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INVESTIGATING THE ROLE OF EXPECTATIONS OF DISCLOSURE IN THE RELATIONSHIP BETWEEN TRAUMA-RELATED SHAME AND SEEKING MENTAL HEALTH SERVICES

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A Thesis

Presented to the

Faculty of

California State University,

San Bernardino

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In Partial Fulfillment

of the Requirements for the Degree

Master of Arts

in

Psychological Science

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by

Holly Timblin

May 2021

# INVESTIGATING THE ROLE OF EXPECTATIONS OF DISCLOSURE IN THE RELATIONSHIP BETWEEN TRAUMA-RELATED SHAME AND SEEKING MENTAL HEALTH SERVICES

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Approved by:

Christina Hassija, Committee Chair, Psychology

Jacob Jones, Committee Member

Kelly Campbell, Committee Member

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ABSTRACT

Sexual assault (SA) is a prevalent health concern. Previous research indicates that the quality of social reactions received upon disclosure of SA greatly impacts the psychological adjustment of survivors (Ullman, 2000). Negative social reactions upon disclosure have been associated with greater self-blame and shame and may deter survivors from seeking mental health services. Presently, little research on survivors' expectations of disclosure exists. The current study investigated whether expectations of disclosure mediate the relationship between shame and seeking mental health services. Participants completed the Trauma-Related Shame Inventory, Expectations of Disclosure Questionnaire, and the Disclosure Questionnaire. Results revealed shame predicted negative expectations of disclosure; $b = 0.72$, $t(84) = 10.60$, $p < 0.001$, *95% CI* [0.58, 0.85]. Positive expectations of disclosure predicted disclosure to mental health professionals; $b = 0.08$, $t(83) = 4.53$, $p < 0.001$, *95% CI* [0.0461, 0.1182], as did shame, $b = 0.04$, $t(82) = 2.36$, $p < 0.05$, *95% CI* [0.01, 0.09]. Neither positive ($b = -0.001$, $p > 0.05$, *95% CI* [-0.0209, 0.0095]) or negative expectations of disclosure ($b = -0.02$, $p > 0.05$, *95% CI* [-0.05, 0.01]) mediated the relationship between trauma-related shame and disclosure to mental health professionals. Findings can lead to new approaches in crisis interventions for individuals who had been sexually assaulted.

*Keywords:* Sexual assault, expectations of social reactions to disclosure, trauma-related shame, mental health professionals

## DEDICATION

This manuscript is dedicated to the psychology department located at California State University, San Bernardino. I would like to thank my committee members for their support and guidance throughout this process. Furthermore, this manuscript is dedicated to my family and friends who have supported me throughout my undergraduate and graduate career.

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# CHAPTER ONE:

# LITERATURE REVIEW

Within the United States, sexual assault is prevalent, and can result in serious physical and mental health concerns. Sexual assault consists of rape (i.e., unwanted penetration by force), sexual coercion, and unwanted sexual contact (Cantor et al., 2015). According to Black et al. (2011), nearly 18.3% of women and 1.4% of men will be sexually assaulted at some point in their lives. Additionally, approximately 51.1% of female survivors report being attacked by an intimate partner and 40.8% of female survivors by an acquaintance. Furthermore, 52.4% of male survivors report being raped by an acquaintance and 15.1% of male survivors by a stranger.

Sexual victimization is increasingly problematic within the United States' college population. The Association of American Universities (AAU) Campus Climate Survey on Sexual Assault and Sexual Misconduct (Cantor et al., 2015) reported that 20.8% of undergraduate women experience sexual assault at 33 of the nation's major universities. Additionally, first year female undergraduates are more at risk of sexual assault compared to other university students (Cantor et al., 2015). Only 31.3% of assaults involving penetration, and 13.9 % of assaults involving sexual touching by physical force, are reported to an organization or agency (e.g., Title IX office, law enforcement; Cantor et al., 2015). Further complicating the issue, survivors of sexual assault may be at heightened risk of experiencing depression, anxiety, substance abuse, low self-esteem, and suicide

attempts (Black et al., 2011). Furthermore, 9 in 10 sexual assault survivors report being attacked by someone they know (e.g., boyfriend, ex-boyfriend, classmate, friend, acquittance, or coworker; Cantor et al., 2015).

Sexual assault is worthy of investigation because of the numerous negative psychological and social consequences it presents. Clasen, Blauert, and Madsen (2018) surveyed 148 adolescents about their sexual assault experiences. The researchers discovered that when the assailant was an acquaintance, social consequences (i.e., alienation from a friend group) significantly hindered disclosure. Furthermore, students reported struggles in course work following the assault due to the assailant attending the same school. Investigating the social effects of sexual assault in college students is essential in understanding the consequences that students may face. These imposed risks to the well-being of sexual assault survivors makes it essential to understand what hinders seeking out mental health resources in hopes of promoting resilience and positive well-being for survivors.

## Disclosure Following Sexual Assault

According to Rennison (2002), sexual assault is the most under-reported crime with approximately 63-75% of sexual assaults not being reported to officials. Sexual assault survivors potentially have a wide range of sources they could disclose to, such as formal sources of support (e.g., police, medical providers, mental health service providers, etc.) and informal sources (e.g., family member, partner, friend, etc.). Sabina and Ho (2014) conducted a meta-

analysis investigating disclosure tendencies. Results indicated that approximately 41% of survivors disclosed to an informal source; typically, survivors disclose to at least one informal source (Sylaska & Edwards, 2014; Dworkin et al., 2019). Friends, specifically female friends, tend to serve as confidants more frequently than family members (Sabina & Ho, 2014, Orchowski & Gidycz, 2012). Furthermore, Sabina and Ho (2014) discovered that occurrence of disclosure ranged from immediately after the assault occurred to up to two years following the event (Guerette & Caron, 2007; Orchowski & Gidcyz, 2012).

