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HELP-SEEKING BEHAVIORS AND COPING STYLES RELATED TO SEXUAL ASSAULT LABELLING

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HELP-SEEKING BEHAVIORS AND COPING STYLES RELATED TO SEXUAL ASSAULT LABELLING

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Abstract

Sexual Assault is defined as non-consensual sexual activity that includes groping and rape. Based on previous research, a large number of people experience sexual assault, which results in trauma and post-traumatic stress. In order to mediate the stress, people try to cope and seek help to manage the distress and trauma stress. Following the assault, people adopt the identity of or are viewed as victim/survivor. This study investigated the difference between sexual assault label, victim or survivor, in terms of coping strategies, approach or avoidant, and help-seeking behaviors. The study was conducted by administering a survey via Amazon's Mturk. A total of 240 participants consented and provided data about their preferred identity label (victim or survivor), their coping strategies and help-seeking behaviors. Overall, there were no significant differences between help-seeking and coping strategies among people who identify as victims or survivors of sexual assault. These finding could lead to a better understanding for the clinicians as the perceptions about the assault label does not interfere help-seeking or coping among this sample. Rather the focus should primarily be on promoting healthy coping and increasing help-seeking.

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Help-Seeking Behaviors and Coping Styles Related to Sexual Assault Labelling

Sexual assault is categorized as a trauma event that can lead to acute and chronic experiences of stress, difficulty in adjustment and poor well-being. It is defined as sexual contact or behavior that occurs without the person's consent such as groping, fondling or rape (RAINN, 2011). Based on existing statistics, approximately one in five women and one in 71 men would be raped in their lifetime (Black et al., 2011). The percentage of rapes reported in the USA increased from 23% (2016) to 40% (2017) while many cases still go unreported. These statistics apply to heterosexual people, however, when the lens is broadened to include non-heterosexual people, the percentages increase. For example, Coulter et al. (2017) examined college students and their likelihood of going through a sexual assault. Their results show that cis gender white men were least likely to face any sort of sexual assault compared to people of color or transgender people. Whereas white heterosexual women were more likely to face sexual assault than their male counterparts, their odds were lower than those who considered themselves as bisexuals. A study by Planty et al. (2013), further indicates that black women are more likely to experience sexual assault than white, Asian or Latina women. It is imperative that when such a large portion of the population is at risk, there would be ways to offer help, and factors that might influence help-seeking.

Besides gender and ethnicities, there are factors that interact with how sexual assault/trauma have an impact on people. For example, Masho & Ahmed (2007) concluded that the age at which the assault occurs influences the post assault symptoms. The authors discovered the that women who experienced assault before the age of 18 experienced more severe post-trauma symptoms compared to those assaulted after the age of 18. In another study, Kaukinen & DeMaris (2005) examined

the effects of childhood assault and concluded that non-White people were exposed to a greater risk to depressive symptoms as a result of childhood sexual assault.

Sexual assault can also result in severe distress and even lead to psychological disorders, including Post-Traumatic Stress Disorder (PTSD; APA, 2013; McLaughlin et al., 2013; Ullman & Filipas, 2001). Examples of distress can experienced include depressive symptoms, closing or distancing oneself emotionally, increased arousal in the forms of difficulty in sleeping, concentration, being jumpy or easily angered (APA, 2013). Many also go through a period of recalling the experience in the form of flashbacks, distressing recollections of the events and nightmares (APA, 2013). Not all people present distress and psychological disorder symptoms in the same way since some of the symptoms may overlap and some may not. However, these symptoms do cause impairment in day-to-day functioning such as child relational problems, anxiety and depression (Westphal et al., 2011).

The disorder or symptoms as a result of sexual assault are not limited to people living in U.S.A. For example, Creamer, Burgess and McFarlane (2001) did a study in Australia and found that rape and molestation both were the traumatic events that participants considered to be most traumatic and were most likely to result in post-traumatic symptoms, in both men and women. Similarly, multiple studies have found that sexual trauma is one of the leading reasons behind persistent traumatic stress and symptoms, whether it occurred during war, combat or day to day life (Himmelfarb et al., 2006; Kang et al., 2005; Kessler, 1995).

Sexual Assault Reporting

There is a common theme of feeling shame and embarrassment after being sexually assaulted. Kilpatrick et al. (1992) found that majority of women were concerned about being blamed by others. Almost two decades later, Wolitzky-Taylor

et al. (2010) found that the most common reasons that caused women not to report sexual assault were fear of reprisal by the perpetrator, followed by not wanting the family to know, and not wanting others to know. In an examination of the most frequent reasons for non-reporting given from studies were blame, secrecy about the assault, not having enough proof, fearing the judicial system and not knowing how to report (Binder 1981; Jones et al., 2002; Sable et al., 2006; Weiss, 2010; Wolitzky-Taylor et al., 2010). Additionally, one unexpected reason of not reporting was the fear of possibly contracting a sexually transmitted disease due to the sexual assault (Mengeling et al. 2014).

This uncertainty and tendency to under-report the assault seems to be common across ages and professionals (Khan et al, 2018). For instance, a study of armed personnel revealed that among women in the Armed Forces, and of the 18 percent of 1339 participants who endorsed being sexually assaulted in the past, three-fourths did not report the assault to the authorities (Mengeling et al., 2014). The reasons included shame and embarrassment, the fear that reporting might negatively affect their careers, while some even blamed themselves. Similar results were also found when people in prison were considered, with men especially being wary of retaliation from other prisoners (Miller, 2010 & Blackburn et al., 2011)

Besides the mentioned reasons, some people may not report the assault because of their perception of the event. Wilson and Miller (2016) ran a meta-analysis on prevalence of unacknowledged rape and found that 60.4 percent of women did not consider their experience as rape even when their experience satisfied the definition of rape. This downplaying was previously explored by Ahrens (2006), in her qualitative study of eight individuals who experienced rape and their disclosure afterwards. The author discovered three ways in which a person was silenced: (1)

when the person faces negative response from their family or friends, or (2) professionals, and (3) how either of them led the person to be uncertain about their experience and undermine it. While this uncertainty can be heightened across all ages, studies indicate that teenagers, in particular, who experience sexual assault at the hands of other teenagers often do not recognize the experience as assault. Secondly, they fear losing their social circle or friends if the perpetrator was someone who belonged in their social life (Weiss, 2013).

