of predictors were formed. The first block included participant demographic variables (e.g., age, race, student status, sexual orientation). This block was the first to be entered into the regression analysis. The second block contained a suite of mental health

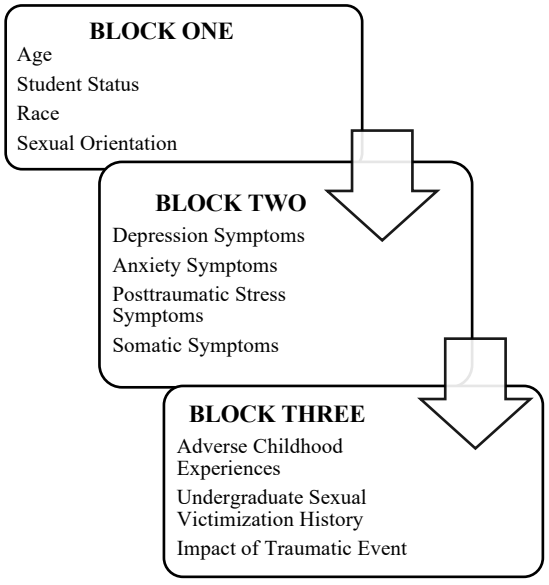

Figure 2: Proposed Block Predictor Clusters

symptom predictors (e.g., depression, anxiety, PTSD, somatic symptoms) hypothesized to be predictive of PTG. The third block contained several trauma history predictors (e.g., adverse childhood experiences history, undergraduate sexual contact victimization history, undergraduate sexual intercourse victimization history, impact of sexual victimization history) believed to further contribute to PTG. In this way, it was possible to measure the extent to which the variance in participants' PTG could be attributed to the main independent variables of the study (i.e., the third block of predictors), over and above the variance that can be explained by their mental health symptoms (block 2) and sociodemographic characteristics (block 1). Given significant contributions of each block over the prior, we then evaluated the independent variance contributions after removing shared covariances with other predictors by calculating the squared semi-partial correlation coefficients associated with each predictor in the full model.

Results

Participants. Two-hundred and six women ranging in age from 18-30 years old (M=21.9, SD=2.54) responded to our survey. Fifty-eight percent of women were current undergraduate students (n=93), with 41% of our sample being alumni who graduated from a four-year institution up to five years prior to the survey (n=63). Eighty-three percent identified as Caucasian, 5% identified as African American or Black, 9% identified as Asian, and 4% identified as a mix of two or more races (See Table 1 for details).

Table 1: Survey Demographic Characteristics

Age	*N=156*	**Childhood GBV Trauma**	*N=156*
18-21	81 (52%)	Physical or Emotional Abuse	57 (37%)
22-25	59 (38%)	Sexual Abuse	21 (14%)
26-30	16 (10%)	Witnessed Domestic Violence	26 (17%)
Race		**Unwanted Sexual Contact History**	
Caucasian	129 (83%)	Never	2 (1%)
African American or Black	7 (5%)	1-2 times	75 (48%)
Asian	14 (9%)	3-5 times	58 (37%)
Mixed	6 (4%)	More than 6 times	21 (14%)
Sexual Orientation		**Unwanted Sexual Intercourse History**	
Heterosexual	119 (76%)	Never	44 (28%)
Homosexual	3 (2%)	1-2 times	96 (62%)
Bisexual	23 (15%)	3-5 times	9 (6%)
Other	11 (7%)	More than 6 times	7 (5%)

Data Preparation. Prior to hypothesis testing, we tested all model assumptions associated with our proposed analytic methods by examining model residuals for normality, linearity, homogeneity of variance of effects parameters, and overly influential outliers. In doing so, it was discovered that the residuals of our outcome of PTG (M=48.2, SD=19.4) and mediator of trauma-related shame (M=18.3, SD=16.9) were skewed to the left, violating normality assumptions for regression residuals, and possibly indicating a non-linear relationship. Data transformations (e.g., natural log of outcome and square root of mediator) were used to correct

for these assumption violations. Residual distributions following these transformations were satisfactorily normal, with no indications of additional model modifications necessary. For our mediation and block regression analyses, 174 and 156 women respectively were considered for analysis due to completeness of their data. In our block regression sample, five overly influential outliers were identified, with standardized residuals exceeding 2 standard deviations of the mean. These observations were overly influential and therefore eliminated from our hypothesis testing of Aim 2.

Mediating Role of Trauma-related Shame (Aim 1). In order to test the hypothesis that trauma related shame mediated the relationship between rape myth acceptance and PTG, mediation analysis was conducted according to Baron and Kenny (1986).

Trauma-related shame (*M*=18.3, *SD*=16.9) and perceived peer rape myth acceptance (*M*=83.7, *SD*=23.9) were found to not be significant predictors of PTG (*M*=48.18, *SD*=19.4) in this sample (*p*=.38, *p*=.49 respectively). Perceived peer rape myth acceptance was also not significantly predictive of trauma-related shame (*p*=.46). These results are not supportive of our full or partial mediation hypothesis (Aim 1) per Baron and Kenny's (1986) methodology (see Figure 3).

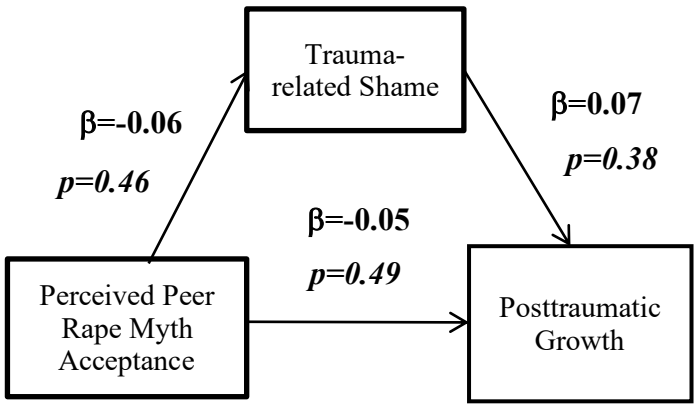

Figure 3: Mediation Results

Contributions of Mental Health and Trauma History on Posttraumatic Growth (Aim 2). Sixty-one participants (30%) of our sample had clinically relevant depression scores (PHQ-8 >9), 30 participants (15%) had clinically relevant "severe" anxiety scores (GAD-7 >14), and 73 participants (37%) had clinically relevant PTSD scores (PCL-5 >32). Sixty-nine percent

of our sample had at least one unwanted sexual intercourse experience. Fifty-one participants indicated that they had experienced four or more ACEs, classifying them as "high risk." Means, standard deviations, and correlations of predictor variables can be found in Table 2.

Table 2: Mean, Standard Deviations, and Correlations among Key Block 2 and 3 Regression Variables

	N=151		Mental Health Status (Block 2)				Trauma History (Block 3)			
	Variables	*M* (*SD*)	PCL	Dep.	Anx.	Som.	IOE	ACE	USI	USC
	PTG	45.13 (16.29)	.24	.05	.15	.21*	.37*	.18*	.12	-.01
Mental Health Status (Block 2)	PTSD	27.28 (18.19)		.79*	.73*	.60*	.53*	.36*	.15	.21*
	Dep.	8.23 (5.30)			.72*	.66*	.35*	.33*	.14	.17
	Anx.	8.15 (5.44)				.62*	.34*	.33*	.10	.11
	Som.	8.86 (5.25)					.31*	.36*	.11	.08
Trauma History (Block 3)	IOE	21.53 (7.78)						.18*	.32*	.19
	ACE	2.32 (2.26)							.14	.08
	#USI	0.91 (0.83)								.48
	#USC	1.72 (0.93)								

PTG = posttraumatic growth; our primary outcome. PCL= posttraumatic stress symptoms. Dep=depression symptoms. Anx.=anxiety symptoms. Som.= somatic symptoms. IOE = impact of victimization events. ACE= Adverse Childhood Experiences. USI= Number of unwanted sexual intercourse experiences. USC= Number of unwanted sexual contact experiences. *=Significant at <.05 level

Clustered variance contributions on posttraumatic growth are reflected in Table 3. We found evidence supporting our hypothesis that mental health predictors contribute significantly to an understanding of PTG beyond demographics alone (an increase in model R^2 = 14%, p<.001), and that measures of trauma history further increase our understanding of PTG (another increase in model R_2 = 14%, p<.001). Given support for our Aim 2 hypothesis, we calculated the independent variance contributions ($_sr^2$) of individual predictors to the full model as shown in Table 4.

Table 3: Contribution of Each Block Predictor Cluster on Posttraumatic Growth

Block (N=151)	R^2	p-value	R^2 increase	Δ p-value
Block 1	0.08	p=.30	--	--
Block 1+2	0.21	p<.01	0.14	<.001
Block 1+2+3	0.35	p<.01	0.14	<.003

Independent variance contributions were calculated by using squared semi-partial correlation coefficients ($_sr^2$) to evaluate the variance contributions of each demographic variable, mental health predictor, and trauma history predictor individually within the full model, after removing any shared covariance with other predictors.

In our full model including all predictors (R^2=0.35), age was found to have a significant independent contribution to our understanding of PTG (p<.05), contributing to 2% variance of the overall model. Depression symptoms (p<.01) and posttraumatic stress symptoms (p<.05) were also found to be independently related to PTG, contributing 4.4% and 2% variance to the overall model, respectively. Trauma history measures including impact of events (p<.001) and experiencing unwanted sexual contact more than ten times (p<.04) additionally attained independent statistical significance on the outcome of PTG, contributing 8.3% and 2%, respectively to the total variance of the model. All other variables were not found to establish significant independent contributions to the variance of the outcome after removing shared covariance with other predictors.

Table 4: Full Model Regression Results

Y=PTG	Predictor	β	Coef.	SE	p-value	$_sr^2$
Demographics (Block 1)	Age	0.24	.12	0.06	.047*	0.021
	Student Status					
	Current Undergraduate (reference)	--	--	--	--	--
	Alumni	0.11	.28	0.30	.356	0.00
	Race					
	Caucasian (reference)	--	--	--	--	--
	African American or Black	-0.05	-0.31	0.46	.509	0.002
	Asian	-0.09	-0.38	0.34	.274	0.006
	Mixed	-0.06	-0.40	0.51	.432	0.003
	Orientation					
	Heterosexual (reference)	--	--	--	--	--
	Homosexual	-0.06	-0.53	0.65	.418	0.003
	Bisexual	0.01	0.03	0.28	.903	0.000
	Other	0.16	0.76	0.38	.050	0.020
Mental Health Status (Block 2)	PTSD	0.32	0.21	0.01	.049*	0.021
	Depression	-0.42	-0.09	0.03	.004*	0.044
	Anxiety	-0.02	-0.01	0.03	.840	0.000
	Somatic Symptoms	0.11	0.03	0.02	.292	0.006
Trauma History (Block 3)	Adverse Childhood Experiences	0.11	0.06	0.05	0.224	0.008
	Unwanted Sexual Contact					
	Never	--	--	--	--	--
	1-2 times	-0.56	-1.34	0.84	.114	0.013
	3-5 times	-0.54	-1.35	0.84	.112	0.013
	6-9 times	-0.22	-1.12	0.91	.222	0.008
	10 or more times	-0.41	-1.91	0.90	.037	0.023
	Unwanted Sexual Intercourse					
	Never	--	--	--	--	--
	1-2 times	-0.00	-0.00	0.21	.993	0.000
	3-5 times	0.09	0.46	0.44	303	0.006
	6-9 times	-0.07	-0.73	0.89	.415	0.004
	10 or more times	-0.05	0.37	0.64	.570	0.002
	Impact of Sexual Victimization	0.38	0.06	1.7	.032*	0.084

Discussion

The present study investigated the potential mediating role of trauma-related shame on the relationship between perceived peer rape myth acceptance and PTG in this sample of female survivors of undergraduate USEs. This study also examined the shared and independent variance contributions of mental health status and trauma history clusters on PTG in survivors of undergraduate USEs. Results showed that trauma-related shame did not mediate the relationship between perceived peer rape myth acceptance and PTG, with perceived peer rape myth acceptance not being significantly related to PTG. We did find, however, that mental health symptoms significantly contributed to the variance in PTG scale scores, above demographics alone, in our sample. Trauma history (e.g., adverse childhood experiences, number of undergraduate unwanted sexual intercourse and contact experiences, impact of sexual victimization) added additional significance to this model, leading the model as a whole to account for 35.27% of the variance of PTG.

Our finding that perceived peer rape myth acceptance was not significantly related to trauma-related shame or PTG was surprising, as many studies have suggested the important influence of peer beliefs on college student adjustment, behavior, and wellbeing (Astin, 1993; Borsari & Carey, 2001; Mutterperl & Sanderson, 2002; Paul, Gray, Elhai, & Davis, 2009). From an ecological perspective, the attitudes and values of the community as a whole should have significant bearing on recovery and growth after trauma (Kelly, Ryan, Altman, & Stelzner, 2000), leading us to expect that if survivors feel that their peers hold high victim-blaming beliefs, they would feel higher shame and be less likely to disclose their experiences or seek professional help (Sable, Danis, Mauzy, & Gallagher, 2006). Relatedly, research has shown that women often internalize societal rape myths, leading to negative self-appraisals (Campbell, Dworkin, & Cabral, 2009; Neville & Heppner, 1999; Neville, Heppner, Oh, Spanierman, & Clark, 2004;

Ward, 1995). This pattern of behavior, reinforced by the normalization of violence within one's environment, could have significant impact on self-blame, posttrauma symptomology, and resulting growth (Andrews, Brewin, Rose, & Kirk, 2000; Campbell, Dworkin, & Cabral, 2009). This idea has been supported by another study of campus survivors of sexual violence, finding that estimated peer rape myth acceptance was significantly correlated with posttraumatic stress symptom burden ($p<.01$), with a medium effect size (Paul, Gray, Elhai, & Davis, 2009). Because survivors of sexual assault are at great risk of having avoidant coping strategies, high levels of psychological distress, and self-isolation (Ullman, 1996), it was surprising that although our sample estimated that their peers held high rape myths ($M=83.7$), their trauma-related shame and PTG appeared unaffected by this perception. Other additional rationale for this disconnect could be that the relationship between variables was obscured by the variance accounted for by personal rape myth acceptance attitudes or other, untested variables (e.g., attributional style, disclosure) not accounted for in this study.

Overall, the seemingly insignificant impact of high perceived peer rape myth acceptance attitudes, points to a need for a better measure to assess the normalization of violence in one's socio-cultural environment. We know that sexual assault does not occur in social and cultural isolation, yet quantitative research on sexual violence has yet to take fully into account how the rape-prone culture in which we live not only tolerates male violence against women but also negatively impacts healing and recovery after sexual violence (Campbell, Dworkin, & Cabral, 2009; Rozee & Koss, 2001). Qualitatively, survivors of sexual violence have frequently mentioned how the normalization of violence within their environment and observed rape-prone attitudes of others significantly impacts mental health symptoms, labeling, meaning-making, and healing after sexual violence (Harned, 2005; Saint Arnault & O'Halloran, 2016, Sinko & Saint Arnault, in press; Sinko, Burns, & Saint Arnault, in press, Ullman, 2010). For example, one

qualitative study found that survivors of date/partner rape blamed themselves after their assault because their experiences did not fit the typical rape stereotype (i.e., violent stranger rape; Harned, 2005). Relatedly, a qualitative review found the importance of relating to others and feeling safe as important benchmarks in their trauma recovery process, revealing the significance of one's interaction with their social environment in their recovery journey (Draucker et al., 2009). Quantitatively, estimated peer rape myth acceptance has been found to be significantly related to disclosure and posttraumatic symptomology, which although seemingly paradoxical on the surface, may indicate that negative disclosure responses from others reinforce negative peer beliefs and posttrauma symptomology (Paul, Gray, Elhai, & Davis, 2009; Ullman, 2000). Ultimately, in order to move the state of the science forward for this population, better assessment of the beliefs and attitudes within one's environment is critical, to understand important influences to growth and recovery in one's social and cultural environment.

