

**Sexual Violence and Psychological Distress: The Roles of Coping Self-Efficacy, Self-Blame,
Shame, Activism, and Feminism**

A Dissertation Presented for the
Doctor of Philosophy
Degree
The University of Tennessee, Knoxville

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August 2023

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Acknowledgements

There are several people I would like to thank, without whom the completion of this dissertation would not have been possible. First, I would like to acknowledge the many survivors who so graciously took the time to complete the survey and share their experiences. Your participation is deeply appreciated. To the sexual assault resource centers that distributed the survey announcement, thank you for your support and willingness to help with recruitment! Thank you to my doctoral committee, Dr. Gina Owens, Dr. Joe Miles, Dr. Dawn Szymanski, and Donna Braquet for your thoughtful questions and meaningful feedback about the design and implementation of this study. To my advisor in particular, Dr. Szymanski, thank you for your invaluable support, encouragement, and guidance throughout this process. Lastly, thank you to my family and friends for lending a listening ear as I worked on this project.

Abstract

In the current study, we investigated potential direct, indirect, and moderated relations in the links between exposure to sexual violence and PTSD symptom severity and depression among a sample of 440 United States women who had experienced sexual assault in adulthood. We found that sexual violence exposure was both directly and indirectly related to PTSD symptom severity via less trauma coping self-efficacy, greater behavioral and characterological self-blame, and more shame. Sexual violence exposure was also indirectly related to depression via the same explanatory variables, except for behavioral self-blame. Contrary to our hypotheses, results indicated that involvement in anti-sexual activism and feminist identification did not buffer the direct and indirect links between exposure to sexual violence and PTSD symptom severity and depression. However, we found that involvement in anti-sexual assault activism was associated with greater coping self-efficacy and higher depression, and feminist identification was associated with less self-blame and shame. Results from this study may inform clinical interventions for survivors of sexual violence and improve overall care for this population.

Keywords: sexual violence, PTSD, depression, activism, feminism

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Chapter 1: Introduction

Sexual violence is a pervasive problem, especially for women and other vulnerable groups. The National Intimate Partner and Sexual Violence Survey (NISVS; Smith et al., 2017) indicates that about one in three United States (U.S.) women report experiencing some form of rape, sexual coercion, or non-consensual sexual contact in their lifetime. Research has consistently demonstrated that exposure to sexual violence is associated with a host of negative mental health outcomes, including increased risk of developing anxiety, depression, problems with substance use, and posttraumatic stress disorder (PTSD; Campbell et al., 2009). Rates of PTSD are especially prevalent among female survivors and reports indicate that between 17% and 65% of women who have experienced sexual assault will develop the disorder (Campbell et al., 2009). Notably, research also shows that PTSD and depression often co-occur, with one study reporting that among a national sample of female rape survivors, comorbidity rates were between 13% and 28% (Zinzow et al., 2012).

Taking into account the high rates of PTSD and depression among women who have experienced sexual violence, it is critical to investigate the factors that may not only explain but also exacerbate or reduce these outcomes. Prior research has extensively examined the various correlates of PTSD and depression among survivors (see Campbell et al., 2009 for review). More specifically, research has documented the role of individual responses and contextual influences, such as social support and reactions to disclosures, on mental health outcomes (Campbell et al., 2009; Ullman et al., 2007; Ullman & Peter-Hagene, 2014).

In addition to these factors, feminist theorists assert that responses to trauma and psychological distress must be understood in the context of sociocultural factors, systems of oppression, and the power inequalities that cause violence to exist (Brown, 2006). In this context,

collective action and consciousness-raising are posited as two unique mechanisms by which personal empowerment and recovery can occur (Brown, 2006; Conlin, 2017). Still, there is little research exploring the role that collective-level efforts (e.g., activism, feminist consciousness) may play in moderating the associations between sexual violence and negative mental health outcomes. Thus, the purpose of the current study was to examine whether involvement in anti-sexual assault activism and feminist identification may moderate the relations between exposure to sexual violence and PTSD symptom severity and depression. In addition, we investigated the potential indirect roles of trauma coping self-efficacy, self-blame, and shame, and whether activism and feminist identification moderate these indirect links through a moderated mediated model.

Trauma Coping Self-Efficacy

Substantial research has explored the different ways survivors cope after experiencing sexual violence, as well as associations between various coping mechanisms and mental health outcomes (Campbell et al., 2009). In addition, recent studies have begun to examine not only coping strategies, but also the importance of coping self-efficacy on psychological health. Coping self-efficacy refers to perceptions of one's own ability to manage the challenges that may emerge after a traumatic event (Benight et al., 2004). Coping self-efficacy is theorized to play a particularly important role in improving self-regulation during trauma recovery and more specifically, to reduce psychological distress by increasing survivors' sense of control over their recovery process (Benight et al., 2015). To date, two meta-reviews have demonstrated a strong correlation between coping self-efficacy and lower levels of distress, including lower severity of PTSD symptoms, following various forms of trauma (e.g., natural disasters, military combat,

physical assaults, intimate partner violence; Benight & Bandura, 2004; Luszczynska et al., 2009).

Research conducted with survivors of sexual violence has yielded similar results. Mahoney et al. (2021) found that among female undergraduates, exposure to sexual violence was indirectly related to more PTSD symptom severity through lower coping self-efficacy. In a sample of female survivors of childhood sexual abuse, negative cognitions (e.g., self-blaming thoughts, negative beliefs about oneself and the world) was indirectly related to psychological distress through coping self-efficacy (Cieslak et al., 2008). Lastly, negative social reactions to disclosures of sexual assault were indirectly related to PTSD symptoms in undergraduate students via less coping self-efficacy (DeCou et al., 2019). These findings indicate that enhanced self-efficacy and personal agency may play a unique and protective role for women at risk of psychological distress post-trauma. Still, the factors that may moderate the indirect effects of coping self-efficacy remain unknown, calling for further investigation to better determine what may strengthen or weaken the relations between sexual violence and coping self-efficacy and between sexual violence and distress via coping self-efficacy.

Self-Blame

Importantly, a survivor's response to sexual violence occurs in a larger sociopolitical context, in which victim-blaming attitudes, rape myths, and negative reactions from institutional systems are highly prevalent (Campbell et al., 2009; Kennedy & Prock, 2016). After experiencing sexual violence, some women may internalize these messages and react by blaming themselves for what occurred (e.g., believing they provoked the assault, thinking they were careless). Self-blame attributions are an unfortunately common response following sexual victimization that have been associated with negative self-appraisals (Miller et al., 2010) and

greater psychological distress (Breitenbecher, 2006). A substantial body of research has demonstrated a positive correlation between self-blame and both PTSD and depressive symptomatology among female sexual assault survivors (Campbell et al., 2009; Frazier, 2000; Koss et al., 2002; Sigurvinsdottir et al., 2020; Ullman et al., 2007). Interestingly, Moor and Farchi (2011) found that self-blame attributions were both significantly higher and more strongly associated with PTSD outcomes among rape survivors than those who experienced other forms of trauma. Taken together, these findings suggest that self-blame plays a uniquely important role in mental health outcomes following sexual violence.