Coping and Help-seeking Behaviors Associated with Sexual Assault

Even though people may not always report sexual assault and their experiences, there are ways through which they try to cope with those experiences. These behaviors could be positive and beneficial to them or be harmful/worsen the emotional pain. Roth & Cohen (1986) describe two general ways in which people cope with distress. The first is avoidant coping, which is getting away from the threat of stress (e.g., not thinking about stress or its aftermath, seeking distraction, or procrastination). Approach coping, on the other hand, involves a process of embracing experiences or behaviors that might stimulate the stress response, which is eventually dealt with.

Avoidant coping maybe employed when the situation is not in a person's control, while approach coping is employed when the person is in control of the situation, which could eventually be cathartic (Roth & Cohen, 1986; Herman-Stabl et al., 1995 & Boals et al., 2011). For example, one of the ways people try to deal with stress is through religion. Gerber et al. (2011) found that positive religious coping (such as benevolent religious appraisals, seeking spirituality and religious forgiveness) was positively related to growth after trauma, whereas negative religious coping (punitive religious reappraisals, spiritual discontent and demonic religious

reappraisals) was positively related to PTSD symptoms. Positive religious coping is a part of approach coping strategies, whereas negative religious coping is a part of avoidant coping strategies (Gerber et al., 2011).

Similarly, optimism is another mechanism that is employed when dealing with stress and stressful situations. Ironson et al. (2005) studied that heightened optimism towards the stress was a part of approach coping and it increased proactive behaviors to mitigate the stress. On the other hand, the author described that distancing oneself and having a pessimist outlook was associated with avoidant coping and depression in the long-term. As the name suggests, approach coping strategies also involves handling the problem directly which results in alternate methods to solve the problem whereas avoidant coping behaviors pertains to distancing oneself from the stressor and hoping the stressor would go away itself (Seiffge-Krenke & Klessinger, 2000). Approach coping is also known as task-oriented coping and avoidant coping is also termed as emotion-oriented coping (Endler, 1997). Campbell-Sills et al. (2006) found that people who deploy approach coping are more resilient to stress than people who use avoidant coping.

Besides the use of coping behaviors, another strategy people use to adjust to distressful and traumatic experience is to seek help. Help-seeking has many definitions; however, it is an attempt to seek external assistance formally (e.g., a professional) and/or informally (e.g., friends and family; Rickwood & Thomas, 2012). However, many do not seek help for a variety of reasons. Some do not seek help because of embarrassment and stigma (Gulliver, Griffiths & Christensen, 2010; Jorm, Wright & Morgan, 2007), secrecy (Chong et al., 2012; Wilson & Deabe, 2012) and cost of care (Vogel & Wester, 2003). Although some people do not seek help, there are several characteristics of help-seekers including demographic patterns. Picco et al.

(2016) did a review of factors that might positively affect help-seeking behaviors and found that one's sex (women more likely), higher education and socio-economic status, previous experience with mental health professionals, and knowledge and understanding of psychological disorders were associated with proactive help-seeking behaviors including seeking professional help.

Despite a tendency to not seek help, help-seeking is associated with increased well-being, both formal and informal. For example, medical professionals reported lower levels of stress and burnouts after a counseling intervention (Ro et al., 2010). The authors studied doctors who enrolled in a counselling program, and the three-year follow up revealed lower cases of burnout and stress from the job compared to at the start of the program. Similarly, students reported positive remarks about therapy at colleges regardless of how it was provided, online or in person (Richards, 2009).

Informal help-seeking, similarly, also helps allay the stress among individuals including children and adults. For example, it helps people who move and experience new cultures (Orjiako & So, 2014), young students who confide in their teachers and friends about bullying (Newman, 2008), coworkers who find workplace environment hostile (Ducharme & Knudson, 2007), victims of stalking who confide in their friends and families (Reyns & Englebrecht, 2014) and people who experience violence from their partners and rely on their social support (Sylaska & Edwards, 2014 & Fanslow & Robinson, 2010). Additionally, informal help-seeking also helps individuals who experience crimes, such as stalking, in reporting to relevant authorities (Sylaska & Edwards, 2014).

Survivor/Victim Identity, Coping and Help-seeking Behavior

If the reasons why people do not report sexual assault or seek help are associated with the shame or embarrassment they experience, it is expected that

perception of self or others when experiencing sexual assault may play a major role in kinds of coping strategies used, help-seeking behaviors and reporting assault. The labels “Victim” and “Survivor” are typically used to describe persons who have experienced sexual assault. Studies are increasingly exploring the connotations associated with these labels/identities. Labeling theories suggest that individuals may begin to internalize the identities associated with a label, which can in turn lead to negative outcomes (Link et al. 1989; Thoits, 2011). Similarly, Hunter (2010) examined how child abuse sufferers were initially referred to as victims, he found that such references led to victim blaming and victimization from society and the justice system. In an earlier study, Leisenring (2006) focused on the change in legalities of abuse especially when domestic violence and abuse were not considered crime but rather private matters between families. Despite the change to consider domestic violence as crime, the recipients of abuse were still considered culpable. This was due to the exit question, which was often used to ask why the person stayed in the relationship. Whether the exit question was intended or not, such a question subtly passed on the blame of continued violence to the victim (Leisenring, 2006). With time however, due to advocacy, the victim discourse was replaced in favor of a survivor discourse. Messamor and Paxton (2020) examined the trends in label usage and found that victim label was still being used more than survivor; however, advocacy organizations are steadily adopting survivor terminology to either replace or combine it with the victim label.