Our finding that clustered mental health symptom predictors significantly contributed to the variance of PTG adds to the conflicting scientific literature supporting the relationship between PTG and distress symptomology in survivors of sexual violence. For example, Kleim and Ehlers (2009) also found that higher PTG levels were associated with greater posttraumatic stress disorder and depression symptom severity in survivors of sexual assault, but these authors found positive relationships between both concepts, where we found a negative relationship between depression symptom severity and PTG, but a positive relationship with posttraumatic stress symptom severity and PTG. In contrast, however, some studies have concluded that PTG is not related to psychological distress at all (Grubaugh & Resick, 2007), while others have found a negative relationship between both concepts (e.g., Frazier, Conlon, & Glaser, 2001). This study adds to the literature on this debate, by supporting the negative and positive relationships respectively between depression and posttraumatic stress symptoms on PTG,

potentially indicating that posttraumatic distress could in fact act as a motivator for future growth and healing, while depression symptomology could hinder one's ability to recognize growth.

Our findings could be explained by the way in which depression symptoms manifest within individuals and impact their ability to cope after traumatic experiences. For example, response styles theory, a theory developed from the depression literature, suggests that self-focused rumination in reaction to a depressed mood may increase negative cognitions (Nolen-Hoeksema, 1991; Shigemoto, Low, Borowa, & Robitschek, 2017). Relatedly, brooding rumination, defined as a passive comparison of one's current situation with some unachieved standard (Treynor, Gonzalez, & Nolen-Hoeksema, 2003), is a construct frequently cited as a manifestation of depression and has been found to uniquely negatively predict PTG compared to other rumination styles (Cann, Calhoun, Tedeschi, Triplett, Vishnevsky, & Lindstrom, 2011; Stockton, Hunt, & Joseph, 2011). Future research is needed to further explore specific adverse mental health symptomology beyond the simple notion of "distress" to fully understand the relationship between PTG and psychiatric symptoms.

Recognizing the significance of one's current mental health symptom burden as it relates to PTG can be comforting for mental health professionals who feel a lack of confidence in their ability to help patients process their trauma after sexual violence (Day, Thurlow, & Woolliscroft, 2003). These findings reveal that focusing on one's current mental health symptoms and stressors is an important first step in empowering patients to grow and heal after sexual violence. Teaching strategies to manage one's depression symptom burden are within many mental health professional's scope of practice and skillset, empowering providers to lay the foundation for future growth after sexual violence by teaching patients these skills. Relatedly, these results indicate that positive and negative post-trauma outcomes can co-occur, highlighting the continued importance of broadening our focus as clinicians beyond distress symptomology, even

in our most distressed patients, to ensure we are properly addressing and fostering growth in this population.

Our finding that trauma history added additional significance, beyond mental health status, to PTG scores highlights the additional importance of understanding one's trauma history in order to foster growth and healing after sexual violence. Although the nuances of one's sexual victimization and adverse childhood experiences history have not been looked at in survivors of sexual assault directly prior to this study, a study conducted by Shakespeare-Finch and Armstrong in 2010 revealed that sexual assault survivors had significantly higher PTSD levels and greater difficulties relating to others and appreciating life when compared to survivors of motor vehicle accidents and those in bereavement, indicating that trauma history does matter when we are trying to understand PTG. Unfortunately, although the Adverse Childhood Experiences Questionnaire (ACE-Q) used in this study has been used widely in the scientific literature, recent critiques have argued that this particular measure may be problematic as it does not encompass many of the typical traumatic experiences individuals could go through (e.g. bulling, death of a parent, foster care, etc.) and makes equivalent vastly different trauma experiences. This is important to consider when interpreting the present study's results, as many of our participants may have had traumatic experiences that were not accounted for in the ACE-Q. The present study adds additional insight to this phenomenon, as the impact of one's sexual victimization was found to significantly contribute to one's PTG both independently and within the trauma history cluster. This finding points to the need for clinicians to ensure that they are using trauma-informed care and are defining and assessing for trauma beyond merely the presence of traumatic events themselves, as in the ACE-Q, but also how a person perceives that they have been impacted by their traumatic history. This supports the Substance Abuse and

Mental Health Service Administration's (2014) working definition of trauma, citing it as not only the event itself, but also about how one experiences and is effected by the event.

Notably, the centrality of one's most traumatic undergraduate USE was the most significant predictor of PTG, uniquely accounting for 8.4% of the total PTG variance. This significant relationship has been found elsewhere in the scientific literature, (Boals & Schuettler, 2011; Groleau, Calhoun, Cann, & Tedeschi, 2013); however, this study was the first we are aware of to discover the unique contribution of trauma impact beyond one's existing mental health symptomology in this population. This is an important distinction to make, as many trauma assessments focus on the number of events or type of trauma experienced, not how central this trauma is to the survivor's identity (e.g., Felitti et al., 1998; Hooper, Stockton, Krupnick, & Green, 2011). Assessing for the centrality of one's trauma in the healthcare setting may promote greater understanding to how relevant one's current mental health symptom burden is to their trauma history, while providing unique information when attempting to predict PTG.

It is also important to note, that the concept of PTG, as it is phrased in Tedeschi and Calhoun's (1996) inventory, may be problematic for sexual violence survivors, indicated by the low levels of growth found in our study sample (M=48.2). Although the captured domains of changes in the perception of the self, changes in the experience of relationships with others, and changes in one's general philosophy of life seem valid in this population (Sinko & Saint Arnault, in press), the concept of PTG states that one experiences such positive changes as a result of their crisis, rather than as a result of personal efforts towards healing and recovery (Tedeschi & Calhoun, 1996). This language may disempower sexual violence survivors and be difficult for them to relate to, as attributing positive changes due to merely experiencing trauma itself, may not give justice to the work and effort many women put into their healing journeys. Relatedly, direct threat to personal physical integrity and the fact that sexual assault is a trauma that is

intentionally perpetrated by another person, may add another dimension to the trauma experience (Shakespeare-Finch & De Dassel, 2009), highlighting the caution that needs to be taken when discussing delicate topics such as sexual violence healing. It is our suggestion that reevaluation is needed to make this measure more relevant for survivors of interpersonal trauma, potentially by changing the stem to attribute growth to one's healing and help-seeking actions, rather than directly to the experience of trauma itself.

This study has several factors that limit the generalizability of the findings, including the Midwestern location of our recruitment site, our cross-sectional design, our primarily Caucasian sample, and the potential presence of self-selection bias, as those who agreed to participate in this study may be at different places in their healing compared to those who chose not to participate. Despite the present study's limitations, this study was the first to our knowledge that attempted to understand the relationship between clustered mental health symptom predictors, clustered trauma history predictors, and PTG in female survivors of undergraduate USEs. The new knowledge created by this study highlights the complexity of understanding PTG in this population, as well as highlights two important areas for clinicians to focus on (current mental health symptoms and trauma impact) when they are working with survivors of campus sexual trauma. Relatedly, the discussion of these results highlight potential measurement issues and direct us to key areas for future psychometric development and clarification to better understand healing after campus sexual violence. Finally, these results provide hope for survivors with complex victimization histories and high mental health symptom burden, as these survivors may have the greatest capacity for healing and growth. Future research should further explore the influence of one's environment on PTG to guide us in the direction of what environmental interventions may be effective to promote and support healing in this population. By understanding what individual processes and socio-contextual factors influence survivors healing

and growth processes after campus USEs, campus service providers can feel better prepared to assess for and support healing in this population.

Chapter III Understanding the Trauma Healing Process of Campus Survivors of Unwanted Sexual Experiences

Introduction

Campus sexual violence has been a topic of increasing public discourse within the past few years, bringing with it the awareness of not only the high number of young adult female survivors who are both within our university institutions and within our general society, but also the need for a better service infrastructure to support recovery for those whose lives have been impacted by this public health issue. In 2015, 27 universities participated in one of the largest studies ever on sexual assault and sexual misconduct, revealing that 23.1% of females, compared to 5.4% of males, experienced rape or sexual assault through physical force, violence, or incapacitation (Cantor et al., 2015).The Bureau of Justice statistics recently conducted an additional campus climate validation study among nine universities, finding similar rates that 20.5% of women within their sample had been impacted by sexual violence at some point during their college careers (Krebs et al., 2007).

Women exist in complex socio-cultural environments that may explain the perpetuation of violence against them, impacting their ability to heal and grow after sexual violence. For example, early research in this area has argued that widespread violence defies individualistic explanations (French, 1993; West, 1995), and only exists if it is legitimized by social discourse (Cuklanz, 1996; Meyers, 1997; Wood, 2001). In the larger Western culture, this appears to be the case, as dominance and superiority for men and deference and dependence for women is frequently normalized, being legitimized through romance narratives to help people make sense of violence within and outside of relationships (Wood, 2001). Relatedly, there is a body of

research that suggests that firm adherence to Western masculine norms may increase the likelihood of perpetrating violence (Kilmartin & McDermott, 2016), and that references to cultural beliefs about violence in America tend to focus on gender norms related to masculinity and power (Sinko, Burns, O'Halloran, & Saint Arnault, 2019). For example, historically mass media has often perpetuated stereotypical gendered norms of male aggression, depicting men having strong sexual needs and desires, while women are often portrayed as interpreting sex as part of love and commitment, with expectations of sexual passivity (Byers, 1996). We hypothesize that these images can be internalized, and have profound implications for the tolerance of violence within our society as well as great bearing on survivors recovery processes. This study will therefore explore the influence of one's social context and resulting internal dialogue on survivor healing goals following undergraduate USEs.

On college campuses specifically, literature to date has pointed to circumstances unique to the college experience that explain the high incidence of violence against women, including a growing conceptualization of a 'rape culture,' defined as an environment in which sexual assault and date rape are tolerated as part of campus life, often causing sexually aggressive behaviors to be normalized within the social milieu (Burnett et al., 2009). Other hypothesized influencing factors include risks stemming from the presence of gender-segregated spaces (e.g. dorms, athletics, and fraternities) as well as social rules and power dynamics associated with 'hook up' experiences (Boeringer, 1999; DeSantis, 2007; Foubert, Garner, & Thaxer, 2006; Garcia, Reiber, Massey & Merriwether, 2012; Sharp, Weaver, & Zvonkovic, 2017). In particular, the presence of unsupervised parties that revolve around substance use, binge drinking, and hooking up, create environments that put women at an even greater risk for sexual victimization due to vulnerabilities associated with intoxication as well as heightened levels of rape-prone attitudes, traditional gender beliefs, and perceived peer support of sexual aggression in these settings

(Bleecker & Murnen, 2005; Boyle & Walker, 2016; Fink, 2010; Humphrey & Kahn, 2000; Murnen & Kohlman, 2007).

Little is known about how university sexual violence resources affect the trauma healing process, with the majority of the literature focusing on reporting rates. Emerging research, however, highlights the potential importance of providing trauma-informed services on campus, as insensitive reactions to disclosure may heighten the traumatic response of survivors (Smith & Freyd, 2013) whereas more positive reactions can promote healing (Ullman & Peter-Hagene, 2014). For example, a 2016 study revealed that women attending colleges with higher levels of sexual violence resources had better emotional health compared to those attending colleges with lower resource levels (Eisenberg, Lust, Hannan, & Porta, 2016). This study, however, failed to mention the individual and socio-cultural factors that may impact the use of these resources (Eisenberg, Lust, Hannan, & Porta, 2016). This is important to understand, as disclosure rates in this population are alarmingly low, with one systematic review finding that survivor disclosure of sexual violence to campus resources ranged from 0% to 15%, and service use ranged from 3% to 20% (Sabina & Ho, 2014). Because of this, additional research is needed to further understand what survivor's healing needs are outside of campus resources, and how one's university environment may influence their ability to seek services or engage in their healing process.

Historically, research on trauma generally has operationalized recovery as relieving posttraumatic stress symptoms which, while useful for focused clinical interventions, often fails to consider the pervasive lingering of shame, self-blame, and mistrust that can persist in the face of symptom relief (Harvey, 1996).The focus on pathologizing feelings can imply that the intensification of symptoms equates to a lack of healing, which may put false pressure on survivors to "move past" their emotions. This is particularly concerning, as one study found that fear of weakness and the need to appear strong created barriers to engaging in the healing

process after GBV (Sinko & Saint Arnault, in press). Nonetheless, these theories have shaped how we have viewed trauma recovery and are critical in understanding positive adaptation after sexual assault. For example, Judith Herman (1997) theorizes that there are three stages of trauma recovery: safety and stabilization, remembrance and mourning, and reconnection and reintegration. Similarly, Taylor (1983) has also examined the process of trauma recovery, proposing a theory of cognitive adaptation, which posits that successful adjustment to stressful life circumstances involves three phases, namely, finding meaning in the experience, regaining mastery over the experience, and restoring one's self-worth. Finally, Harvey (1996) understood recovery from psychological trauma as consisting of authority over the remembering process, integration of memory and affect, affect tolerance, symptom mastery, self-esteem and self-cohesion, safe attachment, and meaning-making.

More recent models concerning responses to traumatic events, and subsequent recovery, highlight the importance of understanding and addressing individuals' negative beliefs and disconnection with oneself, others, and the world (e.g. Ehlers & Clark, 2000; Foa & Rothbaum, 1998; Sinko & Saint Arnault, in press). Supporting and expanding upon these beliefs is the construct of posttraumatic growth (PTG), conceptualized as positive changes being attained by some individuals as a result of their survival of a highly stressful event (Tedeschi & Calhoun, 1996). The literature on PTG has encompassed a variety of traumatic experiences, highlighting the importance of changes in the perception of the self, changes in the experience of relationships with others, and changes in one's general philosophy of life (Tedeschi & Calhoun, 1996). Ultimately, this body of literature indicates that by making meaning out of one's traumatic event, one can overcome initially high levels of psychological distress eventually achieve some sort of growth after their trauma (Tedeschi & Calhoun, 1996).

Despite progress looking at positive growth in trauma survivors, research in posttraumatic growth and trauma recovery has often been generalized to all types of trauma, potentially missing the important nuances associated with sexual trauma specifically. For example, one study revealed that sexual assault survivors had significantly higher PTSD levels and greater difficulties relating to others and appreciating life when compared to survivors of motor vehicle accidents and those in bereavement (Shakespeare-Finch & De Dassel, 2009). The authors conclude that the direct intentionality and threat to personal physical integrity perpetrated by another person, may add another dimension to the trauma experience (Shakespeare-Finch & De Dassel, 2009). This highlights the need to look further into sexual trauma specifically, to identify pertinent barriers and facilitators to personal growth and healing.

Studies that have looked at healing after sexual violence and GBV, though not directly looking at campus survivors of USE specifically, can provide clues as to what this population may find helpful to their healing processes. For example, a qualitative meta-synthesis that focused on sexual violence healing revealed the importance of relating to others, feeling safe, and re-evaluating the self (Draucker et al., 2009). Unfortunately, out of the 51 reports used in this synthesis, only 12 reports stated their purpose was to describe how individuals heal, adapt, or recover from sexual violence, with others focusing on survivor's "lived experience" more broadly (Draucker et al., 2009). A more recent study revealed the importance of reconnection within oneself, others, and the world as foundational to the GBV healing process (Sinko & Saint Arnault, in press). This study looked at GBV survivors generally, however, and did not explore potential developmental and situational differences between participants. Therefore, future research is needed to further understand the trauma healing process after campus USE specifically by asking holistic, survivor-centered questions about healing within this unique

socio-contextual domain, to help improve professional interactions with survivors to promote empowerment and growth in this population.