Importantly, self-blame can be categorized as either behavioral or characterological (Janoff-Bulman, 1979). Behavioral self-blame refers to when survivors attribute an assault to their own behavioral actions, whereas characterological self-blame occurs when survivors believe they were assaulted because of their character or personality. Some research suggests that characterological self-blame may be more strongly related with PTSD symptoms than behavioral self-blame (Ullman et al., 2007). However, research indicates that both types are positively correlated with psychological distress (Breitenbecher, 2006; Koss et al., 2002), suggesting that both behavioral and characterological self-blame may play an important role in survivors' mental health.

Shame

Shame is another possible explanatory variable in the relation between sexual violence and psychological distress that is acquiring more recent attention in the literature. Shame is a complex and multifaceted emotion in which individuals engage in highly negative judgments of the self (Budden, 2009). Experiencing shame is often incredibly painful and involves feelings of powerlessness, humiliation, inferiority, and isolation (Budden, 2009; Wilson et al., 2006).

Subsequently, shame may have particularly negative effects on mental health, and especially among individuals who have experienced violence and trauma (Wilson et al., 2006). In a recent meta-analysis, López and colleagues (2019) found evidence of a reliable correlation between shame and symptoms of PTSD across various trauma types. Studies have indicated a positive association between shame and PTSD symptoms among survivors of intimate partner violence (Beck, 2011), street harassment (Carretta & Szymanski, 2020), and physical violence (La Bash & Papa, 2014). While less extensive, research also suggests a positive association between shame and depression (Andrews et al., 2002), with recent studies demonstrating a relation between these variables among female sexual assault survivors (Bhuptani et al., 2019; DeCou et al., 2017).

Shame may be an especially important concept to better understand mental health outcomes following an experience of sexual violence. Evidence suggests that individuals exposed to interpersonal violence (e.g., sexual abuse, assault) reported greater shame compared to those exposed to non-interpersonal trauma (Ford et al., 2006). Relatedly, La Bash and Papa (2014) found that interpersonal trauma was indirectly related to PTSD symptoms via shame, but that shame was not an explanatory variable in the relation between other traumatic events (e.g., illness, natural disasters) and PTSD symptoms. It may be that women experience higher rates of shame following sexual violence in part because they have internalized societal beliefs that they are somehow responsible for their victimization (Weiss, 2010). It may also be that women who have experienced sexual violence are prone to receiving negative reactions from others (Ullman & Filipas, 2001), which in turn may induce a shameful response (DeCou et al., 2017). Indeed, negative social reactions were indirectly related to PTSD and depressive symptoms via shame among college sexual assault survivors (DeCou et al., 2017) and victim-blaming responses to

rape disclosures were indirectly related to depression via shame among a sample of community women (Bhuptani et al., 2019). While this emerging research is intriguing, few other studies have investigated the indirect relations of shame in the link between exposure to sexual violence and psychological distress. Further research and replication is needed, as well as examination of the factors (e.g., activism, feminism) that may moderate the relationship between sexual violence and shame and between sexual violence and distress through shame.

Involvement in Anti-Sexual Assault Activism

In addition to examining the associations between sexual violence and PTSD symptom severity and depression, and the potential explanatory variables of these links, it is important to investigate factors that may moderate these relationships. One potential moderator is involvement in anti-sexual assault activism. Researchers theorize that involvement in activism may reduce the impact of negative mental health outcomes by offering a mechanism by which individuals can confront the systems of oppression that contribute to their distress (Szymanski & Owens, 2009). In this context, anti-sexual assault activism can be understood as an especially empowering response to sexual violence – its goal is to eliminate the conditions that cause such violence to exist – and may have a unique impact on psychological health.

Generally, empirical research has indicated that activism is associated with positive psychological outcomes, including greater positive affect and personal growth (Klar & Kassir, 2009). Feminist collective action in particular has been linked to life satisfaction and well-being (Conlin et al., 2020), adaptive coping (Foster, 2000), and higher self-esteem (Leavy & Adams, 1986). Research also suggests that activism addressing specific forms of discrimination may buffer the corresponding impact of such discrimination on an individual's mental health. For example, among sexual minority women, feminist activism was found to moderate the

relationship between sexist experiences and psychological distress (Szymanski & Owens, 2009). Among sexual minority women of color, DeBlaere and colleagues (2014) found that sexual minority collective action buffered the link between heterosexist experiences and negative mental health outcomes.

Emerging literature on anti-sexual assault activism suggests that these pathways may also exist among individuals who have experienced sexual violence. A meta-synthesis of qualitative research indicated that engaging in social action efforts developed as part survivors' recovery efforts from sexual assault (Draucker et al., 2009) may promote a number of psychological benefits. Indeed, in a recent qualitative study Strauss Swanson and Szymanski (2020) found that involvement in anti-sexual assault activism helped survivors develop self-understanding, acted as a useful coping strategy, boosted personal agency and self-confidence, provided meaningful connection with others, and enhanced a sense of life purpose. As a result of these experiences, survivors involved in activism may find opportunities for psychological growth. Among a sample of sexual assault survivors, Strauss Swanson and Szymanski (2021) found a positive association between involvement in anti-sexual assault activism and positive psychological functioning (i.e., posttraumatic growth and positive affect), as well as significant indirect effects of community connection, coping self-efficacy, and meaning in life on these links. These findings provide initial evidence that involvement in anti-sexual assault activism may help promote psychological well-being. However, no research has yet examined how anti-sexual assault activism may also protect against negative mental health outcomes among women who have experienced sexual violence. More specifically, the potential moderating role of anti-sexual assault activist involvement on these outcomes remains unknown.

Feminist Identification

Another potential moderator that may impact how women respond to sexual violence and the subsequent impact on psychological distress is feminist identification. Feminism offers a framework to understand how patriarchy, misogyny, and sexism perpetuate injustice and oppression. As a result, holding feminist beliefs may increase the likelihood that women externalize rather than internalize feelings of blame following sexist experiences (Szymanski & Owens, 2009). Endorsement of feminist values has been found to buffer the relationship between sexist discrimination and psychological distress among women (Landrine & Klonoff, 1997). Relatedly, survivors who identify as feminists may be more likely to contextualize their experiences and less likely to internalize victim-blaming attitudes that often exacerbate distress. Gefter and colleagues (2013) found that female survivors of male-perpetrated physical and sexual abuse reported that feminist beliefs helped to reduce feelings of self-blame and shame. In contrast, survivors who did not believe sexism played a role in their abuse attributed the experience to their own faults (Gefter et al., 2013). In another study, feminist identification buffered the indirect link between stranger harassment and PTSD symptoms through self-blame, with greater endorsement of feminist identification linked to lower self-blame attributions (Carretta & Szymanski, 2020). These findings suggest that feminism may protect against some of the negative appraisals that often follow sexual violence.