While the term “survivor” may reduce victim blaming and other negative perceptions, the term survivor has its own problems. In being a survivor, people are often identified by their trauma as they conquered their trauma, which in turn becomes central to their identity (Phillips & Daniluk, 2004). To explore how the

survivor labeled influenced perceptions, Schwark and Bohner (2019) found that women who were portrayed as survivors garnered more positive ratings than women who identified as victims. Similarly, Papendick and Bohner (2017) did a study asking German and English students their perceptions about survivor/victim scenarios provided to them. The results showed that participants, regardless of their nationality (both German and English) and gender, viewed survivor scenarios more positively than those of victims'. Secondly, participants of English nationality perceived women who labeled themselves as survivors as more psychologically stable than those who labeled themselves as victims, while there was no significant difference for students of German nationality.

While victim/survivor labels can have negative effects, the labels may be used to garner sympathy/empathy, although one group may suffer at the expense of the other. For example, Dunn (2005) believed that the word victim was necessary to bring abuse cases to court and criminalize abuse. However, this rendered the people who were abused without choice to define themselves. To dissuade such implication, policy makers opted for the term survivor; however, the author found that when the assaulted person was considered not helpless, the help offered to them was reduced.

Currently, what is not yet clear in the limited studies on this topic is the relationship between victim/survivor label, coping behaviors and help-seeking behaviors among those who have been sexually assaulted. Cole (2019) explored whether ascribing the label for oneself affected the PTSD symptoms that a person experienced. The author found that identifying oneself as victim or survivor did not significantly affect PTSD scores. However, when the study considered the victim/survivor identity on a continuous scale, higher scores towards survivor identity was associated with higher PTSD symptoms. This finding is interesting and contrary

to expectations. This result may be because of education. As mentioned by Cole (2019), being more educated made participants more aware of their symptoms, or they even employed more approach strategies resulting in more willingness to experience the post traumatic symptoms. In other words, awareness of symptoms may lead to more distress rather than lower symptoms. However, the author did not test this idea.

Research Question

This study was therefore interested in further examining the factors that influenced coping and help-seeking behaviors among people who have experienced sexual assault, and if coping strategies and help-seeking behaviors differ for those who view themselves as victims or survivors. As mentioned above, there are different subtleties attached to the label, victim or survivor, both from the person's own point of view and the perceptions of others. It was therefore hypothesized that there will be a significant positive association between help-seeking behavior and survivor identity, while there will be a significant negative association with help-seeking behavior and victim identity among those who have experienced sexual assault. Secondly, it was hypothesized that survivors of sexual assault would engage significantly more in approach coping strategies and fewer avoidant coping behaviors. Lastly, victims of sexual assault would engage in significantly more avoidant coping strategies and fewer approach coping strategies.

Method

Participants

Participants were recruited using MTurk, an online source. The proposed sample size for this study was a total of 250 participants which is more than the minimum sample size of 146 required to determine medium effects using 6 predictors and with a power of 0.80 (G*Power v3.1, Faul et al., 2009).

The final sample for analyses were 240 participants. About 41% of the participants endorsed being female. Participants' age ranged from 18 to 64 (M = 30.2, SD = 8.4). In the overall sample, 67% of the participants lived in the United States of America, 28% lived in India, and the rest (5%) were from across 7 different countries. From the sample, 70% of the people identified as victim. Overall, around 48% were White, 30% were Asian, 15% were Black and 5% were Hispanic/Latinx.

Procedure

Participants were asked to complete a survey that took approximately 20-30 minutes. The survey was comprised of several measures (Appendix A-E) related to the research question. Participants were presented with a screener about sexual assault and access to main study was conditional on their endorsement to a past sexual assault. At the end, the participants were debriefed about the nature and purpose of the study. Each participant received a monetary compensation of $1 for their participation in the study. Prior to accessing the survey, participants were asked to acknowledge that they had read, understood the purpose of the study and signed the informed consent form. Participants who chose not to sign/participate after reading the consent form were allowed to withdraw from participation. Only participants who consented got access to the survey. Participants could withdraw at any time while

filling the survey. Data collected was anonymous and kept confidential. At the end of the survey, participants could request results of this study.

Measures

The measures gather information about experience with sexual assault, help-seeking behaviors, coping behaviors and how they identify if ever assaulted. Additionally, information about the demographics was asked. Before the survey started, participants were required to answer a screener question about sexual assault as described by Rape, Abuse & Incest National Network (RAINN, 2011). Some questions in the survey were randomized, to counterbalance any effects of testing fatigue.

Coping strategy (Brief COPE; Carver, 1997)

Carver (1997) designed brief version of COPE (brief-COPE) and addressed some criticisms regarding the length of the full version that he came up with in 1989. In this version, each of the 14 subscales had two items (one, which previously had highest loading on the subscale and the other item, was guided by the research). Stratta et al. (2014) categorized the 14 subscales into 2 factors of approach style coping (eight subscales) or avoidant style coping (six subscales). The eight approach style coping subscales were: Acceptance, Religion, Planning, Positive Reframing, Using Instrumental Support, Active Coping, Using Emotional Support and Humor. The six Avoidant style coping subscales were: Self-Distraction, Venting of Emotions, Self-Blame, Behavioral Disengagement, Denial and Substance Use. Avoidant coping strategies refers to the behaviors an individual engages in to avoid facing the problem directly. These behaviors are also called emotion oriented (Stratta et al., 2014). The other category, approach, refers to the behaviors that an individual

engages in to tackle the problem headfirst and tries to solve it. Another way to describe these behaviors would be call them task oriented or problem focused.