Taken together, research on the societal context of rape myth culture, hook up expectations, sexual violence recovery, and the unique social milieu indicates the increasing importance of better understanding social and cultural influences of USE and how these elements influence survivor reactions and healing processes. By better articulating specific social-contextual barriers or facilitators to trauma recovery through survivor's voices, interventions can be targeted to create a safer environment for survivors as they navigate the trauma healing process within this university social context.

The purpose of this study is to explore trauma healing among female survivors of campus USEs. Our research will examine the complex relationships among contextual and internal influences to USE healing through the utilization of narrative interviewing, a technique that may be a critical therapeutic gateway to facilitate trauma healing due to its ability to enable people to make sense of their social worlds (Androff, 2012; Saint Arnault, 2017; Wood, 2001). Additionally, we hope to better articulate what survivors want and experience through their healing process, to help point to interventions that can specifically target developmentally relevant healing objectives.

Methods

Study Design and Procedures. This was a qualitative analysis of trauma recovery stories that used narrative interviewing techniques with a convenience sub-sample of women who answered a prior online survey about USEs they had when they were enrolled as an undergraduate. This study was approved by University of Michigan IRB (HUM 00144780). Individuals who were eighteen or older, self-identified as female, self-identified as having had an "unwanted sexual experience while enrolled as an undergraduate," and who were currently

enrolled in an undergraduate program or graduated from one within five year prior to completion of the survey were eligible to enroll in the study. In order to recruit these women, an email link to a survey was sent out through a Southeastern Michigan university sexual assault center to their student volunteers, ally subscribers, and alumni group. This email link was also posted on a Southeastern Michigan university health system research portal, a site designed to connect individuals who have interacted with the health care system to relevant research opportunities. The anonymous survey was around 30 minutes in length and contained a variety of self-report questionnaires about trauma-related distress and recovery. At the end of the survey, participants were given the option to provide their contact information in a separate survey not linked to their data in order to receive a $10 gift card as well the option to be contacted if they would like to participate in an hour to an hour and a half in-person interview for an additional monetary incentive. Participants who expressed interest in the interview portion of the study were contacted by study staff within two weeks upon completion of the survey to schedule an appointment for their interview and 24 women completed the interview process.

The interview was scheduled within two weeks of completion of their survey and was conducted at a private room in a Southeastern Michigan School of Nursing. All eligible participants were provided with an informed consent form for participation and audio-recording of the interview. The interviews ranged from 70-95 minutes in length. Participants were given copies of completed activities as well as local psychological support resources upon completion of the study. After each interview, digital voice recordings and photocopied activities were uploaded to a secure, research drop box.

Study Sample. Twenty-four women ages 18-26 (M=22.06, SD=2.22) were included in this analysis. Thirteen women were current undergraduate students at a four-year institution and 11 were alumni. Eighteen identified as Caucasian, three identified as African American or Black

and three women identified as Asian. For undergraduate sexual victimization experiences, all mentioned events during the interview involved male perpetrators with 19 women disclosing substances were involved at least some of the time. Demographics and victimization history for this sample can be seen in Table 5.

Table 5: CENI Sample Demographics and Victimization History

Age	*N=24*	**Childhood GBV Trauma**	*N=24*
18-21	8	Physical or Emotional Abuse	5
22-25	8	Sexual Abuse	3
26-30	8	Witnessed Domestic Violence	3
Race		**Sexual Victimization History**	
Caucasian	18	Sexual Assault	10
African American or Black	3	Domestic/ Dating Violence	9
Asian	3	Complex trauma	8
Sexual Orientation		**Unwanted Sexual Intercourse History**	
Heterosexual	16	Never	6
Bisexual	8	1-2 times	14
USE Perpetrator History		3-5 times	3
Romantic Partner	10	More than 6 times	1
Casual or First Date	5	**Unwanted Sexual Contact History**	
Non-romantic Friend	4	Never	1
Acquaintance	6	1-2 times	11
Authority Figure	1	3-5 times	7
Stranger	9	More than 6 times	5

Measures. Participant data for this study was collected with the Clinical Ethnographic Narrative Interview (CENI), a semi-structured interview developed by the Denise Saint Arnault for an NIMH-funded study examining the interactions between distress experiences and help-seeking for first-generation Japanese women living in the United States (Saint Arnault, 2017; Saint Arnault & Fetters, 2011; Saint Arnault & Shimabukuro, 2012). Since its development, the CENI has been adapted to study GBV recovery and has been utilized in over 150 survivors of trauma in eight different countries to identify socio-cultural themes of help seeking and healing. Studies that have used the CENI have demonstrated its ability to assist participants in organizing and articulating meaning about emotionally difficult experiences (Sinko, Burns, O'Halloran & Saint Arnault, 2019; Sinko & Saint Arnault, in press).

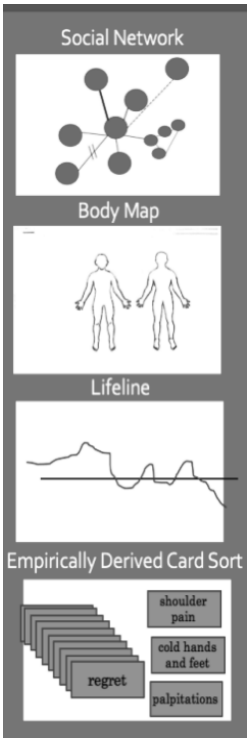

Figure 4: CENI Activities

The CENI lasts about 90 minutes and utilizes four unique participant activities (see Figure 4) to investigate social and cultural experiences, beliefs, barriers, and facilitators to healing from GBV. Each activity's product remains in view during the interview, with the opportunity for the individual to have a copy of her products at the end of the interview. We begin the interview with a *social network map* to frame help seeking within the social context. Next, we invite the participant to use *body mapping* to place their distress onto their body and focus on their internal process (Meiring & Müller, 2010; Meyburgh, 2007). Then, the participant completes a retrospective overview of triumphs and distress in their life in a *lifeline,* to find patterns and link past and subsequent events, emotions, and actions (Frank, 1984; Gramling & Carr, 2004; Shimomura, 2011). Finally, the participant completes a *card sort* referencing her most recent low point, to describe her distress and healing in detail on a focused event, creating a map of her symptom

clusters (Borgatti, 1999; Canter, Brown, & Groat, 1985; Saint Arnault & Shimabukuro, 2016). For the purpose of this project, women were also asked to remove symptom cards from their clusters that were no longer impacting them presently, to better understand current feelings and symptoms and identify what their needs may be going forward. Additionally, we also asked women to define healing and explain what facilitated and created barriers to their healing process.

Analysis. The qualitative analysis was carried out to identify the extent to which socio-contextual factors influenced one's internal processing after USE as well as the nature and meaning of healing for survivors. Interviews were transcribed, with the accuracy of the transcription checked and finalized by the interviewer. Transcripts were read and re-read with the central concepts identified. ATLAS.ti qualitative software was used for data management and analysis (Muhr, 2006). Codes were developed based on internal and contextual influences of healing, as well as participant's perspectives of components of healing. Codes were collapsed if their frequencies were less than ten. Theory generation occurred through systematic identification of grounded and axial codes in line-by-line constant comparison, consistent with grounded theory methodology (Strauss & Corbin, 1998). Code co-occurrences were then analyzed and hypotheses were generated based on the data. We used these hypotheses to further interrogate the data to better understand the interactions between themes, creating our full model. An audit trail using personal, theoretical and analytic memos was maintained and was reviewed every other week by the dissertation chair, with coding concepts and emerging hypotheses being discussed at length in research team meetings for verification of accuracy.

Findings

The Healing Journey. Survivors indicated two key influences of their healing, one's social context as well as how one makes meaning of their experiences. These two concepts

appeared to interact and directly impact each other, creating either barriers or facilitators to reaching one's healing goals. Ultimately, once one made meaning of their experience and integrated trauma into their identity, survivors were able to meet identified healing goals as they began their rebuilding process and reintegration into society. This lead to the creation of our Healing after Undergraduate Unwanted Sexual Experiences model (See Figure 5 for details). Each component of healing will be discussed below.

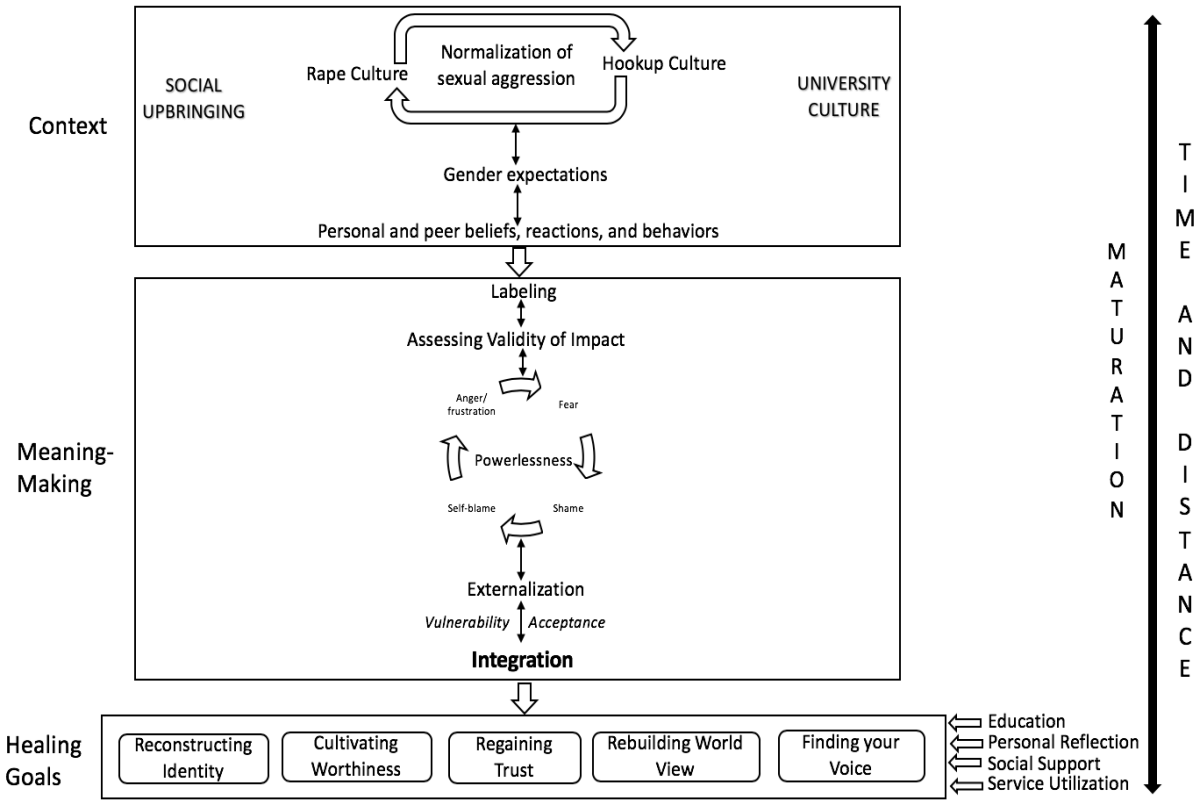

Figure 5: Healing After Undergraduate Unwanted Sexual Experiences Model

The Role of Social Context. One's social context was found to not only influence survivor's healing processes, but also how they made meaning out of their experiences. Survivors referred to two specific contexts in reference to their healing, their social upbringing and the university culture they were within during and after their assault. Within one's larger social upbringing, important areas survivors received messages from included the media, one's family and friends, as well as their school and teachers as they grew and developed. For

example, one participant said, “I think one (barrier to my healing) is definitely stuff in the media, that women report rape because it was sex that they didn’t want. I think that’s a huge thing. Especially with my story, I could see that it could be turned that like ‘Oh, you are just upset because you didn’t want to have sex that one time’” (Participant GP2007). Another recalled; “So, that was another barrier. Just, like, the topic in general, with the household I grew up in, is not welcomed or not tolerated” (Participant PO205). One final participant noted experiencing unwanted sexual touching during middle school and remembered reflecting, “Well, this is what happens…I better get used to it, but also, I better be careful of what kind of clothing I wear. Like, I was wearing a skirt that day, and was not super short, because my parents were like…. You know, we had a dress code at school, so also being aware of what I wore, like “Oh, don’t wear too short of skirts because you don’t want to draw that kind of attention.’” (Participant GP2007). The internalization of messages such as these at a young age seemed to stick with survivors even after they left their households and began their time at their university, impacting how they viewed their role in their USEs.

It is important to note that not all messages within one’s social upbringing were unhelpful, however. For example, one participant noted how her parents intervened in potentially unsafe situations while she was in high school by saying, “they found out that I was like using (social media dating site) doing really unsafe sh**. They talked to me about, and I got all upset with them…but really it was like they were paying attention and they were willing to talk to me about those things, and really support me” (Participant CH1528). Growing up in environments where sexuality and myths about sexual violence were discussed, seemed to be helpful to survivors, opening a channel for discussion if things arose at their university and empowering them to seek help and not be ashamed of their experiences.

Within one's university culture, survivors also received messages about what it means to be a woman and how one should respond to sexual violence. These messages could be helpful or harmful depending on what messages survivors were receiving. For example, one woman noted, "Going to college was super helpful…I feel like at [college name], like this focus on sexual assault and recognizing it, and it is just like a different environment, like high school or my little town, like I had never heard anyone talk about, but here it is very open conversation" (Participant NO2172). Another, however, commented on the University's requirement to let students know about violent offenses on campus, reflecting "[I felt] ashamed, and I was also a little bit nervous, because in the report these bi***** were like 'Oh, the accused…went into the building with the consent of the two.' I don't know, it felt like they were blaming us. It felt like the report was like 'Well, they let him in to their dorm with them'" (Participant NY0304). Differing beliefs about how universities handle sexual violence were found, but the majority of our participants who chose to engage the university system expressed disappointment in how they felt the school "delegitimized" their experiences. For example one recalled, "Technically I don't think that the University could expel him…I was kind of angry that the university couldn't have more teeth to that, considering what had happened" (Participant GR2424).

Within both contexts, women commented on the normalization of male sexual aggression that was "allowed" or "tolerated" within the hook up culture of universities as well as within the greater rape culture in society. This was depicted by statements such as, "I think in my head I rationalized 'Oh, well he's a boy and boys do that'" and "it is a culture that we live in, and its very anger-inducing just thinking about that it's allowed to happen…girls just laugh it off, or they think it is not a big deal when it is …" (Participant GR2424; Participant DE199128). Statements such as these highlight not only the normalization of violence within this context, but also how this normalization can be internalized, influencing beliefs and expectations of how

genders should interact in sexual scenarios as well as how individuals should react to sexual violence. For example, one woman commented, "I have always been the gatekeeper and I don't [want] to be the gatekeeper" (Participant GP2007). One participant further supported this idea by commenting, "I guess I worry…of disconnect, as in like "If I don't subserve or do what (boys) want, I will ruin my relationship with them" (Participant BH0907). Many commented on how men were often given the benefit of the doubt, especially if they had a good reputation at the school. This made survivors feel that they would not be believed. One participant put it this way: "People would be like 'No, of course, he would never do that…so you must not be remembering correctly, so it was just bad sex and now you are upset about it'… kind of denying and not wanting to face the reality that so-called good men do horrible stuff." (Participant GP2007). Overall, it appeared that one's social context greatly influenced women's recovery experiences, and the messages internalized from their surroundings caused them to hide their experiences from others to protect themselves from judgement and further harm.

The Role of Meaning-Making. One's internal dialogue after USE was often influenced by the messages they were receiving from their social and university contexts. This often positively or negatively impacted two key identified meaning-making steps of their healing process: their internal appraisal of their USE experience as well as their cascade of negative emotions that stuck with them long after their assault experience.