Feminism may also help to enhance feelings of self-worth and empowerment among survivors. Feminist beliefs and identity are generally associated with greater self-efficacy (Eisele & Stake, 2008), higher self-esteem (Fischer & Good, 1994), and assertiveness (e.g., being more comfortable and likely to confront perpetrators of harassment, being more likely to address sexism; Ayres et al., 2009; Leaper & Arias, 2011). In addition, among a sample of Polish women

who experienced sexual trauma, identification with a more strongly developed feminist identity was associated with higher self-esteem and lower levels of depression compared to those who identified with a less developed feminist identity (Kucharska, 2018). These findings suggest that feminist identification may act as a potential protective factor for women who have experienced sexual violence. However, to the authors' knowledge, no other studies have examined the moderating role of feminist identification among this population.

The Current Study

As shown in Figure 1, in our hypothesized model we explored potential direct and indirect relations between sexual violence exposure and both PTSD symptom severity and depression among a sample of U.S. women. In addition, we investigated involvement in anti-sexual assault activism and feminist identification as moderators in the (a) sexual violence exposure and PTSD symptom severity and depression links, (b) sexual violence exposure and trauma coping self-efficacy, self-blame (both behavioral and characterological), and shame links, and (c) indirect relations between sexual violence exposure and PTSD symptom severity and depression. Our specific hypotheses were:

1. Sexual violence exposure would be directly and indirectly related to more PTSD symptom severity and depression via less trauma coping self-efficacy, higher endorsement of self-blame attributions, and more shame.
2. Involvement in anti-sexual assault activism and feminist identification would moderate the direct relations between sexual violence exposure and PTSD symptom severity and depression. More specifically, the relations would be weaker when activism and feminist identification are high and stronger when activism and feminist identification are low.

3. Involvement in anti-sexual assault activism and feminist identification would moderate the relations between sexual violence exposure and trauma coping self-efficacy, self-blame, and shame. Specifically, the relations would be weaker when activism and feminist identification are high and stronger when activism and feminist identification are low.

4. Involvement in anti-sexual assault activism and feminist identification would moderate the indirect relations between sexual violence exposure and PTSD symptom severity and depression. Specifically, the indirect relations would be weaker when activism and feminist identification are high and stronger when activism and feminist identification are low).

Because PTSD and depressive symptoms are frequently affected by a sexual assault survivor's prior history of other types of traumatic events (Koss et al., 2002; Nishith et al., 2000; Ullman, 2007), we included trauma history as a control variable in our analyses.

Chapter 2: Method

Participants

The initial sample comprised of 659 participants who began our online survey. Two participants who did not report an incident of sexual assault and therefore did not meet eligibility requirements, were eliminated from the dataset. In addition, 214 participants who did not complete the online survey (173 who left the entire survey blank and 41 who left at least one measure blank), one who indicated they did not seriously participate in the survey, and two who incorrectly answered two or more of three attention checks (i.e., a question that asks for a specific response), were not included in the study. This resulted in a final sample of 440 participants.

Of the 440 participants in the final sample, 90% ($n = 394$) identified as a woman, 9% ($n = 40$) as genderqueer/non-binary/gender nonconforming, 1% ($n = 6$) as a different identity (e.g., nonbinary woman). Five percent ($n = 22$) identified as transgender and 95% ($n = 418$) as not transgender. In terms of sexual orientation, 35% ($n = 155$) of participants were heterosexual, 28% ($n = 125$) bisexual, 14% ($n = 61$) pansexual, 8% ($n = 34$) queer, 7% ($n = 29$) lesbian or gay, 4% ($n = 16$) asexual, 3% ($n = 12$) questioning, and 2% ($n = 8$) a different orientation, such as demisexual and fluid. The sample was 86% ($n = 378$) White, 6% ($n = 25$) Biracial/Multiracial, 2% ($n = 10$) African American/Black, 2% ($n = 7$) Asian/Asian American/Pacific Islander, 2% ($n = 10$) Hispanic/Latino/a/x, 2% ($n = 7$) Native American/American Indian/Alaskan Native, and 1% ($n = 2$) Middle Eastern/Middle Eastern American. Participants ranged in age from 18 to 73 years old ($M = 33.43$, $SD = 12.26$).

Regarding socioeconomic status, participants reported being lower middle class (38%, $n = 166$), working class (26%, $n = 114$), upper middle class (23%, $n = 103$), poor class (10%, $n =$

44), wealthy class (1%, $n = 4$), and not sure (2%, $n = 9$). Forty percent ($n = 178$) reported being currently enrolled in a college or university. Of these participants, 18% ($n = 32$) were first year students, 8% ($n = 15$) sophomores, 12% ($n = 22$) juniors, 7% ($n = 13$) seniors, 46% ($n = 84$) graduate students, and 7% ($n = 12$) other. Of the 60% who were not current students ($n = 262$), 2% ($n = 4$) completed less than a high school diploma, 19% ($n = 49$) attained a high school degree, 12% ($n = 32$) an associate's/two-year college degree, 31% ($n = 81$) a bachelor's/four-year college degree, and 37% ($n = 96$) a graduate/professional degree. Participants reported living in different geographical regions, including the South (33%, $n = 146$), Midwest (28%, $n = 121$), Northeast (23%, $n = 100$), and West (16%, $n = 72$). Percentages have been rounded and may therefore not add up to 100%.

Because there are no power analysis guidelines or calculators for moderated mediation models, we used the following suggestions to determine our minimum sample size. Weston and Gore (2006) recommended a minimum of 200 participants for path/indirect effects analysis when reliability of scores on measures used is good. Fritz and MacKinnon (2007) recommended a minimum sample size of 148 to be able to detect a small to medium effect size of 0.26 and 462 to be able to detect a small effect size of .14 for simple mediation with 80% power. For moderation, Aiken and West (1991; p. 164, Table 8) suggested of a sample size of 108 to achieve statistical power of .80 in detecting an interaction for large and moderate effect sizes for predictor and moderator variables measured with reliabilities of .80, variance accounted for by the main effects is .20, and inter-predictor correlations around .50. To detect a small effect 752 participants would be needed; however, obtaining that large of a sample for this study was unrealistic.