The Cronbach's alpha for the approach and avoidant strategies were 0.66 and 0.61 respectively (Stratta et al., 2014). All 14 subscales had a Cronbach alpha from 0.50 to 0.90, and excluding venting, denial and acceptance all had a value higher than 0.60, and the scales had a test-retest reliability between 0.56 and 0.92 (Baccali, Surucu &Ilhan, 2013)

This study used all items of the Brief COPE since there is limited understanding of coping behaviors among the vulnerable population of interest. All the items were rated on the scale of 1-4, where 1 = I haven't been doing this at all, 2 = I have been doing this a little bit, 3 = I have been doing this a medium amount and 4 = I've been doing this a lot. Their scores on each of the two categories were averaged with higher scores indicating more use of the coping behavior.

Help-seeking Behaviors (GHSQ; Wilson et al., 2005)

General Help-seeking Questionnaire (GHSQ; Wilson et al., 2005) was used to measure participant help-seeking behaviors. Wilson et al. (2005) developed it by recruiting 218 high school students to fill out the questionnaire. The survey is divided into three parts: The first part consists of 10 questions pertaining to help-seeking intent. Example, *"Please circle the number that shows how likely is it that you would seek help from a Parent"* The second part consist of four questions about visiting a professional. Example, "*How many visits did you have with the mental health professional*?" The third part asks whether there have been help-seeking (formal or informal) behaviors "*in the past two weeks*". For this study, "*past two weeks*" was rephrased to "*since the sexual assault*". This is to ensure that participants give responses related to the research question.

According to Wilson et.al (2005) GHSQ has a Cronbach's alpha of 0.85 and a test-retest reliability of 0.92 over a three-week period. They calculated the correlation between intent and behavior between two-week periods. The correlations were moderate for informal sources as there were few students who endorsed seeking help from informal professionals. Olivari et al. (2017) did a review on GHSQ and found Cronbach's alphas were higher for different disorders such as depression, suicide and substance abuse equal to 0.82, 0.87 and 0.79 respectively.

This study used the whole survey. Part 1 (10 questions) was scored on a Likert scale, with 1= *extremely unlikely* to 7 = *extremely likely*, similar to original scale. Scoring for this part was summed responses (last item was reverse scored), with higher scores meaning higher health-seeking behaviors. Section 2 (4 questions) was about whether they have visited a mental health professional. Only the first question, a dichotomous yes/no response, was scored and added to the total Help-Seeking Behavior. Section 3 was scored same as section 1 but the questions related to the past help-seeking behaviors and the responses were dichotomous. The third part was scored by summing up the number of times participants have sought help from the sources stated. Higher scores meant more help-seeking behaviors.

Labelling

Questions regarding victim or survivor identity/label were adapted from Cole's (2019) study. The participants were asked about whether they consider themselves as survivors or victims on a scale of 0-100 with the range being 0 (victim) to 100 (survivor), as well as the same question asked as a dichotomous variable (survivor = 1, victim = 0). For this study, the scale of (1-100) was changed to 1-7 (0= Entirely a Victim and not at all Survivor, 7 = Entirely a Survivor and not at all

Victim) to reduce ambiguity of estimation of such a wide range while still allowing variability in response.

Demographics

The participants were asked background information such as college year, ethnicity, whether they were a veteran etc. The covariates included in the survey were participant's age, religion/religiosity and sex assigned at birth. In addition, they were asked whether they live in U.S or not, and whether they have ever been diagnosed with a mental disorder before.

Results

Descriptive analyses

Descriptive analyses were run as part of the process of cleaning the data and to ensure normal distribution of variables. Correlations were conducted between predictors, covariates and outcomes to identify and understand relationships and control for variables that might affect the results. Covariates accounted for were age, religiosity and sex assigned at birth.

The three main variables were checked for normality and the data distributed normally. Mean scores for approach and avoidant coping were all normally distributed. Data for seven participants were excluded as they either did not meet the attention check criteria, or responses to each item showed no variability thereby, contradicting themselves. Additionally, data from one participant was excluded as their reported age was lower than age 18, bring the final sample size to 240. See Tables 1 and 2 for descriptive analyses.

A Chi-square test was conducted to examine the association between country of origin and sex of participants. Results from the tests showed that there was a significant difference between country of origin and sex of participants (Table 1), since there were more male participants from India as compared to participants from USA [X^2 (2, N = 240) = 6.3, p = .04, φ_{Cramer} = .16]. However, no significant difference was found between country of origin and sexual assault label [X^2 (2, N = 240) = 2.35, p = .39] or sex of participant and sexual assault label [X^2 (2, N = 240) = .56, p = .46].

Table 1

Participant Demography by survivor/victim label

	Male		Female	
	Survivor	Victim	Survivor	Victim

USA	28(12%)	59(25%)	25(10%)	49(20%)
India	10(4%)	35(15%)	7(3%)	15(6%)
Others	2(1%)	8(3%)	0	2(1%)

Table 2

Mean, S.E, Standard Deviation and Range for the variables

	Religiosity	Age	Victim/Survivor label (Continuous)	Help-seeking Behavior	Approach coping	Avoidant coping
Mean	0.85	30.22	3.3	50.5	44.34	32.5
S.E	0.02	0.54	0.11	0.73	0.07	0.08
SD	0.36	8.39	1.7	11.23	1.11	1.23
Range (Min-Max)	0-2	18-64	1-7	10-68	18-59	12-45

Note: Religiosity was coded with 0 being the lowest and 2 being the highest.

Preliminary analyses were conducted to include covariates what might be correlated with help-seeking and coping behavior in the regression analyses. Correlation analyses indicated that only age and religiosity were significantly correlated with help-seeking and coping behaviors and were therefore entered as covariates in the main analyses. The identity label variable was measured as both a dichotomous (0 = victim, 1= survivor) and continuous variable (1 = entirely a victim, 7= entirely a survivor). Correlation analyses indicated a weak association between the two measures of victim/survivor identities; therefore, each hypothesis was run using both the dichotomous identity label and continuous identity label in separate analyses; see Table 3 for summary of correlation analyses.