Labeling was defined as assigning a category and assessing the validity of one's experience in comparison to similar experiences that occur within one's social world. This was the first key internal influencer of healing identified by our participants. For example, one woman noted "it was helpful to me that (my friend) labeled what happened as sexual assault…there was part of me who was wondering if it was bad enough, and if it really was, and sort of like questioning my own experience and my own feelings" (Participant FH0207). This

woman went on to say, “putting a name to it allows you to do something, as opposed to just wondering, or sort of being stuck in your feelings of what was this, what happened, why am I feeling this way, and what is going on” (Participant FH0207). Labeling one’s experience was often very difficult for women; however, due to their fears that their experience was not “bad enough” or that they were “making a big deal out of nothing.” For example, one participant recalled, “When I initially told my friends, it was before I realized what had happened. I knew I felt weird about it, but I didn’t know how to categorize it…I told it more in a funny story way, so later my friends wouldn’t believe me about what had happened, because I made a joke out of it” (Participant CO0303). Another commented, “No one’s assault or adverse sexual experience is cut and dry…I mean, this is obviously horrible, but if someone jumped you in an alley that you didn’t know and raped you…I would have an easier time reporting that personally, because it fits into a narrative that people are comfortable with” (Participant BO1912). Many women expressed similar sentiments as the participant above, noting the urge to compare their situation to others in attempt to legitimize their experience. For example, one woman recalled that after attending a survivor “speak out” event, “there were so many girls that…like, some girls it happened in their bed, and they couldn’t sleep in their bed anymore. Some girls, it was super brutal…sexual assault and rape shouldn’t be a hierarchy of what is bad and what is worse, but that is how I compared mine” (Participant DE0507). Ultimately, resolving the internal battle of “claiming” whether or not what one experienced was truly wrong seemed to be the first step to resolving much of the negative self-talk that manifested in survivor’s brains after their USE. One woman summed this process up by saying, “(Part of it is) being able to define that you were hurt. Because like I said, I was like ‘Oh, it wasn’t a big deal’, but then I think when I owned, like ‘Oh no, that was a messed-up thing’, that’s when I began to heal kind of…that was the beginning of the healing process I think. (Participant DE199128).

Assessing Validity of Impact was defined as assessing the residual feelings associated with one's experience or event in order to determine how one is allowed to respond to a given situation. Once one reconciled how they could label their experience, many struggled with this process, wondering how upset they were "allowed" to feel, especially because many of them did not feel intense emotions until awhile after their USE. For example, one woman recalled, "(I was afraid that) my friends would think I was just making a big deal out of it, because it wasn't the actual forcible penetration or anything like that. They were like, you know, it's just one of those things where I'm like "Oh, is that big of a deal, and should I care that much" (Participant DE199128). Another recalled, "…in the back of my mind, I thought like 'You need to be done with this and this needs to be over'. Nobody in the world, out of eight billion people would ever tell me that, but I was like 'You need to be done with this, and we are not doing this anymore.' Like, 'This is your last time (going to therapy), like if you can't do it now, you are done' (Participant TR2213). Women often wrestled with a fear of allowing themselves to be vulnerable, because they believed that being vulnerable made them seem needy or undesirable to be around. By doing this, however, they often suppressed their pain after their experience, enabling it to impact their daily life long after their USE. Ultimately, allowing oneself to feel their negative emotions and being patient with the process appeared to be important to the meaning-making process. One participant put it this way, "…accept that if you are not getting better and healing at the rate that you wanted to, that's okay…accept it and don't put pressure on yourself to get through it faster, and to take those points that are painful and make that an opportunity…" (Participant SO054).

Negative Emotions also played a role in the healing process, despite them being debilitating at times. By allowing themselves to feel their negative emotions after sexual assault, women often had a period of time that they felt consumed by their distress, manifesting in

feelings of shame, self-blame, fear, frustration, and anger. These emotions seemed to activate each other, causing women to feel overwhelmed and powerless. For example, one woman explained, "…it just kind of feels like this weight, like very very cliché and stereotypical (Participant MI1032). Another recalled that as a result she, "…wasn't very connected to (herself) and I didn't really value [herself]" causing her to "not want to be alone with [herself]" (Participant CH1528). Ultimately, addressing and processing these emotions was essential to reconciling negative self-talk and continuing to move forward in the healing process. One woman put it this way,

> Healing is not as a linear process, and understanding that the low points...it is not really progress in a sense if you are not having those types of experiences, I suppose. You are still probably shoving things to the side, so don't see it as a setback. Not that these things will never really heal, but (you will) kind of carry them differently (Participant IA2291).

Another woman commented, "I guess if I were just answer right away, I would say healing is moving on, but I think true healing is admitting things and dealing with it" (Participant FH0207).

Importantly, normalization within one's environment often influenced women's feelings of responsibility for their USEs because "they should have known better." For example, one woman commented, "But, I blame myself too, any time a boy said something stupid, or if I got groped or something like that, I was like 'Oh, I did something wrong' because I'm stupid or I'm whatever" (Participant DE19928). Another recalled, "I am kind of used to it because I see trends happening, and I see how boys think, and it's my fault or the classic whatever 'Oh, I should have been more careful'" (Participant BH0907). This feeling of personal responsibility was often reinforced by others within the participant's context. For example, one woman recalled, "…when I told my guy friends, it was definitely not helpful, because they were very much like 'Why were you alone with him', 'Maybe you should date better guys'" (Participant FH0207).

In order to carry their negative emotions differently, women seemed to need to **externalize** their experience in some way. They described that they needed to take it out, and

look at it objectively. This externalization allowed them to look at their situation from another's perspective and recognize that 'the problem was the problem,' rather than the person being the problem. Once the women recognized this, they said it was important for them to continue to allow themselves to be vulnerable, practiced self-acceptance, and make the decision to focus on rebuilding. One woman put it this way:

> These are all internal. Shame and guilt are internal struggles with yourself. No one can really help you or guide you through. I mean, they can to a certain extent, but that decision ultimately has to be up to you, whether or not you are going to feel responsible, guilty, or shameful and unworthy in some senses. It takes, I think, a lot of…. I don't know how else to say this, except other than grit or just like……. Not dedication, but you have to be willing to commit to it in some sense. That's my opinion (Participant IA2291).

Healing Goals. Forming an identity one was proud of seemed particularly important to our sample. For many, understanding where trauma fit into their identity was a particularly difficult task, but an important defining moment in their healing journey. We defined trauma integration as incorporating one's trauma into their identity with the acknowledgement that it is an important part of who they are, but does not define their existence. This definition was created by synthesizing the healing definitions of nine women in our sample who specifically cited successful identity integration in their definition of healing. For example, one participant said,

> Healing is a process. It is finding ways to integrate what I have been through with who I am, both despite it and because of it. It's not about trying to get rid of the pieces of me that have been shaped by it, because that's never going to happen. Just, hating parts of myself and that's not going to help. It's about trying to accept parts of myself and work through what has happened by kind of talking about it, and by talking about it in ways that I acknowledge that I didn't deserve it, and it wasn't something that was okay (Participant CH1528).

Another explained,

> Well, I was thinking about this the other day, like when you injure yourself and a wound and you are bleeding and stuff, you are always going to have a scar. It is going to be visible and your skin isn't going to back to the way it was, so like, I should stop thinking of how my life would be without this, and healing would be going back to normal, because that is impossible, because something happened and it changed me. So, healing, I guess, would using this experience to make me a better me, and learning a lot from it, and using it to not only help me, but help other people (Participant DE507).

By accepting one's USE as an assault, and attempting to integrate it in their rebuilding process, survivors expressed feeling able to begin to pursue their desired healing goals and aspirations. After reviewing the data, five key healing goals were identified. These goals were: reconstructing their identity, cultivating worthiness, regaining trust, rebuilding their worldview, and finding their voice. These goals were met with the help of personal reflection, resource utilization, social support, and education about sexual violence and its impact.

Reconstructing Identity was defined as learning who one is after trauma by acknowledging and enhancing the positive attributes within oneself while accepting and being patient with what one considers negative. This was often difficult for survivors, especially when they reflected on their role in their USEs. For example, one person reflected, "I should have ended the relationship earlier, like way early. I feel like it went on too long. I think I feel kind of stupid for letting it go on as long as it did, because that relationship is not me. Like, I never thought of myself as the kind of person who would be in an emotionally abusive relationship" (Participant GP2007). Reconciling these feelings and reconstructing who one was therefore very important in repairing the relationship one had with themselves. A different participant reflected on this in her definition of healing by saying, "I would say healing is like the strength to move forward and not letting the thing that hurt you hold you back, and still being who are and pursuing what you want…And learning to love yourself, I think (Participant NO2172).

Cultivating Worthiness was defined as fostering positive beliefs about one's value through self-reflection, engaging in activities, and interacting with people who empower individuals to feel capable and deserving of respect and healing. This is something that often required an intentional effort for survivors, as they often compared and measured their worth based on what people around them were accomplishing. For example, one participant reflected, "I just feel super different. Like, I feel like I am not good enough to be around and stuff…from

the outside it just looks like (everyone has) all their things together. I just feel like I will never get there (Participant MI0321). Pushing back against these feelings and fostering environments that made survivors understand their own worth was incredibly important. One participant reflected on her journey to regain self-worth by saying, "Yeah, and I have been really working on it…I have been trying to really put my energy where it is helpful to me…pursue what makes me feel good about myself, which is my art…I feel like after all of this, I feel good about myself, and I feel proud of where I am" (Participant CH1528).

Regaining Trust was defined as feeling as though one is capable of their own decision-making and can be vulnerable with others in order to connect with them on an authentic level. After many of our participant's assault experience, they retreated and withdrew within themselves in fear of further violation or of other people witnessing their suffering. Many also began to mistrust their abilities to keep themselves safe due to self-blame and the personal responsibility they felt for their experiences, creating further reasoning for isolation. One person reflected on this in this way, "The fear was just kind of like my actions. Are the actions I took during these events, are they going to impact me in the future, like badly in the future? Like, is this going to affect my future relationships with people" (Participant AN2414)? Resolving these feelings and allowing oneself to be vulnerable with others was a key recovery goal for survivors, as this created a support network they could lean on and often helped them realize that the people around them did want to help. For example, one participant said, "I think for so long I had thought that if I just kind of angry or salty with people, or didn't make new friends, that I would be almost better off, and now I realize that's not the case. So, letting more people into my life because I can trust them, and just giving people the benefit of the doubt when I need them" (Participant CL099).

Rebuilding Worldview was defined as feeling safe and optimistic about one's future by finding and acknowledging the positives within one's life and the world around them. Survivors often struggled to feel safe in their world post USE and this dictated what they felt comfortable and able to do within it. For example, one person said "Yeah, it has been frustrating, because I do a lot of things on my own…so it is just frustrating for me to be held back… I like going places at night too, so it's even worse, because in the back of my mind I'm like 'What if something happens'" (Participant AN2414)? By challenging one's fears and acknowledging the good around them, survivors felt better able to do the things that they wanted to do while still keeping themselves safe. One person discussed this idea by saying, "I think getting myself out of my comfort zone was also something that helped with that, because you start to put things in perspective, which is nice…there is so much more out there. I think having that reality check was nice and helpful" (Participant SO054).

Finding your voice was defined as feeling able to stand up for oneself and/or against social injustice related to USE. Many survivors consistently heard rape myths being discussed within their families and social circles, further reinforcing the shame and self-blame that they felt. One participant recalled,

> There was an article that came out that year about a girl at Amherst, who wrote about a guy who raped her. I remember hearing the boys talking about it in my house, just staying really stupid things. In my heart, I knew it was wrong, and like why are you blaming the victim. But at the same time, I was like "oh", like I'm not gonna say anything. I didn't feel articulate enough, and I didn't feel like…. I don't know.. yeah (Participant DE19928).

Although it was often difficult, by standing up for injustice related to USE or by just feeling able to stand up for themselves in their everyday lives, survivors were able to rebuild their confidence and feel a sense of justice. One participant reflected, "I think my big takeaway is that I am really really strong… I lost, he won and he got away with it... most importantly though, I stood up for

myself, even if the judge didn't. Personally, I am glad that I said this isn't okay, that I validated my own feelings" (Participant CH1528).

Healing after Undergraduate Unwanted Sexual Experiences Model

Results of our analysis culminated into the Healing after Undergraduate Unwanted Sexual Experiences Model which can be seen in Figure 5. The theoretical model provided here was the result of using the grounded theory techniques of hypothesis generation and test to discover the processes by which the concepts found in this study interacted, as well as how these processes facilitated or impaired healing (See Table 6 for definitions of main concepts).

Table 6: Definitions of Key Concepts in Healing After Undergraduate USEs Model

Model Concept	Definition
Rape Culture	A society or environment whose prevailing social attitudes have the effect of normalizing or trivializing sexual assault and abuse" (Oxford Dictionary, n.d.).
Hook Up Culture	A culture accepts and encourages casual sexual encounters, including one-night stands and other related activity, without necessarily including emotional bonding or long-term commitment (Freitas, 2013).
Meaning-making	The process of how people construe, understand, or make sense of life events, relationships, and the self (Ignelzi, 2000; Gillies, Neimeyer, & Milman, 2014).
Labeling	Assigning a category and assessing the validity of one's experience in comparison to similar experiences that occur within one's social world.
Assessing Validity of Impact	Assessing the residual feelings associated with one's experience or event in order to determine how one is allowed to respond to a given situation.
Powerlessness	Feeling as though one is unable to self-manage and take control of their suffering due to an overwhelming amount of negative emotions.
Externalization	Establishing a context where people themselves are separate from the problem in their lives.
Integration	Incorporating one's trauma into their identity with the acknowledgement that it is an important part of who they are, but does not define their existence.
Reconstructing Identity	Learning who one is after trauma by acknowledging and enhancing the positives within oneself while accepting and being patient with what one considers negative.

Cultivating Worthiness	Fostering positive beliefs about one's value through self-reflection, engaging in activities, and interacting with people who empower individuals to feel capable and deserving of respect and healing.
Regaining Trust	Feeling as though one is capable of their own decision-making and can be vulnerable with others in order to connect with them on an authentic level.
Rebuilding Worldview	Feeling safe and optimistic about one's future. Finding and acknowledging the positives within one's life and the world around them.
Finding your Voice	Feeling able to stand up for oneself and/or against social injustice related to USE.

Context. This model depicts the process explained by the women in which one's social upbringing, as well as university culture, are contexts where there is a pervasive normalization of male sexual aggression that manifests both within the hookup culture as well as within the broader rape culture in our society. These factors can be internalized, influencing how both men and women are taught and expected to act within their gender, creating personal as well as social beliefs as to how individuals should react to sexual violence and behave within society.

Meaning-making. When a woman experiences an USE, she attempts to make meaning out of her experience or the event. The first part of meaning-making is labeling one's experience. If one labels her experience as "unwanted," she then assesses the validity of its impact to determine how she is allowed to respond to a given situation.

When an experience is labeled as, in fact, an unwanted experience or an assault, and is also acknowledged as having a negative impact on her wellbeing, a cascade of emotions results, influenced by one's internalized personal beliefs as well as her experience within her social world. The resulting feelings (anger/frustration, fear, shame, self-blame) often activate each other, causing one to ruminate over these emotions, creating feelings of powerlessness.

In order to get out of this rumination cycle, one needs to be able to externalize their experience, defined as establishing a context where people themselves are separate from the

problem in their lives, or in simpler terms, coming to the awareness that the person is not the problem, rather the problem is the problem. Once one comes to this awareness, they are then able to actively engage in their healing and begin to integrate their trauma within their identity by allowing oneself to be vulnerable as well as accepting oneself and one's situation. Ultimately, once one begins to integrate, desired healing goals include reconstructing identity, cultivating worthiness, regaining trust, rebuilding one's worldview, and finding one's voice. These goals can be achieved through education on USE and USE impact, social support, personal reflection, as well as service utilization. Influencing one's overall healing process is time since last event, space from triggering environments, as well maturation during this critical developmental time. Healing was not found to be a linear process, and participants frequently found themselves moving forwards and backwards within this process as they navigated their social worlds.