Procedures

Our study was conducted via a web-based survey available to participants through the

online survey tool Qualtrics. To be eligible to participate in the study, individuals needed to identify as a woman, be at least 18 years old, identify as having experienced non-consensual sexual contact in adulthood (age 14+), and live in the U.S. We recruited participants from undergraduate psychology courses at a large Southern university of Tennessee as well as through social media advertisements on Facebook and e-mail research announcements to the targeted population. Student participants recruited from our university received course credit for participating. E-mail announcements, including a hypertext link to the web-based survey, were sent to a variety of women's resource centers, listservs, organizations, and personal and professional networks. We only recruited women for this study because women experience sexual violence at significantly greater rates than men and subsequently may be more likely to experience negative outcomes, including PTSD, in their lifetime (Cortina & Kubiak, 2006; Elliot et al., 2005).

Before beginning the survey, participants were given information regarding the study, including their rights as a participant, via an informed consent form. To provide consent, participants were asked to click a button that redirected them to the survey. Eligible participants then completed a series of self-report measures assessing exposure to sexual violence, trauma coping self-efficacy, self-blame, shame, involvement in anti-sexual assault activism, identification as a feminist, PTSD symptom severity, depression, and demographics. Participants heard about the survey from internet advertisements on social media (85%; $n = 373$), undergraduate psychology courses (8%; $n = 36$), a sexual assault related group, organization, or listserv (3%; $n = 15$), a friend or colleague (2%; $n = 9$), and "Other" (2%; $n = 7$).

Measures

Sexual violence exposure. We used the 10-item Sexual Experiences Survey – Short Form Victimization (SES-SFV) to assess various experiences of sexual victimization and their frequency (Koss et al., 2007). Participants were asked to indicate whether they have experienced different forms of sexual violence, including the type of coercion that may have occurred during each potential incident. Participants were also asked to specify the number of times they were exposed to each form of victimization since age 14 years. Example items indicating various incident types followed by different forms of coercion include, “Someone had oral sex with me or made me have oral sex with them without my consent by taking advantage of me when I was too drunk or out of it to stop what was happening” and “Even though it did not happen, someone TRIED to have oral sex with me, or make me have oral sex with them without my consent by threatening to physically harm me or someone close to me.” We calculated total sexual victimization experiences utilizing a severity ranking scheme previously supported by Davis and colleagues (2014), in which we multiplied the severity rank of each sexual victimization experience by the frequency of that experience and then sum those totals for a participant’s final score. Scores on the SES-SFV have good psychometric support (Koss et al., 2007), including evidence of construct validity (via correlations with related sexual assault measures; Davis et al., 2014).

Trauma coping self-efficacy. Trauma coping self-efficacy was measured using the 9-item Trauma Coping Self-Efficacy Scale (Benight et al., 2015). Participants were asked to indicate how capable they are in successfully dealing with their experience(s) of non-consensual sexual contact since age 14. Example items include: “Get my life back together” and “Be optimistic since the traumatic experience.” Each item is rated on a 7-point Likert-type scale from

1 (*not at all capable*) to 7 (*totally capable*). Mean scores were used with higher scores representing more trauma coping self-efficacy. Alpha was .92 in a sample of female rape survivors (Mahoney et al., 2021). Benight and colleagues (2015) also found support for test-retest reliability (range = .57 to .81), structural validity (via exploratory and confirmatory factor analyses), and construct validity (via negative associations with posttraumatic stress symptoms and negative cognitions, worry, and depression and positive associations with psychological well-being). Alpha and omega for the current sample were both .87.

Self-blame. We used two 5-item subscales of the Rape Attribution Questionnaire (Frazier, 2002, 2003) to measure behavioral and characterological self-blame. Participants were asked to respond to various items that follow the stem in the past 30 days “How often have you thought: I experienced non-consensual sexual contact in adulthood (since age 14) because...” Sample items include: “I should have resisted more” and “I am just the victim type.” Items are rated on a 5-point Likert-type scale from 1 (*never*) to 5 (*very often*). Mean scores were used with higher scores representing greater self-blame in response to sexual violence. Frazier (2002, 2003) demonstrated support for reliability (α 's ranged from .78 - .91), 6-week and 6-month test-retest reliability (ranged from .62 - .75), content validity (via expert review), and construct validity (via positive correlations with psychological distress). Alpha and omega for the current sample were both .92 for the behavioral self-blame subscale and .82 for the characterological self-blame subscale.

Shame. Shame was assessed using the Abuse-Specific Shame Questionnaire (Feiring & Taska, 2005), which consists of eight items measuring feelings of abuse-related shame. Participants were asked to respond to each statement as they relate to their experience(s) of non-consensual sexual contact in adulthood (ages 14+). Example items include: “When I think about

what happened, I want to go away by myself and hide” and “When I think about what happened, I wish I were invisible.” Items are rated on a 3-point Likert type scale (0 = *not true*; 1 = *somewhat true*; 2 = *very true*). Mean scores were used with higher scores indicating more shame in response to sexual violence. Feiring and Taska (2005) provided evidence of reliability ($\alpha = .86$) and construct validity (through positive relationships with non-abuse specific shame, non-verbal shame, and symptoms of PTSD). Alpha for the current sample was .88 and omega was .89.

Involvement in anti-sexual assault activism. We used the 20-item Involvement in Anti-Sexual Assault Activism Scale (Strauss Swanson & Szymanski, 2020), which measures participants’ engagement in anti-sexual assault activist activities. Example items include: “I am involved in one or more anti-sexual assault organizations and/or groups” and “I educate others about sexual assault issues.” Participants rated each item on a 7-point Likert-type scale ranging from 1 (*very untrue of me*) to 7 (*very true of me*). Mean scores were used with higher scores indicating more involvement in anti-sexual assault activism. Strauss Swanson and Szymanski (2020) demonstrated support for reliability ($\alpha = .95$) and content (via expert review), structural (via exploratory factor analysis), and construct (via positive correlations with other measures of activism, feminist identification, and helping behaviors) validity. Alpha for the current sample was .93 and omega was .94.

Feminist identification. Feminist identification was measured using the 4-item Self-Identification as a Feminist Scale (Szymanski, 2004), which assesses if participants identify as a feminist to themselves and others, importance of feminist principles, and endorsement of the feminist movement. Sample items include: “I identify myself as a feminist to other people” and “I support the goals of the feminist movement.” Responses for each item are rated on a 5-point

Likert-type scale ranging from 1 (*strongly disagree*) to 5 (*strongly agree*). We used mean scale scores with higher scores indicating greater feminist identification. Support for reliability ($\alpha = .93$), structural validity (through exploratory factor analysis), and construct validity (through positive associations with other measures of feminism and negative associations with traditional gender norms and conservatism) was demonstrated by Szymanski (2004). Alpha and omega for the current sample were both .93.