Table 3

Bivariate Correlation Coefficients for controlled variables

	1.	2.	3.	4.	5.	6.	7.	8.
1.Sex	-							
2.Religiosity	-.04	-						
3.Age	.03	-.07	-					
4.Victim/Survivor label	.05	-.05	.18**	-				
5.Victim/Survivor label (Cont.)	.15	-.12	.25***	.38***	-			
6.Helpseeking Behavior	-.02	.37***	-.29***	-.06	-.07	-		
7.Avoidant Coping	-.14*	.34***	-.24***	-.1	-.18**	.71***	-	
8.Approach Coping	-.09	.39***	-.22***	.04	-.03	.71***	.79***	-

Note. *: $p < 0.05$, **: $p < 0.01$, ***: $p < 0.001$; 4. Victim/Survivor Label: 0 = Victim, 1 = survivor.

Main Analyses

Hypothesis one

Regression analyses were conducted to examine whether the label someone identified themselves with after being sexually assaulted (i.e. survivor or victim) would predict help-seeking behavior. After controlling for age and religiosity, the results showed that the label a person identifies with did not significantly predict help-seeking behavior. Table 4 shows summary of the analyses both dichotomous and continuous label variables were entered as predictors of on help-seeking behavior in separate analyses.

Table 4

Regressing Identity Labels on Help-Seeking Behavior

	Identity Label (dichotomous)	Identity Label (Continuous)

	Unstandardized coefficients		Standardized coefficients	Unstandardized coefficients		Standardized coefficients
	β	Standard error	Beta	β	Standard error	Beta
Religiosity	10.75	1.8	.35***	10.75	1.8	.35***
Age	-.36	.08	-.27***	-.36	.08	-.27***
Label	.26	1.45	.01	.25	.4	.04

Note. *: p < 0.05, **: p < 0.01, ***: p < 0.00. Dichotomous Identity label: 0 = victim, 1 = survivor; Continuous Identity Label: Higher Scores Denote Preference for Survivor Identity Label

Hypothesis two

A similar regression was conducted with victim/survivor labels (both dichotomous and continuous) predicting approach coping behaviors, while controlling for religiosity and age. The hypotheses were not supported as there was no significant associations between either forms of the identity label and the outcome. Results are summarized in Table 5.

Table 5

Regressing Identity Labels on Approach Coping

	Identity Label (dichotomous)			Identity Label (Continuous)		
	Unstandardized coefficients		Standardized coefficients	Unstandardized coefficients		Standardized coefficients
	β	Standard error	Beta	β	Standard error	Beta
Religiosity	1.16***	.18	.34***	1.16***	.18	.34***
Age	-.03**	.01	-.12**	-.03**	.01	-.12**
Label	.23	.14	.1	.04	.04	.07

Note. *: p < 0.05, **: p < 0.01, ***: p < 0.00. Dichotomous Identity label: 0 = victim, 1 = survivor; Continuous Identity Label: Higher Scores Denote Preference for Survivor Identity Label

Hypothesis three

Lastly, there were non-significant findings when identity labels were regressed on avoidant coping while controlling for religiosity and age, with summary reported on Table 6.

Table 6

Regressing Identity Labels on Avoidant Coping

	Identity Label (dichotomous)			Identity Label (Continuous)		
	Unstandardized coefficients		Standardized coefficients	Unstandardized coefficients		Standardized coefficients
	β	Standard error	Beta	β	Standard error	Beta
Religiosity	1.1***	.2	.32***	1.1***	.2	.32***
Age	-.03**	.01	-.22**	-.03**	.01	-.19**
Label	-.11	.16	.1	.04	.04	.07

Note. *: $p < 0.05$, **: $p < 0.01$, ***: $p < 0.00$. Dichotomous Identity label: 0 = victim, 1 = survivor; Continuous Identity Label: Higher Scores Denote Preference for Survivor Identity Label

Discussion

This study intended to analyze the relationship between the labels applied to people who have experienced sexual trauma and behaviors such as help-seeking and coping strategies (approach or avoidant coping). The results from this sample suggests that identity labels (victims or survivors) of sexual assault are not significantly associated with help seeking or coping behaviors post assault. Also, there was no significant associations regardless of how the identities labels were measured (dichotomous level or on a continuous level). This non-significant finding supports the findings of Cole (2019) that PTSD symptoms did not differ depending on the label someone uses (i.e. victim or survivor). Bernsten & Ruben (2007) posited that it is not someone's identity (trauma victim or trauma survivor) but the event centrality of the trauma that predicts the post-trauma stress. How central the person believes the traumatic event to their identity is affects the severity of symptoms, rather than the identity that is used. Similarly, Maercker & Muller (2004) examined how post-trauma stress severity differs among people who experience sexual assault. Rather than victim or survivor identity, it was the social acknowledgement from the people around them that affected the distress severity. It could be that it is not the victim/survivor identity of the person who goes through the assault, rather it is the perception about the person and their experience that predicts the stressor severity.

Coping strategies and help-seeking behaviors were significantly correlated with each other. There might be instances where priming of one measure might have influenced the response to the other measures. It would be an interesting idea to see how people respond to the measure independently without being part of the same study. Although participants were asked about previous professional help, the quality, consistency, length and recency of such help was not assessed. This could be one of

the reasons that might affect why someone might not choose to engage in further help-seeking behavior. It might be beneficial to study these factors in the future. Lastly, the number of sexual assaults differed for participants. This variance in instance might have influenced their approach towards coping strategies and help-seeking behaviors. Similar to the factors mentioned previously, it could also be an interesting aspect that could be studied in the future.

The majority of the sample consisted of males. This may have influenced the pattern of findings since most studies related to sexual assault usually have more female participants. One reason for higher male respondents may be due to higher than usual male participation in survey research on MTurk, especially in India (Difallah, Filatova & Ipeirotis 2018). Regardless, such findings for predominantly male sample provides impetus for further research since many males reported sexual assault yet limited study on them (Ullman & Filipas, 2005; Steel et al., 2004).