Discussion

The present study sought to understand the internal and contextual influences of survivor healing after undergraduate USEs. We identified key contextual influences including the normalization of sexual aggression, manifesting from both rape and hook up culture in the university and broader societal environment. Key internal influences included making meaning of one's experience, achieved through labeling one's experience, reconciling and accepting negative emotions, and ultimately externalizing and integrating their experience within their identity. We also sought to understand the nature of healing after campus USEs and a model was constructed to highlight identified healing goals. Key healing goals identified included reconstructing identity, cultivating worthiness, regaining trust, rebuilding one's worldview, and finding one's voice.

Our findings that one's social context can greatly influence survivor's internal processing and meaning-making of their USE is an important addition to the scientific literature on campus

violence against women. Similar to our findings, other studies have pointed to the support of the perpetuation of university sexual violence through both the campus social scene and the management of sexual assault cases by institutional governing bodies. Few, however, have gained these insights through the perspectives of women who have been violated within this system. For example, Armstrong, Hamilton, and Sweeny (2006) found gender roles within the social hierarchy at college parties contribute to women's degradation, with men typically having the ability to exercise control over most aspects of party and social situations, while often exhibiting peer support for disrespecting women. Similarly, it has been argued by many campus sexual assault researchers that the hushed nature surrounding the communication of date rape and assault on college campuses and the normality of these experiences perpetuate rape culture ideology as well as remove all accountability from those who engage in these behaviors (Burnett et al., 2009; Giraldi & Monk-Turner, 2017). Finally, McMahon (2010) argues that college students, along with the larger society, typically consider women responsible for the sexual violence acted out against them (Boyle & Walker, 2016; Burnett et al., 2009; Fraser, 2015). These findings were confirmed through our study as well as a qualitative review of social media posts concerning rape culture on college campuses who found a variety of permissive themes including "get over it," "just college fun," "lighten up," "not that serious," "this isn't rape," "women as sexual objects," and "they are just college kids" (Giraldi & Monk-Turner, 2017). This paper adds to the scientific literature on these phenomena by highlighting the lived experiences of women who experienced sexual violence as they navigate this sexually aggressive culture both before and after their USEs, indicating that this culture not only perpetuates violence, but also creates social and cultural barriers to healing after USEs.

Our findings also revealed the importance of culture on survivor healing and adjustment. The normalization of sexual aggression in greater American culture has been discussed at length

in the scientific literature related to the perpetuation of violence against women, but limited studies have attempted to measure how it can impact resulting survivor healing and reintegration after campus USEs. References to cultural beliefs about sexual violence in America can be found in the media and online, normalizing and desensitizing the mistreatment of women, while creating a public acceptance of sexually violent behavior (Bemiller &Schneider, 2010; Weaver, Carter, & Stanko, 2013). The influence of the Western normalization of violence and its impact on resulting beliefs, attitudes, and behaviors, has been discussed at length in the sexual scripts literature, highlighting noticeably different messages for both men and women (Garcia, Reiber, Massey, & Merriwether, 2012; Jhaly, 2007; Phillips, 2000; Wiederman, 2005). In this literature, for men, sex is often portrayed as nonrelational and central to male identity, giving men permission to be active sexual agents (Garcia et al., 2012). Women, on the other hand, are often portrayed as sexual objects or gatekeepers, setting the expectation that they should be sexually passive compared to men (Garcia et al., 2012). Our study, among others, revealed that these beliefs about sexual relationships have bled into the university hook up culture manifesting in rape myths and sexually aggressive social norms where heterosexual men typically control the terms of hookup encounters (Wade, 2017). Our findings add to the body of literature on this phenomenon, indicating that women often internalize these societal myths and norms, leading to negative self-appraisals after sexual violence as well as difficulties reintegrating into the socio-sexual milieu (Campbell, Dworkin, & Cabral, 2009; Neville & Heppner, 1999; Neville, Heppner, Oh, Spanierman, & Clark, 2004; Ward, 1995).

Interestingly, our research not only revealed how one's socio-cultural context can impact healing, but also how it can impact one's tolerance and expectations of suffering after USEs. Qualitatively, a number of studies have supported our finding that the normalization of violence within one's environment and observed rape supportive beliefs can significantly impact

individual's ability to label, make meaning, and heal after USEs and other forms of GBV (Harned, 2005; Sinko & Saint Arnault, in press; Sinko, Burns, O'Halloran & Saint Arnault, 2019; Ullman, 1996). Similarly, women in our sample often compared themselves to other "more severe" USE scenarios that they had heard about both through their social circles and online, often making their experience not feel legitimate or that they were being "dramatic" by reporting or seeking help. This feeling has been suggested elsewhere, as others have found that the more normative sexually aggressive situations become among college women, the less likely they may be to label them as sexual assault and hence seek resources or care after their experiences (Deming, Eleanor, Covan, Swan, & Billings, 2013). For example, Kahn, Jackson, Kully, Badger, and Halvorsen (2003) found that 85% of their sample of 504 college women who had experiences that met the legal definition of sexual assault but did not label their experiences as rape. Other studies have supported these findings, indicating that due to the narrow cultural definition of rape, as well as often co-occurring alcohol use, many survivors blame themselves or mistakenly believe that their experience was not severe enough to be reported (Bannon, Brosi, & Foubert, 2013; Iconis, 2008; Moor, 2007; Peterson, & Muehlenhard, 2004). Importantly, however, our participants frequently reported frustrations at themselves that they were "not healing fast enough" even if they believed their situations were legitimate, often leading women to suffer in isolation, in fear of being judged by others for being "weak." This fear of vulnerability, manifesting in anger towards oneself over not "getting over" a situation fast enough, has been found elsewhere in American gender-based violence contexts, but has not yet been described to our knowledge among female university students (Sinko, Burns, O'Halloran & Saint Arnault, 2019; Sinko & Saint Arnault, in press). The degree to which this was mentioned in our study, points to the need for greater insight into this phenomena to help create interventions to reconcile these fears of weakness, normalize the suffering women are experiencing, and

empower women to report and seek help for their experiences regardless of what society is telling them, should they believe that is what they need.

Overall, this research supports the perspective of trauma recovery as a meaning-oriented, sociocultural enterprise, demonstrating a need for better measurement tools to assess the impact of one's socio-cultural environment, on distress, healing, and recovery after sexual violence (Campbell, Dworkin, & Cabral, 2009; Rozee & Koss, 2001; Sinko, Burns, O'Halloran & Saint Arnault, 2019). Although we know that sexual assault does not occur in social isolation, present quantitative research on sexual violence has yet to take into account fully how the sexual violence culture in which we live can impact survivor processing after USEs, and this may be the key to understanding why survivors often differ in their healing processes and how systems can better support survivor healing and adjustment. Although some tools (i.e. rape myth acceptance; McMahon & Farmer, 2011) have attempted to measure individual's rape supportive attitudes, few scales to our knowledge have attempted to measure how one perceives the rape supportive attitudes of one's peers and greater socio-cultural atmosphere as a means to better understand what influences survivor's suffering and healing after USEs. Ultimately, in order to move the state of the science forward for this population, better assessment of the beliefs and attitudes within one's environment is critical, to understand important influences to growth and recovery in one's social and cultural environment.

Our study also adds to our understanding of survivor's internal dialogue and why some may choose to not seek help or engage in the healing process. By identifying the interaction between internal and contextual influences, we can more thoroughly examine why women may take many years before leaving their abusive situation or before fully engaging in their healing. Some of our findings were supported by a review synthesizing barriers to seeking care after sexual violence indicating emotional states (e.g. shame and self-blame), fear of external exposure

(e.g. fear of not being believed, assailant retaliation or punishment, public exposure) and environmental factors (e.g. organizational barriers, rape myths; Munro-Kramer, 2014) as key influencers as to why women did not seek care after their campus sexual violence experiences. Further understanding the relationships between these identified social and internal variables is needed going forward, to better understand how the internalization of one's environmental values can impact ones processing and healing after campus sexual violence.

Importantly, the findings from this study add to scientific theories about survivor's trauma recovery by creating the first model to our knowledge to attempt to describe the internal and socio-cultural influences of the *process* in which young adult women make meaning and heal from their USEs. Although some theories about healing after trauma have supported similar meaning-making ideas (i.e. Herman, 1997's three stages of trauma recovery, Taylor, 1983's theory of cognitive adaptation, and Tedeschi & Calhoun, 1996's PTG), building on these themes and theories is essential in this population in order to further understand gendered and developmental nuances to create culturally-relevant areas for intervention. For example, our study discovered the importance of identity reconstruction in undergraduate USE survivors' healing processes, revealing perhaps that due to the critical developmental stage many of our participants were in during their USEs, appropriately forming both their personal and intimate identities as they heal from their traumatic experiences may be an important area for inquiry in the future. As a result, future research is needed to further understand the role of an individual's personal identities in their healing process as well as compare and contrast healing themes across identity groups. Relatedly, our findings have not only pointed to specific healing goals that survivors are looking to achieve (i.e. reconstructing identity, cultivating worthiness, regaining trust, rebuilding worldview, and finding your voice), but also places where they can get stuck in their healing. For example, we found that many college women minimize their experiences due

to fearing that their experience was “not severe enough” or because they fear of being labeled as “dramatic.” Insight to additional cultural and social structures that perpetuate and inform these beliefs can point to areas of intervention to reconcile these “paralyzing” experiences within the survivor. This could create tangible areas for individual, social, and university level interventions to make the university environment a more supportive place for survivor healing.

This is a qualitative study, and as such, is not intended to be generalizable. Aspects of our study, however, should be noted. This was a Midwestern sample affiliated with a major university. There is a possibility that there was self-selection bias, such that we did not speak to women who did not label their experiences as unwanted or were uninterested in discussing their healing processes. In addition, the sample were primarily Caucasian therefore, future research is needed to better understand the healing process of other cultures, genders, and sociodemographic characteristics. Future research should focus on how racial and socio-economic differences can influence survivors healing processes to better understand how the nuances of one’s social context and upbringing can further impact the power dynamics of sexual violence and healing on a college campus. Additionally, future research should look at the healing processes of women who are college-aged, but did not attend a university, as this population has been estimated in other studies to have even higher rates of sexual violence and may have differing healing supports compared to university women within their communities (Department of Justice, 2014). Despite the specific sample, the findings of this study help illuminate the process of survivor healing and provide a theoretical framework that can be tested to better understand barriers, facilitators, and goals of survivor healing, grounded in the voices of female participants. The new knowledge created by this study has the potential to impact not only survivors own understanding of their own potential healing paths, but also how we as clinicians can empower and manage the expectations of survivors in both the clinical setting and in our interactions with

them within our social worlds.

The present study has the potential to better equip survivors with the knowledge needed to navigate their own healing journeys and identify what their needs may be going forward. Additionally, this study reveals the importance of empowerment and promoting strength in this population to mitigate cultural messages telling women that their experience is “not worth” seeking help for as well as that by seeking help, they are somehow “weaker”. Encouraging professionals to focus on survivor healing goals, rather than solely focusing on negative responses to USEs, can help empower and support survivors to realize the strengths within themselves and promote their abilities to integrate their trauma into their identities.

Future research should diversify outcome measures to more than just mental illness diagnoses in survivors of USEs, to more accurately target healing and recovery beyond the alleviation of negative mental health symptoms. Future research is also needed to further expand upon and test the themes identified in this analysis, with the goal to reevaluate existing trauma recovery measures to ensure trauma recovery is being captured through a holistic, socio-cultural lens. By changing the narrative and focusing on healing rather than deficit, we can help survivors realize their own power and worth, guiding them through the difficult areas of healing, while giving them faith that they are not damaged goods and can and will have the ability to heal and grow after their USEs.

Chapter III Using Photography to Describe the Day-to-day Healing Journeys of Survivors of Unwanted Sexual Experiences

Introduction

It is estimated that 35% of women worldwide have experienced physical and/or sexual violence (UN Women, 2015). Specifically, there is a growing epidemic on college campuses in the United States regarding this type of gender-based violence (GBV), as college-aged females (ages 18-24) have consistently had the highest rates of rape and sexual assault victimization when compared with females in other age groups (Krebs et al., 2007). On college campuses particularly, it is estimated that 23.1% of females have experienced rape or sexual assault as an undergraduate (Cantor et al., 2015). Importantly, it is possible that the statistics presented are vastly underestimated, as it is estimated that only 20% of student survivors ages 18-24 report sexual violence to law enforcement (Department of Justice, 2014).

The emotional distress caused by sexual violence lasts well beyond the assault experience, often causing internal blame and feelings of shame, as well as a wide range of negative psychological outcomes (e.g., PTSD, depression, anxiety, and suicidal ideation; Eisenberg, Lust, Hannan, & Porta, 2016; Feiring, Taska, & Lewis, 2002; Jordan, Campbell, & Follingstad, 2010). These negative outcomes have been shown to interfere with student's everyday lives, correlating to higher transfer and college dropout rates, as well as impacting women's academic success, social and professional relationships, and long term professional and career attainments (Department of Justice, 2014; Eisenberg, Lust, Hannan, & Porta, 2016; Potter, Howard, Murphy, & Moynihan, 2018; Sinozich & Langton, 2014).

Recent political attention has been focused on female survivors of sexual assault on college campuses due to the high victimization rates of women in these settings. Specifically, in 2007, it was estimated that 19% of undergraduate women had experienced an attempted or

completed sexual assault since entering college (Krebs, Lindquist, Warner, Fischer, & Martin, 2007). Despite recent university efforts surrounding prevention of rape and other forms of sexual violence in these settings, the high incidence of sexual violence occurring on university campuses have not decreased. For example, in 2015, more than 150,000 students from 27 universities participated in one of the largest studies ever on sexual assault and sexual misconduct. Results indicate that 23% of female undergraduate and graduate students across the 27 schools experienced some form of unwanted sexual experience (USE) - from kissing to touching to rape-carried out by force or threat (Cantor et al., 2015). These high prevalence rates facilitate awareness of the growing number of survivors housed within our university institutions and beyond, substantiating the need for research around healing and recovery to improve campus and community support for survivors.

Healing after Unwanted Sexual Experiences. Despite the growing understanding of the short and long-term consequences of campus USEs, very little research has focused on the trauma healing processes of these women, with the majority of literature focusing on adverse outcomes, service utilization, and reporting. Even less research has tried to understand survivors' day-to-day recovery processes through experience sampling. A qualitative meta-synthesis of 51 reports discussing healing after sexual violence revealed the importance of relating to others, feeling safe, and re-evaluating the self as key benchmarks in a survivor's trauma recovery process (Draucker et al., 2009). One limitation identified by the authors, however, was that only 12 synthesized reports stated their purpose was to describe how individuals heal, adapt, or recover from sexual violence. Other reports included in the review focused on survivor's "lived experiences" more broadly without specifically asking the survivor about their recovery goals and processes, potentially missing important intricacies contributing to trauma healing (Draucker et al., 2009). Relatedly, this review primarily synthesized studies that focused on evaluating

healing from a retrospective lens, with no studies allowing participants to evaluate their healing experiences in real time through experience sampling, a promising methodology to capture the daily dynamics of life during and after USEs (Sullivan, Khondkaryan, Dos Santos, & Peters, 2011). Therefore, additional research is needed to expand our knowledge of the day-to-day healing experiences of campus USE survivors to better understand how one's social world can promote or inhibit survivor growth and positive change.