PTSD symptom severity. We measured PTSD using the 20-item PTSD Checklist-5 (PCL-5; Weathers et al., 2013) which assesses the symptoms of PTSD based on criteria from the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5; Blevins et al., 2015)*. Participants reported how much they had been concerned by each problem in the last month in response to their experience(s) of non-consensual sexual contact in adulthood (ages 14+). Example items include: “Feeling very upset when something reminded you of the stressful experience?” and “Having strong negative feelings such as fear, horror, anger, guilt, or shame?” Participants rated each item on a 5-point Likert-type scale from 0 (*not at all*) to 4 (*extremely*). Mean scores were used with higher scores indicating greater PTSD symptom severity. Support for internal reliability (α s ranged from .94–.95), one-week test-retest reliability ($r = .82$), and structural validity (through confirmatory factor analysis) was demonstrated by Blevins and colleagues (2015). Support for construct validity was demonstrated by strong correlations with related PTSD measures, moderate correlations with constructs such as depression, and weak correlations with unrelated constructs, such as mania (Blevins et al., 2015). Alpha and omega for the current sample were both .95.

Depression. Depression was assessed using the 8-item Patient Health Questionnaire (PHQ-8; Kroenke et al., 2009). Example items include: “Feeling down, depressed, or hopeless”

and “Feeling tired or having little energy.” Participants reported how often they experienced each symptom over the past 2 weeks on a 4-point Likert-type scale ranging from 0 (*not at all*) to 3 (*nearly every day*). Mean scores were used with higher scores indicating greater depression. Support for internal consistency reliability ($\alpha > .85$) has been demonstrated by Kroenke and colleagues (2001). Support for construct validity has been shown by Kroenke and colleagues (2009) with evidence that the PHQ-8 score predicted a diagnosis of depressive disorder as well as the DSM criteria. Alpha for the current sample was .89.

Trauma history. Trauma history (excluding adult sexual assault) was assessed with nine items from the Trauma History Screen (THS; Carlson et al., 2011) that are consistent with DSM-5 Criterion A for a PTSD diagnosis (American Psychiatric Association, 2013). Example items include “Hit or kicked hard enough to injure – as a child” and “A hurricane, flood, earthquake, tornado, or fire.” Participants were asked if they had experienced each potentially traumatic event with a “no” (coded 0) or “yes” (coded 1).” Mean scores were used with higher scores indicating greater trauma history. Carlson et al. (2011) provided support for test-retest reliability and temporal stability across four samples. In addition, construct validity was supported by positive correlations with other trauma exposure measures and PTSD symptoms.

Chapter 3: Results

Descriptives and Preliminary Analyses

For each variable, absolute values for skewness (range = .04 – 1.90) and kurtosis (range = .44 – 3.89) met recommendations for univariate normality (i.e., skewness < 3, kurtosis < 10; Weston & Gore, 2006). There were three multivariate outliers found in the dataset (Mahalanobis distance $p < .001$). However, these outliers did not indicate a particular pattern in their responses so we did not see a reason to remove them. Moreover, all three cases had a Cook's distance less than 1 (highest Cook's distance = .06), demonstrating that they did not significantly affect the model (Field, 2013). Table 1 shows participant reports of sexual assault by type and form. Table 2 shows descriptive statistics and bivariate correlations among all study variables. At the bivariate level, we found that women exposed to higher rates of sexual violence were at greater risk for PTSD symptoms ($r = .39$) and depression ($r = .27$).

Analyses of Cross-Sectional Indirect Relations

To examine our hypothesized models of direct and indirect relations (Hypothesis 1), one predicting PTSD symptom severity and the other depression, we used bootstrapping analyses through the PROCESS SPSS macro (Hayes, 2018; Model 4). Trauma history was entered as a covariate. Bootstrapping analyses with 5,000 bootstrap resamples was used to produce 95% confidence intervals for the indirect effect. If the confidence interval does not contain zero, the indirect effect is considered significant and meaningful. Two multiple parallel cross-sectional mediation models were conducted, predicting each outcome variable.

Figure 2 shows the results of our model predicting PTSD symptom severity. The test of indirect effects using bootstrapping analyses revealed that sexual violence exposure was both directly and indirectly related to PTSD symptom severity via trauma coping self-efficacy (mean

indirect [unstandardized] effect = .002; SE = .001, 95% CI [.001, .003]), behavioral self-blame (mean indirect [unstandardized] effect = .0004; SE = .0002, 95% CI [.0001, .001]), characterological self-blame (mean indirect [unstandardized] effect = .001; SE = .0003, 95% CI [.0004, .002]), and shame (mean indirect [unstandardized] effect = .002; SE = .001, 95% CI [.001, .003]). In addition, the variables in the model accounted for 59% of the variance in PTSD symptom severity scores.

Figure 3 shows the results of our model predicting depression. The test of indirect effects using bootstrapping analyses revealed that sexual violence exposure was indirectly related to depression via trauma coping self-efficacy (mean indirect [unstandardized] effect = .002; SE = .001, 95% CI [.001, .003]), characterological self-blame (mean indirect [unstandardized] effect = .001; SE = .0004, 95% CI [.0004, .002]), and shame (mean indirect [unstandardized] effect = .001; SE = .0003, 95% CI [.0001, .002]). Contrary to our hypothesis, no indirect relations were found for behavioral self-blame (mean indirect [unstandardized] effect = -.0003; SE = .0002, 95% CI [-.001, .0001]). In addition, the variables in the model accounted for 39% of the variance in depression scores.

Moderation of Direct and Indirect Relations Analyses

For the moderation of direct relations (Hypotheses 2 and 3), we used hierarchical multiple regression analysis. In our analysis, we used mean center scores for variables involved in the interaction terms. We entered trauma history as a covariate in Step 1, main effects in Step 2, and interaction effects in Step 3. Evidence for a moderator effect is indicated at Step 3 by a statistically significant increment in R^2 and beta weight. Contrary to our hypothesis, results demonstrated that involvement in anti-sexual assault activism and feminist identification did not moderate the direct relations between sexual violence exposure and PTSD symptom severity,

depression, trauma coping self-efficacy, behavioral self-blame, characterological self-blame, and shame (see Table 3). Although activism and feminist identification did not serve as buffers, it is important to note that activism was directly related to more coping self-efficacy and depression, while feminist identification was directly related to less self-blame and shame in the regression models.

To examine moderation of indirect relations (i.e., cross-sectional moderation mediation; Hypothesis 4), we used Model 10 of the Hayes (2018) PROCESS macro using bootstrapping analyses with 5,000 bootstrapping resamples. Trauma history was entered as a covariate. Results of the Index of Partial Moderation Mediation were used to determine significance. Contrary to our hypothesis, involvement in anti-sexual assault activism did not moderate the indirect effect of sexual violence exposure on PTSD through trauma coping self-efficacy (Index of Partial Moderation Mediation = $-.0001$, BootSE = $.0003$, 95% CI [$-.0007$, $.0006$]), behavioral self-blame (Index of Partial Moderation Mediation = $.0000$, BootSE = $.0001$, 95% CI [$-.0002$, $.0002$]), characterological self-blame (Index of Partial Moderation Mediation = $.0000$, BootSE = $.0001$, 95% CI [$-.0003$, $.0003$]), and shame (Index of Partial Moderation Mediation = $-.0003$, BootSE = $.0003$, 95% CI [$-.0009$, $.0002$]). Similarly, results indicated that feminist identification did not moderate the indirect effect of sexual violence exposure on PTSD through trauma coping self-efficacy (Index of Partial Moderation Mediation = $.0002$, BootSE = $.0005$, 95% CI [$-.0008$, $.0012$]), behavioral self-blame (Index of Partial Moderation Mediation = $.0002$, BootSE = $.0002$, 95% CI [$-.0001$, $.0005$]), characterological self-blame (Index of Partial Moderation Mediation = $.0004$, BootSE = $.0003$, 95% CI [$-.0001$, $.0010$]), and shame (Index of Partial Moderation Mediation = $.0001$, BootSE = $.0005$, 95% CI [$-.0007$, $.0010$]).