Demers and colleagues (2017) surveyed participants from eight universities about their experiences with sexual assault, who they disclosed their unwanted sexual experience to (i.e., informal helpers), the feedback they received, and their goals and hopes associated with disclosing. The researchers discovered sexual assault survivors reported to informal helpers, community helpers, community authorities, friends, immediate family members, therapists, advocates, and police. Some participants reported to multiple sources. The most common recipient of disclosure were friends. The rates of disclosing to formal sources (e.g., mental health professionals) appear significantly lower as compared to disclosure to informal sources (Sylaska & Edwards, 2014; Dworkins et al., 2019). Accordingly, survivors tend to report primarily to informal sources, mostly friends. However, survivors may not receive the necessary resources to promote positive psychological outcomes and resilience if they do not disclose to formal support, such as mental health professionals.

Disclosing traumatic events can help alleviate psychological and physiological distress (Pennebaker & Beall, 1986). Individuals who feel that they cannot confide in others about distressing events believe they must alter and control their behaviors, thoughts, and feelings (Pennebaker & Beall, 1986). Pennebaker and Beall (1986) investigated whether engaging in writing about distressing events influences long-term health and short-term physiological arousal and negative moods. The researchers discovered that documenting the emotional consequences of traumatic events and the facts that occurred during the events resulted in increased short-term physiological arousal and negative mood; however, participants also experienced fewer long-term medical issues and fewer hospital visits. Based on the findings of Pennebaker and Beall (1986) disclosing, and processing traumatic events diminishes risk of future health concerns; it seems that withholding information impacts both psychological well-being and physiological well-being. Therefore, it is important to promote disclosure among survivors of sexual assault. Allowing oneself the opportunity to process a traumatic event by documenting thoughts and feelings or disclosing to a informal or formal source may potentially promote positive psychological outcomes. In order to promote disclosure among survivors of sexual assault, we must understand what hinders or promotes the rate of disclosure.

Ahrens and colleagues (2007) interviewed female sexual assault survivors about their expectations and outcomes of disclosure. Seventy-five percent of survivors disclosed to an informal source; over half received positive feedback (e.g., encouraged to seek professional help) from the person they disclosed from.

Less than one-third of survivors reported believing that disclosing their assault resulted in detrimental consequences. Furthermore, survivors received positive feedback from formal sources when the formal source initiated the conversation. Additionally, survivors reported deciding to disclose their assault for a variety of reasons, including seeking assistance, emotional support, catharsis, tangible aid, and seeking prosecution. When the conversation was initiated by the other person, survivors reported engaging in disclosure in order to explain behavior, discuss the assault, were asked what was wrong, or the person was present when the assault took place. In most cases, the survivor initiated the conversation.

Dworkin and colleagues (2019) reviewed empirical literature regarding the impact of social reactions to disclosure on the well-being of survivors. Researchers discovered that negative social reactions (e.g., victim-blaming) is associated with post-trauma psychopathology (e.g., PTSD). Assistance and emotional support are the most common reasons for disclosure (Ahrens et al., 2007). Furthermore, some survivors may disclose with no expectations in mind, they choose to disclose based on the belief that the person(s) they disclose cares about their well-being; however, detrimental consequences can be presented when the survivor is faced with negative reactions (Dworkin et al., 2019). In some cases, survivors may expect negative social reactions due to experiencing PTSD (Dworkin et al., 2019). Receiving negative social reactions when expected may reinforce a negative worldview and increase the severity of psychological distress (Dworkin et al., 2019). The likelihood of disclosure may be

greatly impacted by the survivor's expectations and the prior reactions they may have received from their social networks. Based on the literature previously discussed, the quality of social reactions, whether it be victim-blaming or receiving access to resources, may impact decisions to disclose.

## Social Reactions to Disclosure

Sexual assault survivors experience a mixture of positive social reactions or negative social reactions following disclosing their assault to a confidant (Ullman, 2000; Ullman & Peter-Hagene, 2014; Starzynski et al., 2005). According to Ullman (2000) negative social reactions to disclosure include victim-blaming, changes in behavior towards the survivors, attempting to control the survivor's behavior (e.g., pressure the survivor to file report), or asserting one's beliefs and feelings onto the survivors. Additionally, positive social reactions include emotional support and providing guidance and resources to the survivors (Ullman, 2000; Ullman & Peter-Hagene, 2014). Both types of disclosure have significant effects on the well-being of the survivor.

### Positive Social Reactions

Survivors might be motivated to disclose to improve their emotional well-being, fulfill perceived social obligations (e.g., encouraged to tell), seek helpful information, or seek action in the form of advocacy, accommodations, or pursue criminal prosecution (Demers et al., 2017). Furthermore, survivors who experienced positive social reactions reported perceiving tangible aid and/or informational support and emotional support (DeCou et. al, 2017). Survivor's

perceptions of who was at fault varies depending on the type of social reaction following disclosure. For instance, survivors who were given positive feedback believed that sexual assault occurs due to the perpetrator and society (Orchowski & Gidcyz, 2015). Survivors had less tendencies to blame themselves or experience shame as a result of the assault. Positive social reactions to disclosure were associated with more adaptive social and individual coping (Ullman & Peter-Hagene, 2014). Moreover, survivors showed that receiving emotional support correlated with an increase in coping behaviors and seeking help (Orchowski et al., 2013). Survivors who received positive feedback were more likely to seek professional help, as well as report the assault, than survivors who received negative feedback. Receiving positive social reactions after disclosure may promote improved psychological outcomes and increase survivors' likelihood of reaching out to advocacy agencies, law enforcement, and prosecution.

Negative Social Reactions

Negative social reactions include experiencing victim-blaming reactions, being treated differently, experiencing others' attempts to take control of the situation, and others' egocentric reactions (Ullman, 2000; DeCou et al., 2017). As a consequence of these reactions, survivors may develop maladaptive coping, interpersonal sensitivity (e.g., feelings of inadequacy), hostility, phobic anxiety, and paranoia (Ullman & Peter-Hagene, 2014; Orchowski & Gidycz, 2015). In addition, survivors who experienced negative feedback report an increased likelihood of experiencing shame; a predictor of PTSD symptoms (Orchowski &

Gidycz, 2015). Negative social reactions associated blame with the perpetrator, survivor's behavior, the survivors' character, society, and chance. Negative reactions from a trusted friend such as, "you should have known better" can potentially lead the survivor to blaming themselves for the event (Orchowski & Gidycz, 2015). Social reactions that tried to control decision making were associated with higher posttraumatic stress, depression, and anxiety. Blaming social reactions were associated with low levels of self-esteem and low engagement in coping (Orchowski, Untied, & Gidycz, 2013).