Photography to Promote Understanding of Healing. Auto-photography is an ethnographic research method used to create a safe container in which the researcher and the reader can see the world through the participant's eyes by the use of photography (Glaw, Inder, Kable, & Hazelton, 2017). Auto-photography began in anthropology in the 19th century and by using photographs as actual data, has built bridges for groups who often feel voiceless in research or in the larger world (Thomas, 2009). Auto-photography has been found to be particularly empowering for participants of marginalized groups by allowing individuals to share their experiences with a research team by using chosen images, rather than verbal speech (Noland, 2006). By facilitating trusted communication between the researcher and participant, autophotography and other visual methodologies have been found to enhance the richness of data by improving rapport building, promoting emotional expression and reflection, as well as facilitating the discussion of previously unknown or unexpressed knowledge (Pain, 2012).

A similar research method to auto-photography is PhotoVoice. PhotoVoice has been utilized in many studies to facilitate discussion of potentially difficult or sensitive topics, providing the foundation for shared knowledge-building through gathering community members to represent their environments and promote social change (Padgett, Smith, Derejko, Henwood, & Tiderington, 2013; Wang, Cash, & Powers, 2000). In GBV specifically, PhotoVoice has been used to transgress violence, or enable participants to disrupt, re-story, and represent their

perceptions and experiences so that they no longer feel defined by their GBV history (see Christensen, 2017 for review). By illustrating the problem, promoting care for the self and others, and harnessing community resources, PhotoVoice has been historically successful in promoting awareness of GBV- related issues, while challenging internalized beliefs and stereotypes that perpetuate stigma.

Photo elicitation is the use of photographs as a stimulus within an interview setting to facilitate a verbal discussion about a particular phenomenon (Harper, 2002; Thomas, 2009). Photo elicitation produces a different kind of data because photography evokes feelings, memories, and information, and because using visual images, the research evokes a deeper part of human consciousness than words alone (Harper, 2002; Glaw et al., 2017). Photo elicitation can be used as an experience sampling approach to capture the daily lives of individuals, while providing a model for collaboration in research where the participants can lead the direction and content of the interview while interpreting their photos and meanings for the researcher (Loeffler, 2004).

Photo elicitation is a particularly promising method for survivors of USEs, as it has been described as a methodology that both empowers and emancipates participants by making their experiences visible while empowering them to tell their stories (Oliffe & Bottorff, 2007). This sensitivity and ability to provide space for autonomy is important when trying to understand struggle and healing after trauma. For example, Frohmann (2005) studied "battered women" using this methodology, finding that this approach placed the choice of photos and the level of disclosure entirely within the control of the participants, enabling them to reflect on their day-to-day lives in a "safe and meaningful way." Ultimately, by providing space for GBV survivors to reflect on their own experiences, studies to date have noted the unique ability of photo elicitation to enable participants to discover specific strategies they can use to heal from violence and

identify resources aimed at ameliorating violence as they seek to provide data for the intended research question (Christensen, 2017). This process has great potential for the use of this methodology to describe healing in survivors of campus USE by enabling participants to be emotionally and physically present in their social worlds as they evaluate how it impacts and influences their wellbeing and growth.

Despite the promise of photo elicitation in GBV survivors, only one study to our knowledge has utilized photo elicitation in survivors of campus sexual violence (Rolbiecki, Anderson, Teti, & Albright, 2016). This study, however, used PhotoVoice as a narrative intervention for survivor healing, rather than using the data it provided to shed light on what the healing process looks like through survivor's eyes. Relatedly, the group discussions typically required for PhotoVoice may inhibit the participation of individuals who desire anonymity in their survivorship, making it critical to create a platform to capture the voices of other individuals who may vary in their healing process. Therefore, the purpose of this study was to describe the day-to-day healing processes of female survivors of undergraduate USEs using a photo elicitation methodology. Understanding and synthesizing shared healing themes from the perspective of survivors is important to ensure future interventions are tailored to mitigate the barriers and promote the strengths of one's social environment. This can lead to a more supportive culture to empower survivors to seek help and heal from their experiences.

Methods

Study Design. This study was part of a larger multiple method project that aimed to better understand healing from USEs on college campuses, and the larger project included surveys (N=206) as well as a retrospective qualitative interview (n=24; Sinko, Munro-Kramer, Conley, Ploutz-Snyder, & Saint Arnault, under review: Sinko, Ploutz-Snyder, Munro-Kramer, Conley, & Saint Arnault, under review). The present study focuses on data collected in the

photo elicitation component of that larger study, which aimed to describe the day-to-day healing processes of our participants through the depiction of both healing and darker moments in their daily lives. We used photo elicitation for a survey subsample of seventeen females who self-identified as having a USE while being enrolled as an undergraduate. Eligible participants in the larger study were over eighteen, self-identified as female, and were either currently enrolled in an undergraduate program, or had graduated from an undergraduate program within five years prior to completion of the survey. Participants were recruited through an email link sent out through a Southeastern Michigan university sexual assault center as well as through a Southeastern Michigan university health system research portal, designed to connect individuals who have interacted with the health care system to relevant research opportunities.

This study was approved by University of Michigan Institutional Review Board (HUM00144780). All eligible participants were provided with an informed consent form for participation and audio-recording of the interview as well as for future publication of their photographs. After completing the survey and the retrospective interview, interested participants were provided with written instructions containing the photography task as well as how to upload photographs to a secure research drop box. Participants were asked to take photographs with their personal cell phones or cameras of "healing moments" (e.g. moments that they felt connected, whole, or well) as well as "darker moments" (e.g. moments that they felt vulnerable, blamed, ashamed, or fearful) throughout the next two weeks. Participants were invited to take as many photographs in either category as they desired, but were asked to select and upload only 7-10 that they would be willing to discuss during their interview two weeks later. Participants were instructed to not take identifiable photographs of human subjects for privacy and confidentiality purposes. Participants were instructed to upload their photographs 48 hours before their interview to a secure research drop box that they were invited to by the study team.

All uploaded photographs were printed for use during the interview. The follow-up interview ranged from 45 to 75 minutes and was conducted at a private room in a Southeastern Michigan university setting. Two digital tape-recorders were used to safeguard against loss of data. During the interview, participants were asked to tell the story behind each of their selected photographs as well as how it relates to their day-to-day healing journey. Participants were then asked to caption each photograph and write the caption along the bottom of each photographic print. Once every photograph was discussed, participants were asked to use pile sorting to cluster their photographs and systematically analyze their own data for key themes. Participants were then asked to define what healing meant to them and discuss what their needs may be going forward. After the interview, copies of the photographs were given to the participant as well as local psychological support resources. Participants then filled out a seven item questionnaire with responses on a three point Likert scale (anchored with "not at all" and "fully") to evaluate the interview methodology.

Participants. Seventeen women ages 18-26 were included in the analysis. Ten women were current undergraduate students at a four-year institution and seven women were alumni. Eleven women identified as Caucasian, three women identified as African American or Black and three women identified as Asian. Fourteen women disclosed substances were involved at least some of the time during these undergraduate USEs. Demographics and victimization history for this sample can be seen in Table 6.

Photographs. Eleven women captured photographs that included other people, nine women captured photographs that depicted a time they were intentionally alone, nine women included photographs of nature, and seven women included photographs that included animals. Four women included photographs that had their faces in them, despite being given instructions to not do so. These photographs were analyzed, but not published due to IRB concerns.

Table 6: Photo Elicitation Sample Victimization History

Age	*N=17*	**Childhood GBV Trauma**	*N=17*
18-21	6	Physical or Emotional Abuse	5
22-25	9	Sexual Abuse	3
26-30	2	Witnessed Domestic Violence	2
Race		**Sexual Victimization History**	
Caucasian	11	Sexual Assault	16
African American or Black	3	Domestic/ Dating Violence	6
Asian	3	Complex trauma	8
Sexual Orientation		**Unwanted Sexual Intercourse History**	
Heterosexual	11	Never	3
Bisexual	6	1-2 times	11
USE Perpetrator History		3-5 times	3
Romantic Partner	7	More than 6 times	0
Casual or First Date	5	**Unwanted Sexual Contact History**	
Non-romantic Friend	3	Never	1
Acquaintance	4	1-2 times	7
Authority Figure	1	3-5 times	4
Stranger	8	More than 6 times	5

Analysis. Holistic and cross-sectional data analyses were conducted by the first author. This analysis structure has been used in other PhotoVoice and photo elicitation studies (see Burles & Thomas, 2013 for example). Holistic analysis involved looking at individual cases within the data set to understand the 'particular in context' or in this case, the healing and darker

themes for the individual themselves (Mason, 2002, p. 165). Cross-sectional analysis was then completed to apply consistent categories found to the entire data set, which enabled identification of similarities and differences in healing and darker moments in our sample (Mason, 2002). By using both of these approaches, we sought to develop a comprehensive understanding of each participant's experiences of healing after USEs, as well as to identify common experiences among participants.

Several close readings of the transcripts contributed to a preliminary sense of the interviews, and identification of thematic categories was achieved by synthesizing the healing and darker themes identified by each individual participant through their photographs and corresponding captions. Once broad themes and sub-themes were determined, the study team printed the photographs and wrote each participant identified theme on the back. The research team then completed pile sorting of the printed photographs to classify and code each photograph under each pre-identified theme. If a photograph did not seem to be applicable to any of the initial thematic categories, reconciliation meetings were held with the first author and her chair to determine additional themes that may not have been captured initially. An audit trail using personal, theoretical and analytic memos was maintained and was reviewed every other week by the dissertation chair, with coding concepts being discussed at length in research team meetings for verification of accuracy. Triangulation between both the larger quantitative survey and the previous narrative interview verified the trustworthiness of findings (Bignante, 2010).

Findings

Meta-narrative: Healing is Not Linear. Overall, healing was described by our participants as a nonlinear process across a continuum that was influenced by both healing and darker moments in their day-to-day lives. Through their photographs, survivors described moments of unpredictability surrounding one's wellbeing and the need for patience when

"setbacks" arose that led them question the progress they had made thus far. For example, one participant took a picture of a multi-colored bath bomb and said, "Emotions in general are kind of like an explosion of different colors like [what is depicted in the photograph]. So, it's like nothing is ever linear to me. It's kind of like an up and down kind of situation, just like how like different colors change" (Participant AT0313). Similar sentiments were echoed among our other participants, with the general message that challenging oneself to engage and be present within both healing and darker moments, although often uncomfortable, was growth producing. Ultimately, understanding that the process takes time, but "looking at [pain] as an opportunity to grow" seemed particularly worthwhile in our sample's day-to-day healing journeys (Participant SO054).

Darker Moments. The darker moments that our participants described typically centered on environments or interactions that elicited distress or triggered difficult memories of their USEs. Common darker emotions that interfered with survivors daily functioning included feelings of fear, anxiety, loneliness, guilt, and worthlessness. The emotions could solicit overwhelm in survivors, leading many to disconnect from their emotions as a protective means of control. Alternatively, some survivors chose to be "intentionally" vulnerable in order to process, acknowledge, and feel their emotions.

Darker Emotions were frequently depicted by survivors photographs (See Table 7 for details). *Fear* was highlighted as a frequent dark emotion that survivors experienced in their everyday lives with ten women mentioning "fear," "being afraid," or "being scared" during their follow up interview while discussing their photographs. Fear primarily manifested when the participants thought about their future and their ability to recover from their experiences, when they had flashbacks or nightmares, or when they felt unsafe as they navigated their social worlds.

Table 7: Darker Moments Themes

Darker Moment Theme	Participants	Exemplar Photo Caption	Exemplar Photo Content	Exemplar Participant Quotation
Fear	AN2414 CL099 GR2424 NO2172 WB279 AN034 CH1528 SO054 CO0303 DE0507	Frustrated Fear	Her dark apartment after she heard guys being rowdy outside	"I guess it's frustrating that women…have fear kind of engrained into them or that extra thought process of like what actions do I need to take to make sure that I'm safe. First, I was scared and then I was annoyed and frustrated I was scared" (Participant SO054).
Anxiety	AK0112 AN034 AN2414 AT0313 BO1912 CH1528 DE0507 GR2424 MI0321 SO054 CL099	Anxiety Overload	Her fingernails that were short from biting them	"I was sitting in my bathroom and I was really anxious…I was having the UTI…I have a really bad habit of [biting my nails] when I'm anxious… my mind was just racing like I was just thinking of everything like going wrong and like how it all relates…just like blaming myself and like worrying." (Participant AN2414).
Loneliness	AN034 AT0313 BO1912 FH0207 GR2424 MI0321 NO2172 RO267 WB297 YO0118	Watching as they drive away	The front seat of a car with two people driving at night.	These are like my close friends and I was sitting in the backseat during this car ride and feeling very detached, um, and depressed and alone. And those moments will just like hit once in a while and I don't always totally know why and like I was just feeling, um, like triggered and weird and anxious (Participant BO1912).
Guilt	AK112 AN034 CH1512 CL099 GR2424 NO2172	Everything is connected	Herself crying	"When you're dealing with trauma and you're in your head about it, you start feeling guilty about it and feeling like you shouldn't be as affected by it… [you] feel guilty by your own emotions like you're overreacting" (Participant CH1512).
Anger/Frustration	AK0112 AN034 BO1912 CH1528 CO0303 DE0507 SO054 FH0207 RO267 YO1008 WB297	Shattered Emotions	Shattered glass on pavement taken after witnessing a woman get injured and robbed by a man	"It just made me mad and pissed me off because, obviously, I just don't see how people could just do [that to a woman]. It happened so quick and [she had] a toddler… I just want to bring more awareness…stop being angry and putting into action" (Participant RO267).

Anxiety was another dark emotion that was frequently mentioned by our participants, with eleven women mentioning "anxiety" or "feeling anxious" during their follow up interview. Anxiety typically manifested when participants felt they could not be successful in their personal or

professional lives due to their mental health concerns, when they felt "out of control," when they were left alone with their thoughts, when they were exposed to triggering stimuli, or when participants worried about how others viewed themselves or their actions. Anxiety was an emotion that many survivors attempted to manage through medication as well as through learned coping skills gained through therapy or the utilization of other mental health services, although many still mentioned struggling to manage these symptoms.

Feelings of *loneliness* were additionally cited by our participants as negatively impacting their emotional wellbeing, described by ten women in our sample as feeling "alone" or "lonely." Loneliness was typically described as feeling as though people did not understand the participant, feeling as though one could not be themselves around others, or discomfort when one was physically alone. Interestingly, many individuals cited that physically being alone was an important part of the healing process and that "finding comfort in being alone" was important (Participant NO2172). Six of our participants specifically mentioned feeling *guilt* during their day-to-day lives. These feelings of guilt occurred when one engaged in coping that they knew was unhealthy (e.g. smoking, self-injury, substance use) as well as when they took time away from work or school to participate in self-care. Interestingly, our participants also appeared to feel guilt when they were feeling negative emotions, doubting whether or not they were "overreacting" or allowed to be upset for this long about their experiences. The final darker emotion that our participants mentioned was *anger or frustration* described as feeling "frustrated," "angry," or "mad." Eleven of our participants mentioned anger or frustration, primarily in the context of the continued perpetuation of violence against women, as well as towards themselves for being unable to get over their situation fast enough as well as at others for not understanding what their needs were. Ultimately, managing these darker emotions was critical for survivors, to enable them to process and validate their experiences.

Response to darker emotions were also frequently depicted in survivors photographs. Participants responded to darker emotions in a variety of ways. Some in the sample disconnected from negative emotions. This was typically depicted by photographs taken in which individuals felt alone or detached while they were in a group setting or when they were participating in activities that distracted themselves from their darker emotions (See Figure 6). Others felt overwhelmed and "weighed down" by these feelings. This was typically represented through pictures that depicted chaos in their physical environment as well as visuals of competing demands piling up. Participants also represented this phenomena by taking photographs of the environment they were in when they were overwhelmed or feeling immobilized by their thoughts (See Figure 7). Ultimately, allowing oneself to feel negative emotions and giving oneself permission to experience these moments without residual guilt seemed healing for participants. For example, one participant took a photograph of her hair on her pillow with the caption "but I need to feel it" in order to depict a time that she allowed herself to be upset in her room in order to validate and cope with her emotional turmoil (Participant AT0313; See Figure 8).