Also contrary to our hypothesis, involvement in anti-sexual assault activism did not moderate the indirect effect of sexual violence exposure on depression through trauma coping self-efficacy (Index of Partial Moderated Mediation = .0000, BootSE = .0003, 95% CI [-.0006, .0005]), behavioral self-blame (Index of Moderation Mediation .0000, BootSE = .0001, 95% CI [-.0002, .0001]), characterological self-blame (Index of Partial Moderated Mediation = .0000, BootSE = .0002, 95% CI [-.0004, .0003]), and shame (Index of Partial Moderated Mediation = -.0001, BootSE, .0001, 95% CI [-.0004, .0001]). Furthermore, feminist identification did not moderate the indirect effect of sexual violence exposure on depression through trauma coping self-efficacy (Index of Partial Moderated Mediation = .0002, BootSE = .0005, 95% CI [-.0008, .0012]), behavioral self-blame (Index of Partial Moderated Mediation = -.0001, BootSE = .0001, 95% CI [-.0005, .0001]), characterological self-blame (Index of Partial Moderated Mediation = .0004, BootSE = .0003, 95% CI [-.0001, .0011]), and shame (Index of Partial Moderated Mediation = .0001, BootSE = .0002, 95% CI [-.0004, .0005]).

Chapter 4: Discussion

While there is substantial research examining factors that impact the relation between sexual violence and negative mental health outcomes (Campbell et al., 2009), there is scant research investigating the role of collective-level efforts, such as activism and feminism, in these models. This study sought to address this gap by exploring the potential moderating role of anti-sexual assault activism and feminist identification in the relation between sexual violence and PTSD and depression, as well as on the potential indirect roles of trauma coping self-efficacy, self-blame, and shame in these links. Consistent with previous research (Campbell et al., 2009), our findings indicated that women exposed to higher rates of sexual violence were at greater risk for both PTSD symptoms and depression. We also found significant indirect effects of trauma coping self-efficacy, self-blame, and shame on these relations, with the exception of behavioral self-blame in the link between sexual violence exposure and depression. It may be that survivors who endorse behavioral self-blame are more likely to perceive sexual violence as being somehow under their control (Peterson et al., 1981), and therefore less likely to experience depression when compared to characterological self-blame. Overall, these findings are consistent with prior studies demonstrating the indirect effect of trauma coping self-efficacy in the sexual violence-PTSD link (Mahoney et al., 2021) as well associations between both shame and self-blame, and negative mental health symptoms among survivors (Bhuptani et al., 2019; DeCou et al., 2017). Results highlight the important role that these variables play in mental health outcomes among this population and indicate the need for interventions that target these factors as part of trauma recovery.

Contrary to our hypothesis, our results demonstrated that activist involvement and identification as a feminist did not moderate the direct or indirect links between sexual violence,

PTSD symptom severity, depression, coping self-efficacy, self-blame, and shame. It may be that activism and feminism are more likely to be associated with positive outcomes (e.g., coping self-efficacy, post-traumatic growth, positive affect; Strauss Swanson & Szymanski, 2021) than to buffer the links between sexual violence and negative mental health symptoms. It may also be that other variables, such as supportive social reactions, play a stronger moderating role. Indeed, some studies suggest that social support moderated the link between exposure to violence and PTSD symptoms among survivors of intimate partner abuse (Babcock et al., 2008) and victims of community violence (Scarpa et al., 2006).

Importantly, while activism and feminist identification did not act as buffers, activism was related to greater coping-self efficacy and feminist identification was related to less self-blame and shame. These findings are consistent with previous studies indicating a link between anti-sexual assault activism and coping self-efficacy (Strauss Swanson & Szymanski, 2020) as well as negative associations between feminist identification and both shame and self-blame attributions (Caretta & Szymanski, 2020; Geftter, 2013). It may be that through activist involvement survivors have an opportunity to utilize their voice, assert their needs, and regain feelings of power and personal control over their recovery. Survivors who identify with feminist beliefs may also understand the systemic factors that perpetuate sexual violence, and thus be less likely to blame themselves for the violence they experienced. These findings suggest that although activism and feminism did not play a protective role in the current study, they may still be important factors to address as part of healing from sexual assault trauma. Importantly, the total mean score on the feminist identification scale was high ($M = 4.42$), indicating that there was limited variability in response to this measure. This may have underestimated the magnitude of the relations between feminist identification and self-blame and shame, and limited our ability

to detect moderated relations using this variable.

Lastly, while prior research suggests a positive association between activism and indicators of positive mental health (i.e., positive affect, post-traumatic growth) among sexual assault survivors (Strauss Swanson & Szymanski, 2021), our results also indicate a positive association between activism and depression. It may be that activism brings about both benefits, as well as challenges for survivors involved in the work. In their qualitative study, Strauss Swanson and Szymanski (2021) found that in addition to feeling empowered and connected with others, sexual assault survivors engaging in anti-sexual assault activism reported experiences of burnout, being triggered, and feeling frustrated by a lack of systemic change. These experiences may help to explain the link between activism and depressive outcomes and highlight the importance of providing support for survivors involved in collective action efforts.

Limitations and Future Research Directions

Our sample was demographically diverse regarding class status, age, and sexual orientation. However, many of our participants identified as formally educated White cisgender women, and therefore our findings are limited and cannot be generalized to diverse groups. Future research is needed to better understand the experiences of women of color, transgender women, and women with diverse educational backgrounds, especially given the high rates of sexual violence that exist for those with minoritized identities (James et al., 2016; Smith et al., 2017). While this study was specific to women's experiences, future research might also explore the role of activism and feminist identification in the lives of men who have experienced sexual violence. In addition, the study relied on self-report data and therefore may be limited because of various forms of response bias (e.g., social desirability bias, recall bias). Lastly, our research design was correlational and cross-sectional, and thus we cannot determine causality between the

variables we investigated. Future studies might benefit from other research approaches, such as the use of longitudinal and experimental designs with sexual assault survivors, to better determine causation.