A separate study conducted by Ullman and Peter-Hagene (2014) investigated whether maladaptive coping, perceived control, and social and individual adaptive coping strategies mediated the relationship between social reactions and PTSD. Researchers discovered that negative social reactions were associated with posttraumatic stress disorder (PTSD), maladaptive coping, and loss of perceived control (Ullman & Peter-Hagene, 2014). Additionally, survivors may not disclose due to fear of retaliation, being financially dependent on their assailant, not wanting a family member or friend to be prosecuted, lack resources, or experiencing cultural barriers (Sable et al., 2006). Negative reactions can be detrimental to the wellbeing of survivors due to most survivors disclosing sensitive information for support or guidance (Dworkin et al., 2019). Unlike positive social reactions, negative social reactions have been associated with worse psychological outcomes and reduced rates of disclosure.

## Seeking Mental Health Services

Many survivors of sexual assault may fear seeking professional health because disclosing to a source becomes a “second rape” (Campbell, 2008). According to Campbell (2008), many survivors do not have access to mental health services, many cases of rape are not prosecuted, and many survivors that go to the emergency room do not receive comprehensive medical care. Sexual assault has numerous negative consequences, such as posttraumatic stress disorder (PTSD), depression, substance abuse, suicidality, repeated sexual victimization, and chronic physical health problems (Kilpatrick & Acierno, 2003). According to Campbell and colleagues (2001), approximately 16 % to 60 % of sexual assault survivors seek mental health services, 26 % to 40 % of survivors report their assault to the police and seek prosecution, and 27 % to 40 % of survivors seek medical care and forensic examinations. Discrepancies in reporting to formal sources is alarming considering the negative psychological outcomes associated with sexual assault. The goal of the current study was to expand knowledge on what hinders disclosure to mental health professionals, in hopes that the findings obtained lead to policy change and advocacy for sexual assault survivors.

Kirkner et al. (2017) aimed to investigate the co-occurrence of PTSD and problem drinking within help-seeking sexual assault survivors. Over a course of 3 years, 1,863 women who had experienced unwanted sexual advances and disclosed about it participated in the study. Researchers utilized Generalized Estimating Equations (GEE) to estimate the effects of PTSD and problematic

drinking behavior. Researchers discovered that more educated individuals experienced more severe PTSD symptoms. Furthermore, positively perceived reaction from others after disclosure increased survivors' chances of seeking mental health treatment. As indicated by Orchowski et al. (2013), individuals who experience positive social reactions following disclosure exhibit higher rates of seeking help from professional sources. Furthermore, survivors exhibiting PTSD symptoms and problematic drinking are less likely to seek treatment for substance use.

Holland (2019) examined college students' trust in resources such as Title IX and sexual assault center (SACS). Undergraduate women (*N* = 840) were surveyed to assess their trust in Title IX and SAC, experience of college sexual assault, and rape myth acceptance (RMA). Researchers discovered that survivors who were high on RMA and who had experienced sexual assault had lower intentions of seeking help and reporting.  For instance, those who accept rape myths (e.g., victim behavior is to blame) may fear that they are to blame or that they are unworthy of seeking resources. Therefore, they do not seek resources. Other reasons why students may not report their experience to authorities is due to not perceiving the incident as harmful or important, not serious to report, unclear if an assault took place (i.e., alcohol involvement), not wanting loved one to know about the incident, fear of hostility from the assailant or police, or anticipating that officials would not take them seriously (Cantor et al., 2015). Unfortunately, perpetrators are frequently acquitted for sexual assault. For instance, in 2018 a Yale University student was found not guilty on accounts of

sexual assault (Wang & Weinstock, 2018). This case was one of very few college sexual assault cases that reached a federal jury. In the trial, the defendant's lawyers rigorously discredited the assault survivor. Publicized cases like these, that place blame and discredit the survivor, send a strong message that discourages survivors from disclosing or reporting their assault to officials for fear of not being taken seriously and being revictimized while on trial. The goal of the present study was to expand the literature surrounding the knowledge of what hinders disclosure, particularly disclosure to formal resources. Sexual assault is a prevalent safety concern worldwide. Sadly, many voices go unheard out of fear of being discredited, unbelieved, or retaliated against. Survivors of sexual assault should not be stigmatized or be in constant fear of how others will perceive them, instead their rights and voices must be protected and preserved through advocates and policies.

## Expectations of Disclosure, Shame, and Seeking Mental Health Services

As previously explored, survivors of sexual assault face various potential deterrents to disclosing to mental health sources. Other potential deterrents are shame and expectations of disclosure (DeLong & Kahn, 2014; MacDonald, 1998). Trauma-related shame refers to negative evaluations of self, feelings of worthlessness and powerlessness, self-scrutiny, self-condemnation, and the behavior tendency to hide and withdraw from others (Kubany & Watson, 2003; Øktedalen et al., 2014). Furthermore, shame involves withholding information due to fear of others' reactions (Dohary & Clearwater, 2012). Shame is a

prevalent emotion among sexual assault survivors (Øktedalen et al., 2014). Shame can result in negative mental health; for instance, previous research has discovered that shame can reinforce traumatic memories thus maintaining PTSD symptoms (Ehlers & Clark, 2000). Furthermore, individuals withhold perceived shameful information from individuals with ongoing close relationships (e.g., family, friends; Tangney et al., 2007). In therapy sessions, approximately 41% of clients withhold information (Hook & Andrews, 2005).

DeLong and Kahn (2014) surveyed 312 U.S. college students about their shame proneness, outcome expectations about disclosure, and disclosure tendencies. Investigators discovered that shame leads to nondisclosure due to perceived risks of disclosure (e.g., nonsupport from counselor). Individuals who are shame-prone perceive negative outcomes (e.g., victim-blame) as detrimental, thus deterring them from seeking resources and hiding symptoms and experiences (DeLong & Kahn, 2014; Hook and Andrews, 2005). Additionally, shame impacts expectations of disclosure and an individual's tendency to disclose distressing information (DeLong & Kahn, 2014). The present study plans to further elaborate the relationship of shame and seeking mental health services. Based on the findings reported by DeLong and Kahn (2014), we predict that expectations of disclosure (positive vs. negative) will mediate the relationship between shame and seeking mental health resources (e.g., therapist).