Other findings (Covariates)

The results showed some significance pertaining to controlled variables in the analyses. The data showed that as people grow older, they engage less in help-seeking behavior, avoidant coping and approach coping. Westerhof et al. (2008) studied that older people are less likely to seek psychological help, and they would rather seek preventative help. On the other hand, help-seeking and coping behavior could also be linked to the span of time that elapsed between sexual assault and their current age. Additionally, a lot of help seeking resources are available to younger people in the form of informal help such as friends and parents, and formal help such as school/college counsellors. Additionally, younger generations express a more positive attitude towards mental health (Mojtabai, 2007).

Religiosity on the other hand was associated with higher help-seeking and coping behaviors. This was not surprising as religiosity is considered as a protective factor against suicidality and drug use, which are common post-trauma symptoms (Burke et al., 2014; Merike et al., 2010; Rostosky et al., 2007 & Zila et al., 2008). Religiosity also presents access to religious leaders as a mean for help-seeking. This relates back to the idea that religiosity is itself method for help-seeking.

Limitations

The data was collected through Amazon's Mechanical Turk (MTurk), therefore participants were only those people who have access to Amazon, computers and internet, which means it leaves out people who do not have access to all three and there might be people who went through trauma, and their victim/survivor identity might affect their help-seeking and coping behavior but were not included in the sample. Although MTurk participants are diverse, research suggests that they are less diverse than the diversity found in general population (Paolacci et al., 2014), which means the result might be less generalizable. Lastly, MTurk participants usually take part in several other studies and might be exposed to research methods the general population otherwise might not be exposed to which might affect how they respond to questions. For example, someone might have wrongly answered the screener question to take part in the study and get monetarily compensated.

Brief COPE was used as a measure to record coping strategies. The measure did not have good validity properties as several subscales had a Cronbach Alpha less than 0.8. Moreover, each subscale had only two items, which might have limited the variability found in coping strategies and preferences (Robinson, 2008; Kline, 2008)

During data collection, the study was opened to all persons older 18 years old who had experienced sexual assault. Our results showed that a substantial number of participants were from India. This was unexpected and may have contributed to overall finding as Indian culture and views of sexual assault may vary from American culture. Data Analysis was run on the whole as separating sample reduced the sample size and rendered the data under powered. This revelation however offers opportunity for future research. Lastly, participants were asked to report how they identify as a victim or survivor. There is currently no normed scale that assesses identity labels. Whereas in the study the question was asked as a single question on both a categorical and ordinal level of measurement, it is possible that responses on label identification could be more accurate with a multi-item measure.

Future Directions

As seen in the study, age and religiosity predicted help-seeking and coping behaviors. Future studies should examine aspects of religiosity that might predict help-seeking behaviors, for instance, sexual guilt (Hackathorn et al., 2015) or Big Five Personality factors (Saroglou, 2002). Religiosity is also a subscale of COPE measure. It would be an interesting idea to test the COPE subscale individually with identity labels, instead of using the entire measure. Similarly, it might also be interesting to study what other factors are associated with help-seeking behaviors of people who have experienced sexual assault, as that would enable clinicians to better understand behaviors, practices or lack thereof, to help clients more proficiently. Additionally, knowledge of other factors that impede help-seeking would also help clinicians spread awareness so that people are more likely to seek help rather suffer without proper care.

Another area for future research is studies about how different cultures understand and seek help-seeking post sexual assault. Such studies will increase clinicians' competency when working with diverse clients and intervention strategies. Culturally specific interventions can help lower the reoccurrence of a symptoms and relapse in progress towards improvement (Paul et al., 2017). Similarly, older people were less likely to seek help. Future studies should also examine ways that can help people to seek help despite their age.

The age at which the person experienced the assault could also be related to the help seeking behavior behaviors and coping strategies. Mckutcheon and colleagues (2010) analyzed several factors that predicted PTSD severity, and among them childhood sexual assault was one of the top three predictors of symptom severity. It might be possible that childhood experience of sexual assault might affect help-seeking and coping strategies rather than the trauma label. This could also be an area for future research as older people might seek less help due to the time elapsed between their assault and current age.

Conclusion

This study aimed to research whether someone's victim or survivor identity would affect their help-seeking or coping behaviors. It was hypothesized that people who identify as survivors would engage in more help-seeking behaviors and approach coping behaviors and less in avoidant coping behaviors. The results did not provide evidence for any of the hypotheses.

Appendix A

Screening Questionnaire:

Before answering the question, please read the following description:

The term sexual assault refers to sexual contact or behavior that occurs without explicit consent of the victim. Some forms of sexual assault include:

- Attempted rape
- Fondling or unwanted sexual touching
- Forcing a victim to perform sexual acts, such as oral sex or penetrating the perpetrator's body
- Penetration of the victim's body, also known as rape

What is Rape?
Rape is a form of sexual assault, but not all sexual assault is rape. The term rape is often used as a legal definition to specifically include sexual penetration without consent.

What is Force?
Force doesn't always refer to physical pressure. Perpetrators may use emotional coercion, psychological force, or manipulation to coerce a victim into non-consensual sex. Some perpetrators will use threats to force a victim to comply, such as threatening to hurt the victim or their family or other intimidation tactics.

After reading the description above, please answering the following question accurately.

Have you experienced sexual assault?