Previous research and the current study highlight the need to better understand the relation between anti-sexual assault activism and various mental health outcomes. More specifically, future research might examine the relation between anti-sexual assault activism and depression, including potential explanatory factors, to better support survivors engaged in activism. For instance, researchers might investigate if being triggered or experiencing activist burnout plays a role. Future research might also examine related variables (e.g., critical consciousnesses, adherence to feminine norms, beliefs about rape myths) that may moderate the direct and indirect relations between sexual violence exposure and negative mental health outcomes. Finally, future studies might also explore how different types of activist involvement impact mental health. For example, researchers might explore differences between activist efforts that are perceived as high versus low cost to survivors and the ways these forms of engagement influence psychological outcomes.

Practice Implications

Given the results from this study it is recommended that clinicians working with women who have experienced sexual violence utilize interventions that increase trauma coping self-efficacy and decrease feelings of shame and self-blame. Clinicians may also consider interventions that emphasize the potential benefits of feminism and activism on mental health outcomes. As part of the assessment process, clinicians might incorporate questions about feminist identification and activist involvement to better understand clients' beliefs about their assault and ways of coping. Clinicians might also explore how feminist beliefs and collective

action might promote healing. As our findings indicate, activism was positively related to coping self-efficacy. Clinical interventions that empower survivors to engage in activist work may be one avenue to foster personal empowerment, make meaning after the assault, and increase a sense of control over the recovery process. Clinicians may also consider interventions that support survivors engaging in collective action efforts. For instance, it may be helpful to support clients around potential triggers that emerge while being involved in activism, identify self-care strategies to manage burnout, and locate community and social supports that offer validation and support.

Our results also demonstrate that greater levels of feminist identification were related to lower levels of self-blame and shame. Given the potential benefits of feminist beliefs on these outcomes, it is recommended that clinicians consider strategies to raise or validate feminist consciousness among clients who have experienced sexual violence. Feminist therapy offers an especially useful framework, as it highlights the ways that systemic injustice contributes to violence and mental health outcomes (Brown, 2006). Indeed, one of the foundations of feminist therapy is an understanding that “the personal is political” (Brown, 1996). This approach may be particularly helpful for sexual assault survivors to externalize, rather than internalize feelings of self-blame and shame, and ultimately aid in trauma recovery. Importantly, feminist interventions are also unique in that they have the potential to promote change at both the micro and macro level. That is, engaging in collective action may encourage healing for an individual survivor while also transforming the systems that perpetuate gender-based violence and oppression. As such, activist involvement and feminist ideology have important implications for both clinical practice and social justice efforts to confront the broader social factors (e.g., patriarchy, sexism, misogyny) that cause sexual violence to exist.

Conclusion

In the current study, we investigated the direct, indirect, and moderated relations in the links between sexual violence exposure and two negative mental health outcomes (i.e., PTSD and depression) among survivors of adulthood sexual assault. Consistent with previous research, our results suggest a positive relation between sexual violence exposure and PTSD and depression, and indicate significant indirect effects of coping self-efficacy, self-blame, and shame on most of these links. While anti-sexual assault activism and feminist identification did not buffer these relations, activist involvement was positively associated with coping self-efficacy and depression and feminist identification was negatively associated with self-blame and shame. Taken together, these findings highlight various pathways that exist between sexual violence and negative mental health outcomes, suggesting the need for interventions to improve care for this population.

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Appendix

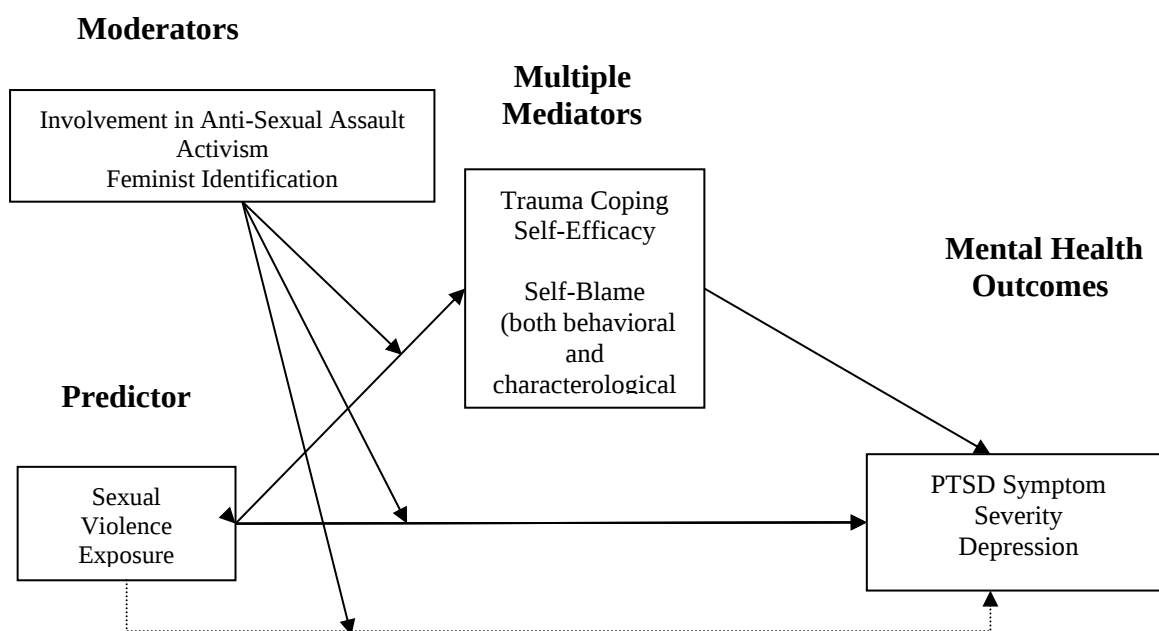


Figure 1. Hypothesized Moderation Mediation Model

Table I

Rates of Sexual Trauma by Type of Assault and Form of Exposure

Type of Assault	Form of Exposure		
	Sexual Contact	Attempted Rape	Completed Rape
Verbal coercion	83% (<i>n</i> = 365)	70.7% (<i>n</i> = 311)	82.9% (<i>n</i> = 365)
Alcohol or drug facilitated	64.3% (<i>n</i> = 283)	49.7% (<i>n</i> = 219)	65.3% (<i>n</i> = 287)
Threat or use of physical force	67.6% (<i>n</i> = 298)	53.9% (<i>n</i> = 237)	73.9% (<i>n</i> = 325)