## Present Study

As discussed, sexual assault is a prevalent concern among the college population. Approximately 20.8% of undergraduate women will experience sexual assault (Cantor et al., 2015). There are numerous negative consequences associated with sexual assault, including PTSD, depression, shame, substance abuse, and suicide (Black et al., 2011). Forty-one percent of survivors disclose a mixture of formal sources (e.g., mental health services) and informal sources (Sabina & Ho, 2014; Demers et al., 2017). Furthermore, the type of social disclosure that survivors receive has a strong influence on their well-being. For instance, positive social reactions (e.g., receiving emotional support and guidance) results in improved emotional well-being and encouragement to seek mental health services (Demers et al., 2017). On the other hand, negative social reactions (e.g., victim-blaming) results in an increased risk for psychological distress (e.g., shame; Ullman & Peter-Hagene, 2014). Additionally, expectations of disclosure impacts seeking mental health services; individuals who experience shame tend to withhold information (Tangney et al., 2007). Therefore, survivors do not seek mental health services. Research on expectations of disclosure is limited; however, expectations of positive or negative social reactions influences the judgements and choices survivors make regarding help seeking behaviors. Therefore, the present study embarks in expanding the literature on expectations of social reactions in regard to shame and utilizing mental health professionals.

The present study investigates expectations of disclosure following sexual assault. Disclosure of sexual assault in the college population is worthy of

investigation because of its growing prevalence on University campuses. It is important to educate college populations about sexual assault and understand survivors' expectations of disclosure.

The present study has the following hypotheses:

H1: Shame will be negatively associated with utilizing mental health resources.

H2: Positive expectations of disclosure will be negatively associated with shame and positively associated with utilizing health services.

H3: Negative expectations of disclosure will be positively associated with shame and negatively associated with utilizing mental health services.

H4: The relationship between shame and utilizing mental health resources will be mediated by expectations of social reactions (negative vs. positive).

# CHAPTER TWO:

# METHOD

## Participants

Individuals with prior exposure to sexual assault were invited to participate in the present study. University students were recruited through SONA, a web-based participant management system. The survey took approximately 30 minutes to complete. Extra credit opportunities were provided to university students following the conclusion of the survey. Sixteen participants did not complete over half of the survey; therefore, their responses were disregarded.

After imputing the data, the total sample size was 86 participants. Seventy-three percent of participants had been sexually assaulted (e.g., rape) ($n$ = 64) and 96.5% of participants had experienced some form of another unwanted sexual experience (e.g., unwanted sexual touching) ($n$ = 83). Additionally, 46.5% of participants had been assaulted within the last 5 years ($n$ = 40). Approximately 96.5% of participants were female ($n$ = 83) and 3.5% of participants were male ($n$ = 3). The average age of participants was 25 ($SD$ = 7.58; Range = 19-50). Approximately 83.7% of participants classified themselves as Hispanic ($n$ = 72). The following are percentages of race: 3.5% of participants were Asian American ($n$ = 3), 4.7% of participants were American Indian or Alaskan Native ($n$ = 4), 39.5% of participants were Caucasian ($n$ = 34), 39.5% of participants classified as Other ($n$ = 34), and 12.8% of participants did not identify their ethnicity ($n$ = 11). When asked about their marital status, 39.5% reported themselves as single

(*n* = 34), 41.9% reported that they were in a committed relationship (*n* = 36), 7% reported that they were living with a significant other (*n* =6), 10.5% reported that they were married (*n* = 9), and 1.2% of participants reported that they were divorced or widowed (*n* = 1). Further demographics information can be found in Table 1.

## Measures

### Demographics Measure

A demographics questionnaire was created to identify participant's sex, age, ethnicity, relationship status, and education level.

### Life Events Checklist

The Life Events Checklist (LEC-5; Weather et al., 2013) is a self-report screening measure concerning traumatic events that may occur in one's lifetime. The questionnaire prompted participants to determine whether a list of 16 events occurred to them at some point during their lifetime (*Happened to me* or *Did not happen to me*). Sample statements include natural disasters, sexual assault, sudden accidental death, etc. The LEC-5 was crucial for the current study to help screen eligible participants. In order to participate, individuals had to have experienced a sexual assault, other unwanted sexual experience, or both. Participants also had to indicate that sexual assault or unwanted sexual experience was the worst event they had experienced in their lifetime and indicate whether the sexual assault or other unwanted sexual experience occurred within the last five years.

Posttraumatic Stress Disorder

Participants completed the 20-item self-report Posttraumatic Stress Disorder Checklist (PCL-5; Weathers et al., 2013), a measure that corresponds to the DSM-5 symptom criteria for PTSD. The questionnaire utilized a 5-point Likert scale (*"Not at all"; "A little bit"; "Moderately; "Quite a bit"; and "Extremely"*). The PCL-5 includes items concerning PTSD symptomatology such as, "*Over the past month, have you experienced repeated, disturbing, and unwanted memories of the stressful experience*?" The Cronbach's alpha in our sample was 0.95.

Depression

Participants will be asked to complete the 10-item Center for Epidemiologic Studies Depression Scale (CES-D-10; Eaten et al., 2004). The questionnaire uses a 4-point Likert Scale (1 = *rarely or none of the time (less than one day)*; 2 = *some or a little of the time (1-2 days)*; 3= *occasionally or a moderate amount of time (3-4 days)*; 4 = *Most or all of the time (5-7 days)*) to examine participants' experiences with sadness, loss of interest, appetite, sleep, guilt, tiredness, and movement. Example statements include: *"I felt depressed"; "I felt that everything I did was an effort";* and *"I felt lonely."* The Cronbach's alpha in our sample was 0.78.

Trauma-Related Shame

The Trauma-Related Shame Inventory (TRSI) measures participants' experiences of trauma-related shame. The questionnaire uses a 4-point Likert Scale (0 = *not true of me,* 3 =*completely true of me;* Øktedalen et al., 2014). Items include internal dimensions of trauma (e.g., "*I am ashamed of the way I felt*

*during my traumatic experience"*) and external dimensions of trauma (e.g., "*If others knew what happened to me, they would look down on me*"). The Cronbach's alpha for this measure in our sample was 0.97.