Figure 6: "Watching As You Drive Away"- Participant BO109

Figure 7: "Inside Out" Participant AN024

Healing Moments. Our participants described healing moments as situations or actions centered on self-care, self-love, connection, hope, peace, and feelings of freedom. These moments were typically influenced by resources survivors utilized to aid in their healing, authentic interactions that these women had with others, as well as self-reflection. Ultimately, like with the darker moments, being intentionally vulnerable seemed important in order to allow oneself to feel and fully experience these healing moments (See Table 8).

Figure 8: "But I Need To Feel It"- Participant GR2424

Table 8: Healing Moments Themes

Healing Themes	Participants	Exemplar Photograph Caption	Exemplar Photograph Content	Exemplar Participant Quotation
Self-love	BO1912 CH1528 DE0507 CH128 RO267 NO2172 GR2424 YO1008 MI0321 SO054 CO0303 FH0207	Artistic validation and acceptance	Ceramic art pieces she created and sold to celebrate the female form	"Part of my art is about normalizing the body and accepting it …I feel like I become more comfortable with myself, you know, when I'm sculpting different stretchmarks and I'm adding cellulite…feeling like the things that I've been taught are flaws in myself don't need to actually be thought of as flaws, they're just parts of bodies that are normal and natural" (Participant CH1528).
Connection	AN034 AT0313 BO1912 GR2424 MI0321 FH0207 DE0507 NO2172 RO267 WB297 YO1008 SO054 CH1528	Vans	A circle of feet wearing similar sneakers	"I went out with a couple of my friends and we didn't plan it but all of us happened to be wearing Vans so we took a picture of it…I just thought it was nice like I don't go out with my friends a ton…I am usually super antisocial, very secluded…but I've been trying to make an effort this spring to hang out with people and make sure that I'm getting out of my house…I felt really included, honestly…I'm like trying to make an effort to be with people again (Participant MI0321).
Hope	AN034 AN2414 MI0321 BO1912	Purple Hope	Feet standing amongst	"I just got this like cool job and I was about to go to this job meeting and I was walking there. I took a picture of my feet with these flowers because I

	GR2424 DE0507 NO2172 WB297 CH1528 CO0303 CL099 SO054 AK0112 RO267		purple flowers	thought that the flowers were beautiful and I was feeling really like hopeful.I haven't like felt really hopeful or successful recently…so, this moment was me feeling like hopeful for this job that I was about to go and talk about. Um, and I guess like noticing that hopefulness…" (Participant BO1912).
Peace	MI0321 CO0303 AK0112 GR2424 NO2172 WB297 YO1008 DE0507 RO267	Feeling at peace with myself and the world	Her partner hiking in a green forest far ahead of her	"So, I went to Niagara Falls for the first time… it just was so serene and quiet and peaceful, and it just felt like you were breathing in all of the clean forest air, and I just felt really at peace there which was nice…I'd like to experience more moments like that, having more of those calm moments where like you feel at peace. You don't feel the pressure of the world. It's a time to like be introspective and just experience things" (Participant WB297).
Freedom	AK0112 AN034 BO1912 CO0303 DE0507 SO054 FH0207 RO267 WB297	Freedom	A steering wheel of a car and the road ahead	"I just like feel free when I'm on the freeway and like driving, listening to music… I'm just like doing me on the freeway and I just like feel good. I don't know why…and like, I don't do anything without music but like the night I got assaulted I drove home. I was on the freeway and I didn't turn on the radio…I will always remember that like I did not turn on the radio..." (Participant DE0507).

Facets of day-to-day healing. Self-love was depicted by twelve of our participants, described as feeling "comfortable" within oneself and "being intentional and setting aside time" to nurture oneself (Participant GR2414). Self-love manifested in a variety of ways including engaging in self-care activities, practicing self-acceptance, reclaiming one's body, and challenging one's negative self-view. Participants often described the journey to self-love as a process, and that they often felt that they had to "fake it sometimes" and "not get down" on themselves when they were not feeling positively about themselves (Participant BO1912). **Connection** was another important aspect of healing, depicted by thirteen of our participants. Connection in our sample was described as feeling "present" or "connected" within oneself, with

others, or with the world. Connection was described through photographs depicting moments of self-reflection, feelings of belonging, feelings of trust, and feelings of wonder and awe. **Hope** was described as healing for fourteen of our participants, described as having faith, seeking positivity, and seeing new possibilities. Hope seemed to typically manifest when our participants felt inspired by others around them, capable that they could handle their future, or competent in their everyday lives and able to reach their goals. Hope of healing or of a safer world seemed incredibly important in this sample, as it helped propel them forward when they felt that they were "set back" or "stuck" in their recovery process (Participant AN2414; Participant CL099). Another type of healing moment that was depicted in our participants' photographs was a moment of **peace**, described by nine women as instances when they felt "peaceful," "relaxed," "calm," or "serene." The majority of the photographs that highlighted feelings of peace included environments that individuals felt were healing to them, moments when one was alone and felt comfortable rather than lonely, or moments when one was surrounded by nature and able to "unplug."

One final healing moment that was mentioned by our participants was feelings of **freedom**. Freedom was depicted by nine of our participants described as moments of "lightness" in which individuals could embrace positive emotions such as enjoyment and happiness. The majority of the photographs depicting feelings of freedom surrounded moments that made the participants laugh, feel able to be silly, or able to have fun, without feeling "weighed down" by their negative thoughts.

Healing promotion. Women explained that engaging in situations that promoted healing was important because they enabled them to identify and engage with their healing moments as they progressed. A variety of situations seemed to promote healing moments, including self-reflecting, utilizing resources, and authentically interacting with others. **Self-reflection** was described by our participants as enabling them to connect with their emotions, appreciate themselves and the things around them, and identify what was working for them and what their needs were going forward. Self-reflection was often facilitated by journaling, allowing oneself to unplug, and confiding in supportive others (See Figure 9). **Resource utilization** was another identified facilitator of healing moments, enabling survivors to learn skills to manage their distress, cope with competing demands, and create a more supportive environment for themselves to heal in. Engaging with resources, particularly mental health resources, facilitated self-awareness, challenged their negative thinking, and enabled them to feel heard and understood. Resource utilization was often depicted by participants taking photographs to represent how they felt prior to utilizing professional services or how they felt after (See Figure 10 for example). Finally, **authentically interacting with others** promoted healing in our participants, depicted by photographs in which they felt "relaxed" around other people, comfortable within their own identity, and able to experience

Figure 9: "Resting Place" - Participant AN024

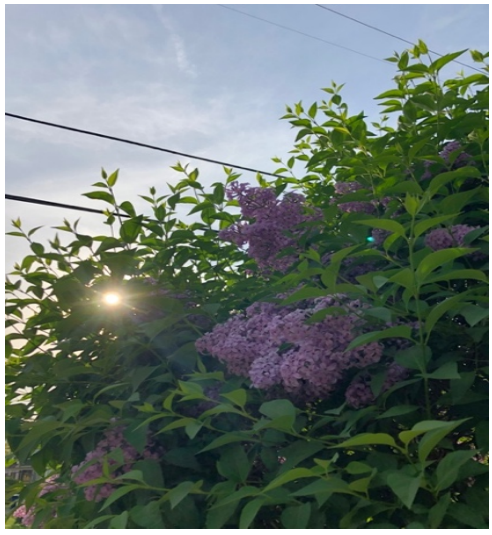

Figure 10: "Looking Up Moving Forward" - Participant NO2172

both dark and healing moments without fears of judgement or scrutiny (See Figure 11). For many, this included being open about their trauma to trust others, to enable their support networks to truly understand their whole selves. In reference to this, one person said, “I express every other part of myself so if I didn’t express [the traumatized] part of myself as well, it would feel really inauthentic. And it would feel like I was telling myself that something was wrong with it” (Participant CH1528).

Healing through Photography. Although not in our additional aims, our interviews revealed the potential usefulness of photography as a healing promotion method in itself. For example, fourteen out of 19 participants indicated on our post interview survey that the methodology “fully” helped them understand how to improve their situation and that it gave them new ways of looking at their problem. Twelve out of 19 participants indicated that they “fully” had a good understanding of the changes that they needed to make to improve their situation. Eighteen out of 19 participants believed that this methodology covered the most important aspects of their healing journey. Example of participant comments pertaining to the methodology included; “this covered themes in a succinct way,” “I did not realize before how I prioritized some things over others when it came to healing, and “I liked being able to keep the photos as a reminder of my process after the study was over.”

Figure 11: "Vans" - Participant MI0321

Discussion

The present study sought to describe the day-to-day healing processes of survivors of USEs through photo elicitation of both healing and darker moments in survivors’ daily lives.

Healing was found to function on a continuum influenced by darker moments (i.e. moments that elicited fear, anxiety, loneliness, guilt, anger, and worthlessness) and healing moments (i.e. rebuilding moments of self-care, self-love, connection, hope, peace, and freedom). Responses to darker moments included feeling overwhelmed, disconnection, and intentional vulnerability. Healing moments were promoted through self-reflection, resource utilization, and authentic interactions.

Healing from sexual violence was described by our sample as a challenging, non-linear process. Our study's metanarrative revealed that the process of healing often felt uncomfortable, creating some feelings of confliction as one toggles between keeping themselves safe while challenging themselves to engage in the process (Sinko & Saint Arnault, in press). Supporting this idea is a qualitative metasynthesis of sexual violence recovery referenced earlier in this article. In this review, the authors revealed a taxonomy of sexual violence healing responses supporting the confliction and disconnection survivors often feel after sexual violence (Draucker et al., 2009). Although the authors highlighted that the key healing domains were relating to others, feeling safe, and re-evaluating the self, under each domain, the authors additionally highlighted confliction between these themes and other self-surviving strategies (e.g. escaping memories vs. being drawn to them, keeping others out vs. seeking the help of others, repairing damaged aspects of self vs. protecting one's identity). Overall, this metasynthesis suggested that managing these complex, often contradictory, survival and recovery strategies can begin to aid survivors in making sense of their social worlds, connecting them to their surroundings while attempting to create a new normal. Our study adds additional evidence to this idea, revealing that for many women, managing these opposing survival strategies, while fully experiencing and embracing both negative and positive emotions, may be the key to successfully adapting and healing after USEs.

Our findings additionally revealed that the day-to-day interaction with one's environment and one's community is particularly influential as one navigates daily healing after sexual violence, particularly due to the mistrust survivors often feel after their experiences (Lonsway, 2017; Koss, Dinero, Seibel, & Cox, 1988). The impact of personal violation on ones' worldview has been reported in numerous qualitative studies, finding that it can impact survivor autonomy as well as shatter ones belief in a safe, benevolent world (Lim, Valdez, & Lilly, 2015; Lilly, Valdez, & Graham-Bermann, 2011; Lim, Adams, & Lilly, 2012). Our findings indicate that environments or individuals that reinforce feelings of calm or goodness can be particularly powerful for challenging one's negative beliefs while promoting healing moments such as hope, freedom, and peace. This can enable individuals to begin to rebuild connection and trust, linked in other studies to contribute to positive adaptation among survivors of sexual assault as well as intimate partner violence (Coker, Smith, Thompson, McKeown, Bethea, & Davis, 2002; Sinko & Saint Arnault, in press; Ullman, 1999). Ultimately, our research further emphasizes the important role support people play as survivors manage their day-to-day feelings and symptoms, making it increasingly important to be mindful of our responses and reactions to survivor distress as well as the environments we create at our institutions, shaped by student rhetoric and external pressures of university life.

Interestingly, four women chose to take photographs of their faces despite being instructed not to do so. This was cited as an important depiction of their healing, as they were proud in their identity and showing their faces was a significant part of that journey. This points to an area for future inquiry, to better understand appropriate restrictions for projects of this kind to protect survivors privacy while empowering them to tell their stories the way they would like them to be told. Future research should push back against assumption that all survivors would want to be anonymous, in order to allow women to combat their shame by fully depicting their

healing experiences and breaking their silence.

Finally, the present study also revealed the promise of photo elicitation and other forms of autophotography in promoting the understanding of sensitive, complex phenomena such as healing and potentially, facilitating healing itself within our participants. By allowing the introduction of participant-driven photographs, photo elicitation allowed the emotions, feelings, and the ideas of the participants to drive the interview process, creating a comfortable place for discussion without the imposition of researcher assumptions (Epstein, Stevens, McKeever & Baruhel, 2006). Relatedly, we noted the unique ability of photography and photo elicitation discussions to make the implicit explicit in our participants by allowing them to externalize their experience, while enabling them to make meaning of their lives and identifying their needs going forward. This was not only observed by the research team, but was also mentioned by participants themselves, as the majority indicated in their post interview evaluations that this methodology helped them understand how to improve their situation and enabled them to look at their problem in a new way. Similar observations have been supported elsewhere when utilizing photography techniques with one author noting that due to the differing parts of the brain that process visual and auditory information, visual images may evoke deeper parts of human consciousness than words alone (Harper, 2002; Glaw et al., 2017).

Preliminary pilot studies have supported these proposed hypotheses and observations, and few have begun to test the ability of photography in promoting healing in similar populations. For example, one study looking at nine survivors of campus sexual assault found that through engaging with a PhotoVoice methodology, participants were able to expose themselves to triggers, facilitate meaning making, build relationships, and promote consciousness raising of the important issue of college sexual assault (Rolbiecki et al., 2016). These authors also found that PhotoVoice was an effective narrative intervention in their

population, reducing study participants' posttraumatic stress symptomology while increasing posttraumatic growth and positive rape attributions (Rolbiecki et al., 2016). Additional research is needed, however, to further explore and test this methodology in a larger sample to better understand its effectiveness as an intervention to promote healing in survivors of USEs.

This study is not meant to be generalizable due to the qualitative nature of our data collection. It is important to note several limitations, however, including our primarily Caucasian, Midwestern sample mostly affiliated with a major university. The findings from this study may have been influenced by priming due to the nested sample design. Additionally, there is a possibility of self-selection bias, such that we did not speak to women who did not label their experiences as unwanted or were uninterested in discussing their healing processes. Future research is needed to better understand the healing process of individuals with differing cultures, genders, and sociodemographic status to evaluate how personal characteristics can influence survivors' healing processes. Despite the specificity of this sample, the findings of this study help illustrate the process of day-to-day survivor healing, grounded in the images of participants social worlds. The new knowledge created by this study has the potential to impact not only survivors own understanding and self-compassion for themselves as they navigate their own healing journeys, but also how support people and clinicians interact with survivors by educating about the day-to-day impact sexual violence can have long after an individual's assault experience.

This study is the first we are aware of to utilize photo elicitation to understand the day-to-day healing processes of female survivors of undergraduate USEs. Future research should continue to explore this methodology in this population to both facilitate a deeper awareness of the mental health impact of sexual violence as well as to potentially promote self-reflection and self-awareness in this population. By empowering survivors to tell their stories and creating an

opportunity for them to reflect on their progress and triumphs, we as researchers can not only better understand the impact of sexual violence, but can also help our participants recognize the strength within themselves.

Chapter IV Conclusion

Summary

This dissertation sought to better understand the lived healing experiences of female survivors of undergraduate USEs through multiple methods. We started by launching an online survey, to better describe the mediating role of trauma-related shame on the relationship between perceived peer rape myth acceptance and PTG (N=174). Through this survey, we also explored the individual and shared variance contributions of demographic, mental health, and trauma history predictors on PTG (n=155) using hierarchical ("block") regression. Results revealed that although trauma-related shame did not mediate the relationship between perceived peer rape myth acceptance and PTG, mental health symptoms and trauma history significantly contributed to 35.27% of PTG variance, with trauma history significantly impacting PTG scores beyond mental health symptoms alone. These results highlighted the importance of assessing not only one's previous victimization history, but also how one integrates trauma into their identity, as the centrality of one's most distressing event significantly and independently contributed to 8.3% of one's posttraumatic growth variance.