1. Yes

2. No

Demographics

Demographic questionnaire

1. What is your age? _____

2. What is your Gender?

    a. Female

    b. Male

    c. Non-binary

3. Who are you attracted to?

    a. Heterosexual

    b. Bisexual

    c. Homosexual

    d. Asexual

    e. Other:_____

4. What is your race/ethnic identity? Please select ALL that apply:

    a. White/Caucasian

    b. Black/African/African-American

    c. Hispanic/Latino/a/X

    d. Asian/Asian-American

    e. Alaskan/Pacific Islander

    f. Other (please specify)

5. Year in college:

    a. Freshman

    b. Sophomore

    c. Junior

    d. Senior

e. N/A (i.e., not currently in college)

6. How religious are you?

a. Not religious at all

b. Somewhat religious

c. Very religious

7. Were you raised in a religious household?

a. Yes

b. No

8. Have you ever been diagnosed with a psychological disorder/mental illness?

a. Yes

b. No

c. Not sure

9. If yes, what diagnoses did you receive?

a. _____

b. Not Sure

10. Have you ever received any mental health treatment/counseling/therapy?

a. Yes

b. No

c. Not sure

11. If yes, how long were you in treatment/counseling/therapy?

a. Less than 6 months

b. 6 months - 12 months

c. 1 year – 2 years

d. More than 2 years

e. N/A because I am still in treatment/counseling/therapy

12. If you are currently receiving treatment/counseling/therapy, how long has that lasted so

far?

a. Less than 6 months

b. 6 months - 12 months

c. 1 year - 2 years

d. More than 2 years

e. N/A because I am not currently in treatment/counseling/therapy

13. Are you a veteran in the military?
    a. Yes, veteran
    b. Yes, but not yet a veteran
    c. No

14. Which country (not city) do you currently live in?

…….

Victim or Survivor Scale (Cole, 2019)

1. How much do you feel like a victim or survivor?

1	Entirely a Victim and not at all Survivor
2	Almost entirely a victim and a little bit survivor
3	Mostly a victim and slightly a survivor
4	Equally a victim and a survivor
5	Mostly a survivor and slightly a victim
6	Almost entirely a survivor and a little bit victim
7	Entirely a survivor and not at all victim

2. If you had to choose one option, how would you prefer to identify yourself?
   0 = Victim
   1 = Survivor

General Help-Seeking Questionnaire (Wilson et al., 2005)

Below is a list of people who you might seek help or advice from if you were experiencing a personal or emotional problem resulting from sexual assault. Please state how likely you would seek help from each of these people for a personal or emotional problem?

		Extremely not likely						Extremely likely
1a.	Partner (e.g., significant other, boyfriend or girlfriend)	1	2	3	4	5	6	7
1b.	Friend (not related to you)	1	2	3	4	5	6	7
1c.	Parent	1	2	3	4	5	6	7
1d.	Other relative / family member	1	2	3	4	5	6	7
1e.	Mental health professional (e.g., school counsellor, psychologist, psychiatrist)	1	2	3	4	5	6	7
1f.	Phone help line (e.g., Lifeline, Kids Help Line)	1	2	3	4	5	6	7
1g.	Family doctor / General physician	1	2	3	4	5	6	7
1h.	Teacher (year advisor, classroom teacher)	1	2	3	4	5	6	7
1i.	Someone else not listed above (please describe who this was):	1	2	3	4	5	6	7
1j.	I would not seek help from anyone	1	2	3	4	5	6	7

2a. Have you ever seen a mental health professional (e.g., school counsellor, counsellor, psychologist, psychiatrist) to get help for personal problems? (select one)

- Yes
- No

If you circled "no" in question 2a, you are finished this section. If you circled "yes" please complete 2b, 2c, and 2d below.

2b. How many visits did you have with the mental health professional?_____visits.

2c. Do you know what type of mental health professional(s) you've seen? If so, please list their titles (e.g., counsellor, psychologist, psychiatrist).

_____

_____

2d. How helpful was the visit to the mental health professional? (please select)

Extremely unhelpful				Extremely helpful
1	2	3	4	5

3. Below is a list of people who you might seek help or advice from if you were experiencing a personal or emotional problem. Tick any of these **who you have gone to for** advice or help for a personal or emotional problem.

		Yes	No	Number of times, if you remember
3a	Partner (e.g., significant other, boyfriend or girlfriend)			
3b	Friend (not related to you)			
3c	Parent			
3d	Other relative / family member			
3e	Mental health professional (e.g., school counsellor, psychologist, psychiatrist)			
3f	Phone help line (e.g., Lifeline, Kids Help Line)			
3g	Family doctor / General physician			
3h	Teacher (year advisor, classroom teacher)			
3i	Someone else not listed above (please describe who this was):			
3j	I would not seek help from anyone			

Coping questionnaire (Brief COPE; Carver, 1997)

Instructions: Below are some ways people try to deal with stressful situations. Read every statement and select the options that best applies to you.

	I haven't been doing this at all	I have been doing this a little bit	I have been doing this a medium amount	I have been doing this a lot
I've been turning to work or other activities to take my mind off things				
I've been concentrating my efforts on doing something about the situation I'm in				
I've been saying to myself "this isn't real"				
I've been using alcohol or other drugs to myself feel better.				
I've been getting emotional support from others.				
I've been giving up trying to deal with it.				
I've been taking action to try to make the situation better.				
I've been refusing to believe that it has happened.				
I've been saying things to let my unpleasant feeling escape.				
I've been getting help and advice from other people.				
I've been using alcohol or other drugs to help me get through it				
I've been trying to see it in a different light, to make it seem more positive.				
I've been criticizing myself.				
I've been trying to come up with a strategy about what to do.				

I've been getting comfort and understanding from someone.				
I've been giving up the attempt to cope.				
I've been looking for something good in what is happening				
I've been making jokes about it.				
I've been doing something to think about it less, such as going to movies, watching TV, reading, daydreaming, sleeping, or shopping				
I've been accepting the reality of the fact that it has happened.				
I've been expressing my negative feelings.				
I've been trying to find comfort in my religion or spiritual beliefs.				
I've been trying to get advice or help from other people about what to do.				
I've been learning to live with it.				
I've been thinking hard about what steps to take.				
I've been blaming myself for things that happened.				
I've been praying or meditating				
I've been making fun of the situation.				

Appendix B: Informed Consent, Screener Question and Debriefing Statement

Informed Consent

Project Title: Help-seeking behavior and coping style related to sexual assault label**.**

Investigators: Shahzor Hashim and Dr. Esther Malm, Dept. of Psychology, Murray State University, Murray, KY 42071.