Expectations of Disclosure

Expectations of disclosure were assessed with the Expectations of Disclosure Questionnaire (DEQ; Clapp et al., submitted for publication). The DEQ will be used to assess the expectations of participants for disclosing their traumatic experiences. This instrument is a 32-item scale that assesses the extent to which trauma victims talk about or disclose memories of traumatic experiences and their attitudes about talking to others about their difficulties. A pilot study with active-duty Marines indicated that this questionnaire has very strong internal consistency reliability. The results for the pre-intervention and the post-intervention both indicated that DE had good internal consistency in both the Negative Section (α = .94) and the Positive Section (α = .94). The positive subscale included questions such as *"I will be better understood*"; whereas the negative subscale included items such as "*Others will think I am weak*." It also predicted improvement over the course of treatment (Clapp et al., submitted for publication).

Disclosure to Mental Health Professionals

A disclosure questionnaire was created for the purpose of this study and measured the degree to which an individual has discussed the details of their traumatic event with their family, friends, partner/spouse, mental health professionals, physicians, members of the clergy, police, and sexual assault rape

crisis center support staff. and the extent to which respondents found their disclosure helpful. Then, participants were asked to rate for each support source the extent to which they found the disclosure experience helpful. Participants rated the extent of disclosure on a 7-point Likert scale (1 = *Not at* all; 7 = *A great deal*). The disclosure questionnaire served the purpose of the measurement of the extent to which individuals disclosed their sexual assault to mental health professionals. The item "*To what extent have you discussed the details relating to your MOST stressful life event to a mental health professional*" was used for the outcome variable. Cronbach's alpha for this measure in our sample was 0.86.

## Procedure

All participants completed an informed consent procedure prior to beginning the surveys. The present study was completed in two phases. In phase one, participants were pre-screened for the history of sexual victimization using the Life Events Checklist. Eligible participants who reported exposure to a sexual assault or other unwanted uncomfortable sexual experience were invited to participate in the present study.  Study measures were administered online via Qualtrics. The Life Events Checklist was presented first to confirm pre-screening, followed by the Posttraumatic Stress Disorder Checklist. Then, the order of the Center of Epidemiologic Studies Depression Scale, the Trauma-Related Shame Inventory (TRSI), the Disclosure Questionnaire, and the Disclosure Expectations Questionnaire (DEQ) was randomized. Following the completion of the surveys, participants received post study information.

## Data Analytic Plan

Shame served as the independent variable and seeking mental health services served as the dependent variables. Specifically, the item "*To what extent have you discussed the details relating to your MOST stressful life event to a mental health professional*" served as the dependent variable. Expectations of disclosure (positive vs. negative) served as the mediator variable. Preacher and Hayes bootstrapping will be utilized to test mediation. A conceptual model is demonstrated below. The present study is a between-person design.

# CHAPTER THREE:

# RESULTS

## Data Screening

Assumption of normality. In order to meet the assumption of normality, *z*-scores must be less than negative/positive 3.3 and have a *p*-value of greater than 0.001. The majority of the variables met the criteria for normality, with the exception of trauma-related shame which was positively skewed ($z = 4.36$, $p < 0.001$) and exhibited normal kurtosis ($z = 0.95$, $p > 0.001$). Refer to Table 1 for further skewness and kurtosis scores. Additionally, data was screened for outliers. All *z* -scores were under the recommended negative/positive 3.3, therefore classifying the data is normally distributed.

Individuals who did not complete over half of the survey were removed from analyses ($n = 16$). Missing data was imputed using the Expectation Maximum (EM) algorithm. There were 11 missing values on race/ethnicity. An explanation for the missing data on race is that participants who were Hispanic did not complete this measure due to a previous question asking if they were Hispanic or non-Hispanic. Estimated means were utilized to supplement the missing values. The missing data is best described as MAR, due to it being linked to a specific item associated with the survey.

## Correlations

Significant associations were found between variables of interest in the present study. Refer to Table 2 for more information on correlations among the variables.

## Mediation Model

A mediation model was analyzed to determine whether expectations of social reactions mediated the relationship between trauma-related shame and the extent of disclosure to mental health professionals (positive vs. negative).

Approximately 1.19% of the variance of positive expectations of social reactions can be explained by trauma-related shame. Furthermore, 21.63% of the variance of extent of disclosure to mental health professionals can be explained by trauma-related shame and positive expectations of social reactions. We discovered small effects. There was no significant direct effect of trauma-related shame on positive expectations of social reactions; $b = -0.082$, $t\,(84) = -1.006$, $p = 0.318$, *95% CI* [-0.2441, 0.0801]. Furthermore, there was a significant direct effect of positive expectations of social reactions on the extent of disclosure; $b = 0.082$, $t\,(83) = 4.528$, $p < 0.001$, *95% CI* [0.0461, 0.1182]. Expectations of positive social reactions were positively associated with disclosing to a mental health professional. Finally, there was a significant direct effect of trauma-related shame on the extent of disclosure; $b = 0.028$, $t\,(83) = 2.037$, $p < 0.05$, *95% CI* [-0.0007, 0.0549]. Higher shame was positively associated with disclosure to a mental health professional. There was no

significant indirect effect; in other words, positive expectations of social reactions did not mediate the relationship between trauma-related shame and the extent of disclosure; $b = -0.007$, $p > 0.05$, *95% CI* [-0.0214, 0.0095].

Trauma-related shame explained 57.2% of the variance for negative expectations of social reactions. Additionally, trauma-related shame and negative expectations of social reactions explained 4.39% of the variance for extent of disclosure to mental health professionals. We discovered small effects. There was a significant direct effect of trauma-related shame on negative expectations of social reactions; $b = 0.718$, $t(84) = 10.595$, $p < 0.001$, *95% CI* [0.5834, 0.8529]. Higher shame was positively associated with negative expectations of social reactions. Furthermore, there was no significant direct effect of negative expectations of social reactions on the extent of disclosure; $b = -0.033$, $t(83) = -1.355$, $p = 0.179$, *95% CI* [-0.0806, 0.0153]. There direct effect of trauma-related shame on the extent of disclosure was marginally significant; $b = 0.045$, $t(83) = 1.945$, $p = 0.0552$, *95% CI* [-0.0010, 0.0900]. Finally, there was no significant indirect effect; negative expectations of social reactions did not mediate the relationship between trauma-related shame and the extent of disclosure to mental health professionals; $b = -0.024$, $p > 0.05$, *95% CI* [-0.0560, 0.0096]. Refer to Figure 1 for visual representation.