Table 2*Means, Standard Deviations, and Correlations for All Study Variables*

Variable	<i>M</i>	<i>SD</i>	1	2	3	4	5	6	7	8	9
1. Sexual Violence Exposure	73.28	38.63	---								
2. Trauma Coping Self-Efficacy	4.59	1.20	-.28*	---							
3. Behavioral Self-Blame	3.18	1.20	.17*	-.33*	---						
4. Characterological Self-Blame	2.48	1.04	.27*	-.48*	.58*	---					
5. Shame	.92	.55	.25*	-.65*	.41*	.51*	---				
6. Involvement in Anti-Sexual Assault Activism	3.91	1.38	.13*	.14*	-.01	-.01	-.05	---			
7. Feminist Identification	4.42	.86	-.10*	.16*	-.11*	-.15*	-.21*	.37*	---		
8. PTSD Symptom Severity	1.90	.99	.39*	-.65*	.42*	.54*	.64*	.03	-.13*	---	
9. Depression	1.40	.80	.27*	-.57*	.24*	.44*	.48*	.06	-.06	.62*	---
10. Trauma History	.34	.22	.38*	-.16*	.07	.13*	.12*	.16*	.05	.31*	.23*

* $p < .05$

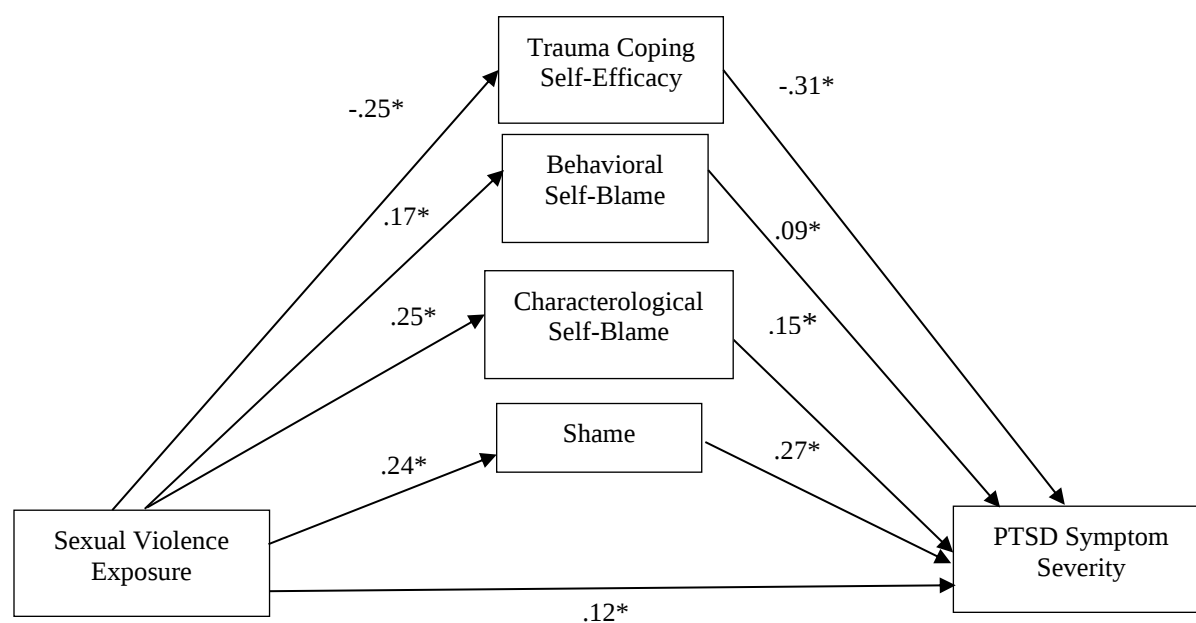


Figure 2

Path Model Predicting PTSD Symptom Severity

Note. Trauma history was entered as a covariate. Values reflect standardized coefficients. Black, solid paths are significant (* $p < .05$).

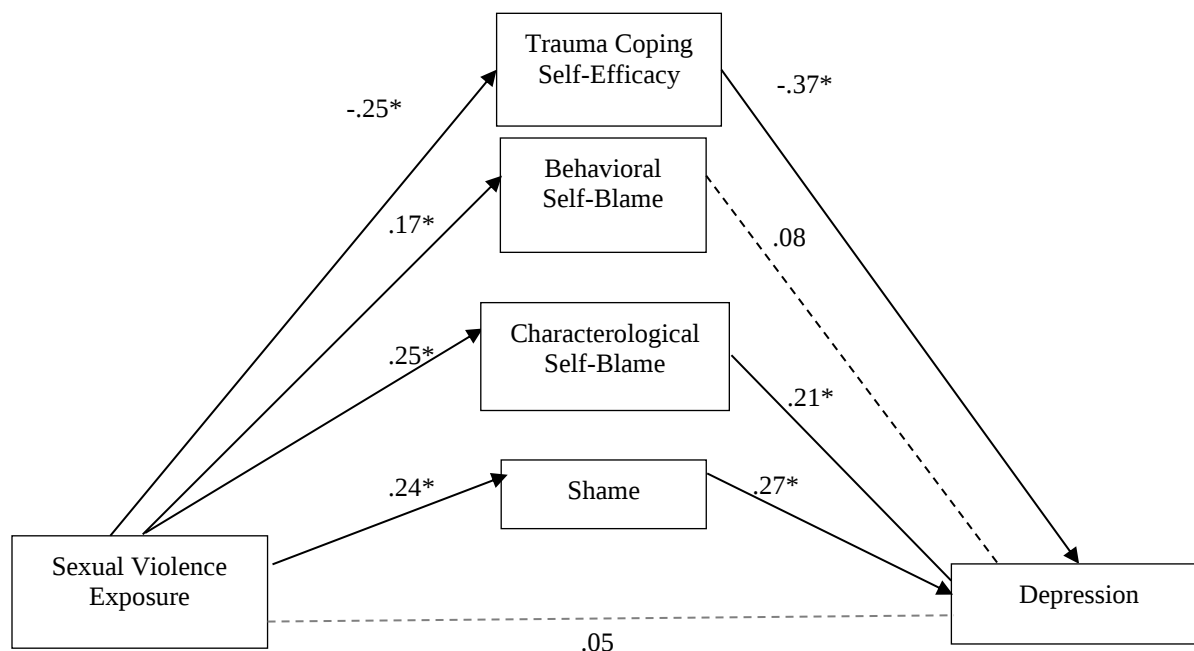


Figure 3

Path Model Predicting Depression

Note. Trauma history was entered as a covariate. Values reflect standardized coefficients. Black, solid paths are significant ($*p < .05$) whereas grey, dashed paths are not.

Vita

Originally from Brooklyn, New York, Charlotte Strauss Swanson's educational and professional pursuits have since taken her to various parts of the country. She received her Bachelor of Arts degree from Occidental College in Los Angeles and her Master's degree in Social Work from the University of Wisconsin, Madison. Her interest in social justice, feminism, and trauma deepened while working as a victim advocate and violence prevention educator on a college campus, and ultimately brought her to the Counseling Psychology doctoral program at the University of Tennessee, Knoxville. Charlotte is very thankful for all the support from her advisor, family, and friends as she completes her dissertation this year.