You are being asked to participate in a project conducted through Murray State University. You must be at least 18 years of age to participate. Below is an explanation of the purpose of the project, the procedures to be used, and the potential benefits and possible risks of participation.

Nature and Purpose of the Project: The purpose of this study is to gain information on help-seeking behaviors and coping mechanism among people who have experienced sexual assault, and how they identify themselves.

Explanation of Procedures: Your participation in this study will require you to complete a survey that measures various sexual assault instances, help-seeking behavior, coping mechanism, and symptoms (if any) about trauma. Your total participation should take no longer than 25 minutes.

Discomforts and Risks: Some of the questions require information of traumatic instances, and can cause discomfort. You should contact your local psychological services provider if you need help. Regardless, please know that you can quit participating at any time without penalty.

Benefits: There are no direct individual benefits to you beyond the opportunity to learn first-hand what it is like to participate in a research study and to learn about some of the methods involved in psychological research. A general benefit is that you will add to our knowledge of the research subject

Compensation: You will be paid $1 for completing this survey.

Confidentiality: Your responses and participation in all tasks will be completely anonymous; they will only be numerically coded and not recorded in any way that can be identified with you. The faculty Investigator will keep all information related to this study secure for at least three years after completion of this study, after which all such documents will be destroyed.

Required Statement on Internet Research: All survey responses that the researcher receives will be treated confidentially and stored on a secure server or hard drive. However, given that the surveys can be completed from any computer (e.g., personal,

work, school), we are unable to guarantee the security of the computer on which you choose to enter your responses. As a participant in this study, the researcher wants you to be aware that certain "keylogging" software programs exist that can be used to track or capture data that you enter and/or websites that you visit.

Refusal/Withdrawal: Your participation in this study should be voluntary. Your refusal to participate will involve no penalty. In addition, you have the right to withdraw at any time during the study without penalty or prejudice from the researchers. For participating in the main study, you will be paid $1. To complete the survey, follow the link below. Thank you for your time!

By clicking on the button below, you are indicating you are at least 18 years old, and your voluntarily consent to participate in this research.

□I am 18years old or older. I have read the information above and consent to participation.

THIS PROJECT HAS BEEN REVIEWED AND APPROVED BY THE MURRAY STATE UNIVERSITY INSTITUTIONAL REVIEW BOARD (IRB) FOR THE PROTECTION OF HUMAN SUBJECTS. ANY QUESTIONS PERTAINING TO YOUR RIGHTS AS A PARTICIPANT OR ACTIVITY-RELATED INJURY SHOULD BE BROUGHT TO THE ATTENTION OF THE IRB COORDINATOR AT (270) 809-2916. ANY QUESTIONS ABOUT THE CONDUCT OF THIS RESEARCH PROJECT SHOULD BE BROUGHT TO THE ATTENTION OF THE RESEARCHERS AT surveyinfo2018@gmail.com.

Non-Qualifying Debriefing:

Thank you for your participation in this survey. The goal of this study was to determine the relationship between the label you identify with after the assault (victim or survivor) and the help-seeking and coping behaviors.

At this point in time, you do not qualify to take part in this study. Thank you for your interest in this study.

Completed Survey Debriefing:

Thank you for your participation in this survey. The goal of this study was to determine the relationship between the label you identify with after the assault (victim or survivor) and the help-seeking and coping behaviors. In this study, you were asked to answer question related to sexual assault, your experience after the assault, how you might identify yourself.

Your participation is not only greatly appreciated by the researchers involved, but the data collected could possibly aid people working with people who have experienced sexual assault. If there is a relationship between the label someone identify themselves as and their coping and help-seeking behaviors, it could tell us how to increase the help-seeking behavior for people who have experienced assault.

Although there are no expected risks associated with participating in this study, if you are feeling any discomfort or distress because of this study, please contact your local psychological services.

Additionally, if you have any questions about your rights as a participant in this experiment, you may contact the Murray State IRB Coordinator at msu.irb@murraystate.edu.

If you have any questions about this study, please contact us at **surveyinfo2018@gmail.com**

Finally, you can ask someone you know who has been through sexual assault to take this survey as it would help us to gather as much information as possible.

Thank you!

Appendix C: IRB Approval Letter

MURRAY STATE UNIVERSITY

Institutional Review Board

328 Wells Hall
Murray, KY 42071-3318
270-809-2916 • msu.irb@murraystate.edu

TO: Esther Malm, Psychology

FROM: Jonathan Baskin, IRB Coordinator JB

DATE: 12/5/2019

RE: Human Subjects Protocol I.D. – IRB # 20-095

The IRB has completed its review of your student's Level 1 protocol entitled *Help-Seeking Behaviors and Coping Styles Related to Sexual Assault Labelling*. After review and consideration, the IRB has determined that the research, as described in the protocol form, will be conducted in compliance with Murray State University guidelines for the protection of human participants.

The forms and materials that have been approved for use in this research study are attached to the email containing this letter. These are the forms and materials that must be presented to the subjects. Use of any process or forms other than those approved by the IRB will be considered misconduct in research as stated in the MSU IRB Procedures and Guidelines section 20.3.

Your stated data collection period is from 12/5/2019 to 12/4/2020.

If data collection extends beyond this period, please submit an Amendment to an Approved Protocol form detailing the new data collection period and the reason for the change.

This Level 1 approval is valid until 12/4/2020.

If data collection and analysis extends beyond this date, the research project must be reviewed as a continuation project by the IRB prior to the end of the approval period, 12/4/2020. You must reapply for IRB approval by submitting a Project Update and Closure form (available at murraystate.edu/irb). You must allow ample time for IRB processing and decision prior to your expiration date, or your research must stop until such time that IRB approval is received. If the research project is completed by the end of the approval period, then a Project Update and Closure form must be submitted for IRB review so that your protocol may be closed. It is your responsibility to submit the appropriate paperwork in a timely manner.

The protocol is approved. You may begin data collection now.

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