# CHAPTER FOUR:

# DISCUSSION

Research investigating expectations of social reactions to disclosure is still in its infancy. This study utilized a new questionnaire evaluating positive and negative expectations of social reactions of disclosure. The goal of the current study was to expand knowledge on the role of expectations of social reactions to disclosure. Various discoveries were made based on our results. Firstly, the present study discovered that shame predicted negative expectations of social reactions to disclosure; however, shame did not predict positive expectations of social reactions to disclosure. Secondly, it was discovered that positive expectations of social reactions to disclosure predicted the extent of disclosure to mental health professionals; however, negative expectations of social reactions to disclosure did not predict the extent of disclosure to mental health professionals. Thirdly, shame did predict the extent of disclosure to mental health professionals. Finally, the present study found that expectations of social reactions to disclosure (positive vs. negative) did not mediate the relationship between trauma-related shame and the extent of disclosure to mental health professionals.

Our first hypothesis predicted that shame would be negatively associated with seeking mental health resources. Shame did predict the extent of disclosure to mental health professionals. Interestingly, it was the opposite direction in which there was a positive association between shame and extent of disclosure to mental health professionals. A possible explanation is that individuals may be

reaching out to mental health professionals for comorbid symptoms, such as depression and anxiety. As reported by Kilpatrick and Acierno (2003), symptomatology such as PTSD, depression, and suicidality are commonly experienced following a sexual assault. Furthermore, disclosing a traumatic experience such as a sexual assault can potentially alleviate psychological symptomology (Pennebaker & Beall, 1986). Our sample had mild to moderate PTSD symptomology ($M = 40.88$), as well as mild to moderate depression symptomatology ($M = 24.49$). Due to survivors experiencing multiple negative symptoms as a result of an assault, it is possible that they may choose to disclose to a mental health provider to help alleviate any psychological distress they are experiencing.

Our second hypothesis predicted that shame would be negatively associated with positive expectations and positively associated with negative expectations. Our hypothesis was supported for negative expectations of social reactions to disclosure; however, it was not supported for positive expectations of social reactions to disclosure. The present study found that shame predicted negative expectations of social reactions to disclosure, however not positive expectations of social reactions to disclosure. These results are similar to the results obtained from previous studies. Survivors who experienced shame as a result of sexual assault may experience negative expectations of disclosure due to feeling of self-scrutiny and perceived self-blame. For instance, self-scrutiny can lead to withholding traumatic experiences due to the fear of not being believed or being blamed for the assault (Dohary & Clearwater, 2012). Positive

social reactions are associated with receiving resources and emotional support (DeCou et al., 2019; DeCou et al., 2017). Shame may not predict positive expectations due to survivors' belief that they will receive helpful and tangible support, or due to placing blame on society or the perpetrator rather than themselves (DeCou et al., 2017; Orchowski & Gidcyz, 2015). Due to research on expectations of social reactions being limited, more research is necessary to uncover the mechanisms surrounding shame and expectations of social reactions.

Our third hypothesis predicted that the extent of disclosure would be positively predicted by positive expectations and negatively predicted by negative expectations. Our hypothesis was supported in regard to positive expectations of social reactions to disclosure; but was not supported for negative expectations of social reactions to disclosure. Results suggest that positive expectations predicted disclosure to mental health professionals, but negative expectations did not. This could be due to personality (e.g., optimism, extraversion). In a study conducted by Amirkhan et al. (1995), extraversion was associated with seeking social support, optimism, and problem solving. Furthermore, extraversion was negatively associated with avoidant behavior. Extraverted individuals are more inclined to seek help due to being optimistic about disclosure outcomes. Extraversion has also been associated with increased resilience following trauma (Agaibi & Wilson, 2005). With this knowledge, positive expectations and disclosure to mental health professionals may be mediated by extraversion. On the other hand, individuals who are more introverted by nature are more likely to

withhold information and expect negative outcomes (Agaibi & Wilson, 2005). Further research is necessary to extend the literature on the role of personality type. An additional explanation for positive expectations predicting disclosure is that individuals who believe that they will not be blamed for the attack and believe that will receive emotional support will seek help from mental health professionals (DeCou et al., 2017; Orchowski & Gidcyz, 2015). If survivors perceive the likelihood of a positive outcome, they are more likely to seek help, versus if they believe they will be blamed.

Our final hypothesis predicted that expectations of disclosure (positive vs. negative) would indirectly affect the relationship between shame and the extent of disclosure to mental health professionals; our hypothesis was not supported. Neither positive or negative expectations mediated the relationship between trauma-related shame and disclosure to mental health professionals. According to Bryant-Davis et al. (2009), ethnic minority women are at an increased risk of sexual assault as well as experiencing higher rates of depression, PTSD, and additional negative outcomes. Majority of our participants were Latina. Additionally, being an ethnic minority may hinder disclosing to mental health professionals due to distrust and cultural expectations. Specifically, for Latin American women, cultural barriers and societal stereotypes potentially hinders seeking help. Feagin and Feagin (1996) reported that societal stereotypes, specifically the perspective of Latinas being hypersexual and promiscuous, potentially leads Latinas to fear disclosing their assault to others. Furthermore, previous research suggests that compared to non-Latinas, Latinas have higher

instances of PTSD symptomology (Bryant-Davis et al., 2009). Lack of diversity in our sample may have contributed to the non-significant indirect effects.

Our findings are consistent with cognitive theories of PTSD, which emphasize the role of negative thoughts about the self, world, and others in the maintenance and development of trauma-related disorders, such as PTSD and depression (Brewin & Holmes, 2003).Individuals who have a negative worldview (e.g., the world is a dangerous place) are more prone to PTSD following a traumatic event. Confirmation that the world is dangerous creates shame among survivors due to placing blame on themselves. Our findings suggest that trauma-related shame predicts negative expectations of social reactions. In exchange of negative expectations of social reactions, individuals choose to not disclose to mental health professionals.