We then utilized the Clinical Ethnographic Narrative Interview in a subsample of our survey participants (n=24) to describe one's healing progress after undergraduate USEs as well as to understand the internal and contextual influences of trauma recovery (Saint Arnault, 2017). Our grounded theory analysis yielded the Healing after Undergraduate Unwanted Sexual Experiences Model. In this model, the normalization of sexual aggression within one's social context was found to influence how one made meaning of their USE, activating a cascade of

emotions (shame, self-blame, fear, anger/frustration) and impacting their ability to integrate trauma into their identity. Through this model, we showed that by externalizing one's trauma and integrating it into one's core identity, survivors of campus USE were able to pursue identified healing goals (i.e. reconstructing identity, cultivating worthiness, regaining trust, rebuilding worldview, and finding your voice). These findings can be used to normalize the mental health struggles that many survivors face as well as promote hope in this population by educating both survivors and service providers about the recovery process.

Finally, we used a photo elicitation methodology to encourage a subsample of our narrative interview participants (n=17) to photograph both healing and darker moments within a two-week timespan following their narrative interview. Willing participants selected 7-10 photographs and were then brought back for a final one-on-one interview to describe the stories behind their photographs, caption each image, and use a pile sorting methodology to identify healing themes and needs going forward. Our holistic and cross-sectional thematic analyses indicated that day-to-day healing functions on a continuum, impacted by darker moments (i.e. feelings of fear, anxiety, loneliness, guilt, anger, worthlessness) manifesting in overwhelm, disconnection, or intentional vulnerability as well as healing moments (i.e. rebuilding moments of self-care, self-love, connection, hope, peace, and freedom) influenced by self-reflection, authentic interactions, and resource utilization. These findings shed light on the impact of USEs long after the assault itself, as well as the important influence of one's interactions, personal decision-making, and environment on survivors' day-to-day wellbeing.

Next Steps

Taken together, the results of this dissertation as a whole significantly contribute to our understanding of undergraduate USE healing, by creating a roadmap that can be used by survivors and service providers to better understand important influences and benchmarks of

survivor recovery. Through our inquiry, we have laid the groundwork for scientific theory to explain survivor's trauma recovery processes and perhaps why women often take many years before fully engaging in their healing. We hope to expand upon the themes identified by adding diverse voices of additional survivors in the United States and abroad, to test the proposed relationships and better capture how one's culture and social upbringing can shape one's recovery needs and desires.

Improving Trauma Recovery Instruments. Looking forward, now that we are aware of particular domains of healing that are important to this population, we also hope to reevaluate existing trauma recovery measures to ensure trauma healing is being captured through a holistic, survivor-centered lens. For example, through our literature reviews, we noticed that the majority of outcome instruments utilized in this population focus on survivor distress, often equating a decrease in symptom burden with healing. While we acknowledge that managing symptoms is an important element of sexual violence healing, our results show that survivors desire more in their recovery experiences.

Although some scientific instruments have measured positive growth or change in this population in the past, many measurement tools have been generated to be applicable to survivors of all forms of trauma, impacting their ability to directly resonate with sexual violence survivors due to the deeply personal and unique nature of this type of traumatic experience (Shakespeare-Finch & De Dassel, 2009). For example, although we used the concept of PTG as our main healing outcome measure for our study, the was the concept as assessed in Tedeschi and Calhoun's (1996) inventory, may be problematic for this population, indicated by our low levels of growth found in this population (M=48.2). Specifically, the stem of the questions "as a result of my crisis" may feel objectionable to assault survivors. Although the captured domains of relating to others, finding new possibilities, personal strength, spiritual change, and

appreciation of life appear to be relevant to this population based on this dissertation's findings and other studies (e.g. Sinko & Saint Arnault, in press), the concept of PTG states that one experiences such positive changes as a result of their crisis, rather than as a result of personal efforts towards healing and recovery (Tedeschi & Calhoun, 1996). This language may feel disempowering to sexual violence survivors and be difficult for them to relate to, as attributing positive changes due to merely experiencing trauma itself, may not give justice to the work and effort many women put into their healing journeys. Particularly due to the emphasis our sample put on feeling strong and capable throughout their recovery experiences, it is our suggestion that reevaluation is needed to make this measure more relevant for survivors of interpersonal trauma, potentially by changing the stem to attribute growth to one's healing and help-seeking actions, rather than directly to the experience of trauma itself.

Further Exploration of Identity and Trauma Integration. Additionally, these dissertation findings uncovered the central importance of identity formation and reconstruction in the young adult healing process, providing an important new window of inquiry in this population. Notably, this study was the first we are aware of to discover the unique contribution of centrality of trauma on PTG beyond one's existing mental health symptomology and victimization history in this population. This is an important distinction to make, as many trauma assessments focus on the number of events or type of trauma experienced as well as resulting mental health outcomes, but do not assess how central trauma is to the survivor's identity and its impact (e.g., Felitti et al., 1998; Hooper, Stockton, Krupnick, & Green, 2011). Future research is needed, however, to evaluate the degree to which trauma integration is healthy, as our qualitative results revealed that while integration of trauma into one's identity was identified as important for participants, equally important was building up other parts of the self that the survivor takes pride in. As movements such as #TimesUp and #MeToo continue to rise on social media

platforms, personal survivorship identity and how that translates to health outcomes is becoming increasingly important to understand to guide survivors as they navigate the socio-political spaces that they are a part of. Because of this, it may be particularly interesting going forward to not only begin to assess the centrality of one's trauma as we try to understand recovery needs in the clinical setting, but also for future research to identify subgroups of individuals along the integration continuum, to discover what degree of integration yields the most promising health outcomes in this population.

Improved Measurement of the Normalization of Violence. This dissertation also revealed the important influence of the normalization of violence within American university culture on not only the perpetuation of violence, but also on one's meaning-making and healing processes. We know that sexual assault does not occur in social and cultural isolation, yet quantitative research on sexual violence has yet to take fully into account how the rape-prone culture in which we live not only tolerates male violence against women but also negatively impacts healing and recovery after sexual violence (Campbell, Dworkin, & Cabral, 2009; Rozee & Koss, 2001). Although some measurement tools capture elements of normalization (e.g. rape myth acceptance), no tools to our knowledge incorporate the cultural messages that young girls get in America through their social upbringing, the media, as well as through the hook up norms and scripts that they are taught through the observation of peers in the high school and university setting. Ultimately, in order to move the state of the science forward for this population, better assessment of the beliefs and attitudes within one's environment is critical, to understand important influences to growth and recovery in one's social and cultural environment. By empowering survivors of campus USE to recognize their strengths and rise above this powerful socio-cultural silencer, we can be begin to create a hopeful university environment that better supports survivor growth and healing needs.

Potential of Interview Methodology for Future Research and Intervention. Finally, although not in our initial aims, this dissertation revealed the importance of our qualitative methodology as a potential intervention for survivors of sexual violence as well as a promising methodological combination to understand abstract phenomena in different areas of study. For example, after the CENI, 23 of our 24 participants indicated that the methodology either "somewhat" or "fully" contributed to their understanding of how to improve their situation and gave them a different idea about what their problems were. Relatedly, all 24 of our CENI participants indicated the promise of this methodology as being the correct approach for them as well as covering important aspects of their story, with twenty participants citing "fully" as opposed to "somewhat" or "not at all" in both of those categories. For our photo elicitation methodology following the CENI, participants similarly noticed the self-awareness gained with all seventeen participants indicating that the methodology either "somewhat" or "fully" contributed to their understanding of how to improve their situation and gave them a different idea about what their problems were. Relatedly, all seventeen of our women indicated the promise of this photo elicitation methodology as being the correct approach for themselves as well as covering important aspects of their story, with fifteen and eighteen respectively citing "fully" as opposed to "somewhat" or "not at all" in both of those categories.

Taken together, as a research method, the CENI and follow-up photo elicitation experience shows great promise in promoting participant engagement while providing rich data about these phenomena of interest. Both methods have narrative inquiry roots and provide the opportunity of validation, cathartic release, as well as the ability to move once implicit traumatic memories into the brain for the processing and storage within one's conscious mind (Crossley, 2000; Koch, Fuchs, Summa, & Mülller, 2012; Saint Arnault, 2017). The interview process as a whole allows the participant to reflect on feelings and experiences in a way they may not have

previously done in the past, causing many to note feeling tangible benefits from the awareness gained through this process (e.g. Sinko & Saint Arnault, in press). Similar observations have been supported elsewhere when utilizing similar techniques with one author noting that visual images may evoke deeper parts of human consciousness than auditory processing alone, enhancing the data collected (Harper, 2002; Glaw et al., 2017).

Additionally important was the ability for the interview style to promote participant comfort. We noted the CENI's ability to facilitate the telling of one's story through open-ended questions and participant activities, maintaining safety of its participants by providing space for autonomy and therapeutically using the trauma narrative the participant is comfortable telling (Saint Arnault, 2017). The structure of the interviews also put the researcher into the role of a compassionate witness rather than an interrogator, building relational trust between the participant and the study team. These are important elements to consider when qualitatively engaging survivors of trauma in narrative research (De Haene, Gritens, & Verschueren, 2010; Richards, & Schwartz, 2002) and anecdotally seemed to promote participant comfort in the research process, promoting willingness for follow up participation and research activity engagement.

The addition of the photo elicitation experience allowed the researcher to get a glimpse of survivor's social worlds, providing experience data collection beyond the retrospective view of the phenomena of interest. Experience sampling, through mediums such as photography, is especially important for the assessment of moods, thoughts, symptoms, or behaviors believed to change over time (Ebner-Priemer, Eid, Stabenow, Kleindienst, & Trull, 2009) giving it great value to this study in particular. Presently, photography has been utilized in many studies to facilitate discussion of potentially difficult or sensitive topics, and have been gaining traction as a feasible and effective means to address a variety of public health concerns, providing rich data

for analysis and dissemination (Cabassa, Parcesepe, Nicasio, Baxter, Tsemberis, & Lewis-Fernandez, 2013; Padgett, Smith, Derejko, Henwood, & Tiderington, 2013; Wang, Cash, & Powers, 2000). By allowing the emotions, feelings, and the ideas of the participants to drive the interview process through their photographs, a comfortable place for discussion can be created (Epstein, Stevens, McKeever, & Baruhel, 2006). Relatedly, the use of the photo elicitation provides rich opportunities for nontraditional research dissemination and engagement, particularly in the college student population, as it is a relatable medium for college-aged students who often use photography to express themselves.

These qualities, among others, make the future use of the CENI in tandem with a photo elicitation experience in other populations quite promising. For example, one study utilized a similar two-interview structure to identify barriers and facilitators in mental health care usage for recent war veterans (True, Rigg, & Butler, 2014). This methodology was proven effective in this study and researchers commented that the use of this methodology allowed for a deeper understanding of mental health care barriers that would have been difficult to capture through a structured questionnaire (True, Rigg, & Butler, 2014). Additionally, the presentation of story-telling and photography data may be more easily digested by the general public, who may not be as comfortable reading research manuscripts compared to hearing stories and seeing visual, depictions of complex phenomena. These products can not only foster empathy, due to the nature of it being grounded in participant voices but can also create visual evidence for future social action and social justice initiatives. Future studies should explore the use of this methodology in other populations, to see if this interview structure is similarly useful in learning about differing phenomena of interest.

Importantly, our study revealed not only the potential of this research methodology as a rich data collection tool, but also suggested the benefit participants may gain by engaging with

this methodology beyond their contribution to science. By creating a space in which survivors are able to explore the significance of their experiences, similar narrative methodologies have been shown to facilitate meaning-making of traumatic experiences (McCann & Pearlman, 1992). In our particular population of GBV survivors, this can lead to a greater comprehension and understanding of the traumatic events experienced and can enable survivors to externalize their traumatic event, an important element of healing highlighted in our Healing after Campus USE model (Androff, 2012; Crossley, 2000; Crossley, 2002; Fugate et al, 2005; Saint Arnault, 2017; Scala, 2003; Sinko & Saint Arnault, under review). Relatedly, we noted the unique ability of CENI activities and photo elicitation to make the implicit explicit in our participants by allowing them to externalize their experience, while enabling them to make meaning of their lives and identifying their needs going forward. This was not only observed by the research team, but was also mentioned by participants themselves, as the majority indicated in their post interview evaluations that this methodology helped them understand how to improve their situation and enabled them to look at their problem in a new way.

Several other studies using the CENI have witnessed similar self-awareness benefits to what we noted in our participants (Saint Arnault & Fetters, 2011; Saint Arnault & Roels, 2012; Saint Arnault & Shimabukuro, 2012, 2016). Additionally, preliminary pilot studies have supported the benefits of photo elicitation discussions Rolbiecki et al., 2016). For example, one study looking at nine survivors of campus sexual assault found that through engaging with a PhotoVoice methodology, participants were able to expose themselves to triggers, facilitate meaning making, build relationships, and promote consciousness raising of the important issue of college sexual assault. These authors also found that PhotoVoice was an effective narrative intervention in their population, reducing study participants' posttraumatic stress symptomology while increasing posttraumatic growth and positive rape attributions. Additional testing of

similar narrative interviewing and photo-elicitation strategies in larger populations is needed, however, to see if any improvement in trauma-recovery related actions occurred after research engagement. Additionally, future research into the healing mechanisms of narrative research and photography methods is needed to help articulate what elements should be incorporated in interventions going forward.

Future Directions

As I disseminate these findings in the upcoming months, I will not only publish three academic manuscripts but will also be incorporating my findings to update the University of Michigan's Sexual Assault Prevention and Awareness Center's survivor recovery handbook. Relatedly, I plan to use survivor stories gained through my research to create an interactive special exhibit on University of Michigan's campus to educate about sexual violence healing. Translating findings in non-traditional ways is an important aspect of my research philosophy, as I find it necessary to make my results digestible and engaging for the populations that could benefit from it most. In this case, there are three main populations that I am targeting: survivors and their valued support people, service organizations that interact with survivors, and individuals who do not have experience with sexual violence but want to be an ally and further their understanding of survivor experiences. By targeting these three groups and engaging them with survivor's photography, advice, and stories, I hope to build understanding and decrease barriers to care for university sexual violence survivors.

My dissertation project, along with other past research experiences, has shaped an emerging program of research surrounding GBV healing which I hope to continue to explore throughout my career as I continue to grow and develop as a nurse researcher, storyteller, clinician, and advocate. As I continue throughout my career, future directions will include:

1. Conduct research on racial and ethnic differences in healing needs of survivors of campus GBV with the goal to provide evidence-based guidelines better equip organizations to provide holistic, survivor-centered care.
2. Conduct research on community, college-aged survivors of USEs that do not attend universities, to help identify gaps in care and create better infrastructure for young community women to feel supported in their healing.
3. Create and test a modified PTG measure using the stem "as a result of my healing" as opposed to "as a result of my crisis" to explore whether or not this better captures healing in survivors of sexual violence.
4. Incorporate photo elicitation into our previously existing, multi-national GBV consortium (MiStory) to better capture socio-cultural elements of day-to-day survivor healing and test whether or not this methodology in tandem with the CENI facilitates help-seeking in this population.

These objectives will be accomplished through a program of research built on the foundation of story-telling, focused on supporting and empowering survivors of trauma while improving the environments that they function within. Specifically, I would like to use the results of these studies to improve survivor messaging strategies, violence policies, clinician training, culturally-sensitive care, and survivor education. By doing this, I hope to better foster and support survivor healing while also bringing their voices to the decision-making table when policies and interventions are being created to support them.

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