## Limitations and Future Directions

No study is without limitation. Firstly, there was no control over the amount of time passed since the assault took place. The majority of participants' assault took place over 5 years ago. Individuals may have already sought professional help between the time the assault took place to their participation in our study. Future research should consider controlling for time passed since the assault in order to prevent confounding variables impacting the results. Furthermore, previous studies suggest differences in disclosure and psychological effects for members of the LGBTQ community. Research suggests that bisexual women are at an increased risk of being sexually assaulted (Balsam et al., 2005). Future

research should consider investigating how sexuality influences expectations of social reactions.

Currently, research on ethnic minorities is limited; however, it is known that ethnic minority women are  at an increased risk of sexual assault (Bryant-Davis et al., 2009). To further complicate the issue, distrust for officials hinders disclosure and participation in research concerning sexual assault. Although our sample was not diverse, our findings have implications for the Latinx population. It is imperative for trauma researcher to understand the underlying mechanisms of culture on perceptions of sexual assault and psychological outcomes associated with various ethnic minorities (Bryant-Davis et al., 2009). Future studies should consider investigating differences in expectations of disclosure among ethnic backgrounds, including perspectives of African American, Asian American, Middle Eastern, and Native American women.

As previously mentioned, research on expectations of social reactions to disclosure is in its infancy. The present study was largely exploratory. Due to negative psychological consequences that survivors may face, it is imperative to diminish the stigma surrounding utilizing professional help. Survivors of sexual assault must have the opportunities to resources that will promote resilience and positive psychological adjustment. Along with sexual assault survivors, other trauma populations (e.g., Military, Intimate Partner Violence) can benefit from the findings suggested. The present study urges fellow researchers to continue research in this new domain of sexual assault investigation.

# APPENDIX A

# TABLES AND FIGURES

**Table 1**
*Demographic and other characteristics of the sample (N=86)*

| Variable | M(SD) | *n*(%) | Range | Sk. | Kurt. |
|---|---|---|---|---|---|
| *Gender* | | | | | |
| Male | | 3(3.5) | | | |
| Female | | 83(96.5) | | | |
| *Age* | 25.8(7.6) | 89 | 19-50 | | |
| *Income* | | | | | |
| $0 - $14,999 | | 51(59.3) | | | |
| $15,000 - $29,999 | | 21(24.4) | | | |
| $30,000 - $44,999 | | 9(10.5) | | | |
| $45,000 - $59,999 | | 4(4.7) | | | |
| $60,000 - $74,999 | | 1(1.2) | | | |
| *Marital status* | | | | | |
| Single | | 34(39.5) | | | |
| In a committed relationship | | 36(41.9) | | | |
| Living with significant other | | 6(7) | | | |
| Married | | 9(10.5) | | | |
| Divorced, Separated, or Widowed | | 1(1.2) | | | |
| *Ethnic background* | | | | | |
| Hispanic or Latino | | 72(83.7) | | | |
| Not Hispanic or Latino | | 13(15.1) | | | |
| Unknown | | 1(1.2) | | | |
| *Racial background* | | | | | |
| Asian American | | 3(3.5) | | | |
| American Indian or Alaskan Native | | 4(4.7) | | | |
| Caucasian | | 34(39.5) | | | |
| Other | | 34(39.5) | | | |
| *Education level* | | | | | |
| Sophomore | | 2(2.3) | | | |
| Junior | | 42(48.8) | | | |
| Senior | | 41(47.7) | | | |
| *PCL* | 40.9(20.4) | | 0-80 | -1.3 | -1.1 |
| *CESD* | 24.5(7.3) | | 10-39 | -0.6 | -1.5 |
| *SHAME* | 41.3(18.3) | | 24-95 | 4.7 | 0.9 |
| *EXP. NEG. REACTIONS.* | 42.9(17.3) | | 18-79 | 1.6 | -1.6 |
| *EXP. POS. REACTIONS* | 43.3(13.7) | | 14-70 | 0.2 | -1.3 |
| *DISCLOSURE- MENTAL HEALTH* | 3.4(2.6) | | 1-7 | 1.5 | -3.1 |

**Table 2**

*Pearson correlations between posttraumatic stress, depression, expectations of social reaction (negative vs. positive), and disclosure to mental health professionals (n = 86).*

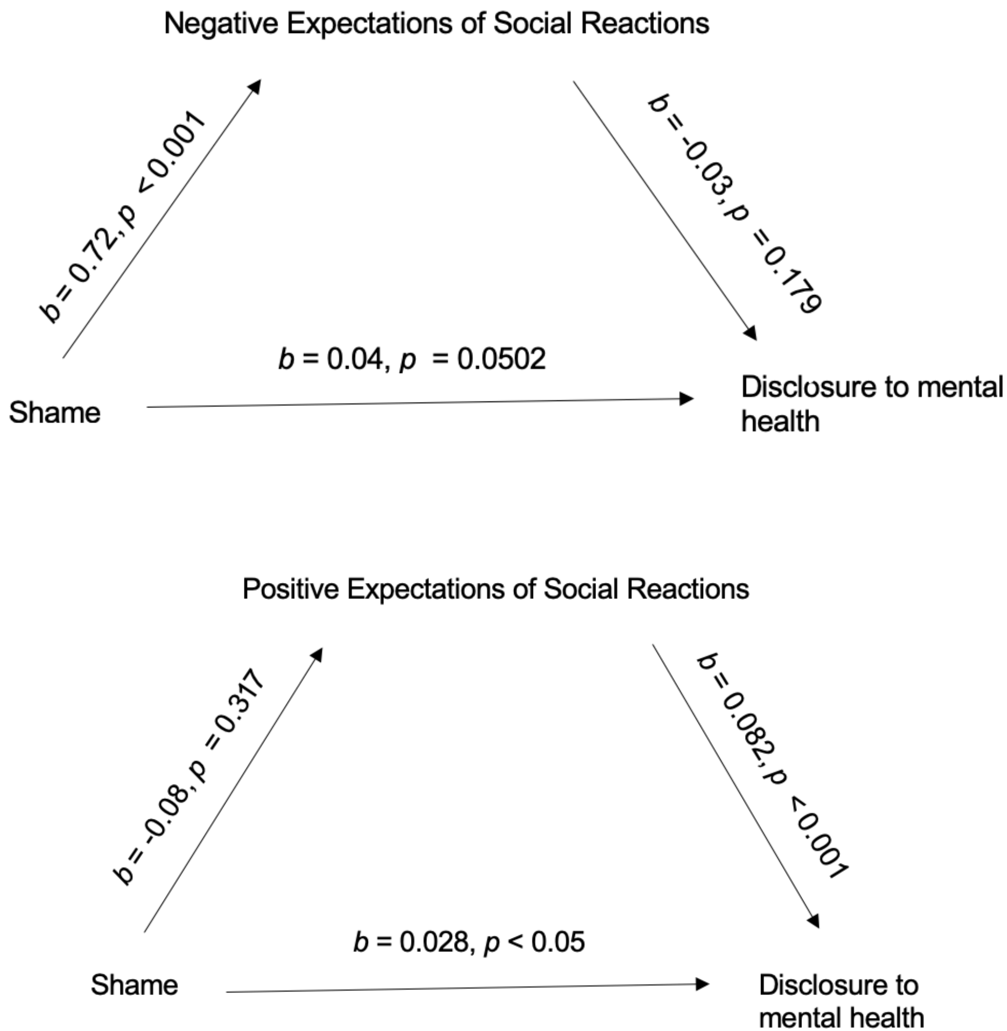
| | PCL | CESD | SHAME | NEG EXPECTS | POS. EXPECTS | DISCLOSURE |
|---|---|---|---|---|---|---|
| PCL | | | | | | |
| *r* | 1.00 | | | | | |
| Sig. (2-tailed) | . | | | | | |
| CESD | | | | | | |
| *r* | .477** | 1.00 | | | | |
| Sig. (2-tailed) | < 0.001 | . | | | | |
| SHAME | | | | | | |
| *r* | .429** | .341** | 1.00 | | | |
| Sig. (2-tailed) | < 0.001 | .001 | . | | | |
| EXPECTATIONS. NEGATIVE SOCIAL REACTIONS | | | | | | |
| *r* | .518** | .410** | .756** | 1.00 | | |
| Sig. (2-tailed) | < 0.001 | < 0.001 | < 0.001 | . | | |
| $EXPECTATIONS. POSITIVE SOCIAL REACTIONS | | | | | | |
| *r* | .133 | -.123 | -.109 | -.105 | 1.00 | |
| Sig. (2-tailed) | .222 | .260 | .317 | .336 | . | |
| DISCLOSURE – MENTAL HEALTH | | | | | | |
| *r* | .169 | .095 | .151 | .019 | .421** | 1.00 |
| Sig. (2-tailed) | .120 | .383 | .166 | .863 | < 0.001 | . |

* *p* <.05,**p*<.001

*Note.* Correlations between various variables.

**Figure 1**

*Mediation Models – Positive vs. Negative Expectations of Social Reactions*




*Note.* The present study discovered that shame predicted negative expectations, but not positive expectations. Furthermore, disclosure to mental health professionals was predicted by positive expectations of social reactions to disclosure, but not negative expectations of social reactions to disclosure. In both models, shame predicted disclosure to mental health professionals. No indirect effects were found for either models.

# APPENDIX B

# IRB APPROVAL LETTER

August 30, 2020

CSUSB INSTITUTIONAL REVIEW BOARD
Administrative/Exempt Review Determination
Status: Determined Exempt
IRB-FY2021-20

Christina Hassija
CSBS - Psychology
California State University, San Bernardino
5500 University Parkway
San Bernardino, California 92407

Dear Christina Hassija :

Your application to use human subjects, titled "Investigating the Role of Shame in the Relationship Between Expectations of Disclosure and Seeking Mental Health Services" has been reviewed and approved by the Chair of the Institutional Review Board (IRB) of California State University, San Bernardino has determined that your application meets the requirements for exemption from IRB review Federal requirements under 45 CFR 46. As the researcher under the exempt category you do not have to follow the requirements under 45 CFR 46 which requires annual renewal and documentation of written informed consent which are not required for the exempt category. However, exempt status still requires you to attain consent from participants before conducting your research as needed. Please ensure your CITI Human Subjects Training is kept up-to-date and current throughout the study.

Your IRB proposal is approved. You are permitted to collect information from **[84]** participants for **[1.5 SONA units]** from **[CSUSB/SONA]**. This approval is valid from **[8/31/2020]**.

The CSUSB IRB has not evaluated your proposal for scientific merit, except to weigh the risk to the human participants and the aspects of the proposal related to potential risk and benefit. This approval notice does not replace any departmental or additional approvals which may be required.

Your responsibilities as the researcher/investigator include reporting to the IRB Committee the following three requirements highlighted below. Please note failure of the investigator to notify the IRB of the below requirements may result in disciplinary action.

- Submit a protocol modification (change) form if any changes (no matter how minor) are proposed in your study for review and approval by the IRB before implemented in your study to ensure the risk level to participants has not increased,
- If any unanticipated/adverse events are experienced by subjects during your research, and
- Submit a study closure through the Cayuse IRB submission system when your study has ended.

The protocol modification, adverse/unanticipated event, and closure forms are located in the Cayuse IRB System. If you have any questions regarding the IRB decision, please contact Michael Gillespie, the Research Compliance Officer. Mr. Michael Gillespie can be reached by phone at (909) 537-7588, by fax at (909) 537-7028, or by email at mgillesp@csusb.edu. Please include your application approval identification number (listed at the top) in all correspondence.

If you have any questions regarding the IRB decision, please contact Dr. Jacob Jones, Assistant Professor of Psychology. Dr. Jones can be reached by email at Jacob.Jones@csusb.edu. Please include your application approval identification number (listed at the top) in all correspondence.

Best of luck with your research.

Sincerely,

Nicole Dabbs

Nicole Dabbs, Ph.D., IRB Chair
CSUSB Institutional Review Board

ND/MG

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