

Women's Experiences of Male-Perpetrated Sexual Assault by Sexual Orientation

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This study examined differences in male-perpetrated adult sexual assault experiences among women of various sexual orientations using a large urban convenience sample ($N = 1,022$). Results showed many similarities in disclosure to others, perceived helpfulness, and attributions of blame, but there were also differences by sexual orientation. Heterosexual women were more likely to experience completed sexual assault than lesbian or bisexual women. Lesbians were more likely to be assaulted by relatives than bisexual or heterosexual women. Finally, bisexual women disclosed the assault to the greatest number of formal support sources, were most likely to tell a romantic partner about the assault, received the fewest positive social reactions overall, and had higher posttraumatic stress disorder (PTSD) symptomatology.

Keywords: violence against women; lesbian; bisexual women

National surveys cite sexual assault figures ranging from 20% to as high as 30% among women in the United States (Russell & Bolen, 2000; Tjaden & Thoennes, 2000). Given that research shows many negative consequences of sexual assault, including fear, posttraumatic stress disorder (PTSD), depression, negative social reactions, and revictimization (Basile, 2005), these figures are especially shocking. Although much research has focused on the negative effects of sexual assault on women generally, little research has examined its specific effects on nonheterosexual women (Balsam, Rothblum, & Beauchaine, 2005). The rates of adult sexual assault for sexual minority women range from 15% to 36%, similar to or slightly higher than the rates for heterosexual women (Balsam et al., 2005; Bradford, Ryan, & Rothblum, 1994; Grundlach, 1977; Hughes, Johnson, & Wilsnack, 2001; Morris & Balsam, 2003; Pitt & Dolan-Soto, 2001; Scheer et al., 2003). Possible differences in lesbian and bisexual women's sexual assault experiences and mental health outcomes postassault remain understudied (Descamps, Rothblum, Bradford, & Ryan, 2000; Hughes et al., 2001; Scheer et al., 2003). Therefore, this study examines male-perpetrated sexual assault experiences and outcomes for lesbian, bisexual, and heterosexual women.

The current study focuses on male-perpetrated assault because men perpetrate most sexual assaults against women in general (Tjaden & Thoennes, 2000). Additionally, studies examining sexual assault by sexual orientation also find that, despite higher rates of assault by women for lesbians and bisexuals than heterosexual women, men still perpetrate a majority of the sexual violence against women of all sexual orientations (Balsam et al., 2005; Bradford et al., 1994; Brand & Kidd, 1986; Moore & Waterman, 1999; Morris & Balsam, 2003). For example, the National Lesbian Health Care Survey consisted of nearly 2,000 lesbians, the majority of whom were White and earned a low income (Bradford et al., 1994). Of the respondents, 15% reported sexual abuse as an adult, with female perpetrators accounting for less than 11% of cases (Bradford et al., 1994). In a sample of predominantly White college students, all of the female survivors of sexual assault in a dating relationship were assaulted by a male dating partner, including four lesbian and two bisexual women (Moore & Waterman, 1999). Finally, a large-scale nationwide convenience sample of lesbian and bisexual women found that most adult sexual assault was perpetrated by men (Morris & Balsam, 2003).

It does appear that lesbians, bisexual, and heterosexual women experience different forms of sexual assault (Balsam et al., 2005; Scheer et al., 2003). Using a community convenience sample of nearly 1,200 lesbian, gay, bisexual, and heterosexual siblings to compare lifetime physical and sexual victimization, the authors showed that lesbian and bisexual women were significantly more likely to experience nonpenetrating sexual coercion, coerced intercourse, and completed rape than heterosexual women. Additionally, bisexual women reported higher rates of nonpenetrating sexual coercion and completed rape than lesbians (Balsam et al., 2005).

Another study used a cross-sectional population-based survey of 18- to 29-year-old low-income women to examine their health and risky sexual behavior (Scheer et al., 2003). Results revealed that lesbians and bisexual women (analyzed together as one group) experienced significantly more coerced and forced sexual intercourse than heterosexual women (Scheer et al., 2003). When compared as independent groups, lesbian and bisexual women did not differ in their rates of these sexual assault types (Scheer et al., 2003). Gender of the perpetrator was not analyzed, although women who had sex with both men and women in their lifetimes reported significantly more coerced sex than women who had sex with men only (Scheer et al., 2003). Significantly more lesbian and bisexual women than heterosexual women traded sex for money or drugs, and this may have yielded differences in rates of coerced and forced sex, which are known risks of sex work in general (Raphael, 2004).

There might be an interaction between gender of the perpetrator, sexual orientation of the survivor, and type of assault. A small community survey of primarily White, economically stable lesbians and heterosexual women found that in general, men were significantly more likely to perpetrate attempted rape against both heterosexual women and lesbians than were women (Brand & Kidd, 1986). Further, heterosexual women and lesbians were equally likely to experience male-perpetrated completed and attempted rape during a dating relationship. However, lesbians were more likely than heterosexual women to experience female-perpetrated completed rape (Brand & Kidd, 1986).

Balsam and colleagues' (2005) study, described earlier, explored these interactions further. Their analyses found that across sexual orientations, most of the adult sexual assaults reported by women in this study (i.e., nonpenetrating sexual coercion, coerced intercourse, attempted rape, rape) were perpetrated by men (Balsam et al., 2005). However, heterosexual women were the most likely of the three orientation groups to experience nonpenetrating sexual coercion and coerced intercourse by a man (98% and 90%, respectively).

Lesbians were the group most likely to have these same assault acts perpetrated by a woman (38.9% and 40.6%, respectively), although again more lesbians were perpetrated against by men than by women. Bisexual women experienced nonpenetrating sexual coercion by a man 95.5% of the time, and 19.7% of the time from women (numbers do not add to 100 because of multiple perpetrators per act) and experienced coerced intercourse perpetrated by a man 85.7% of the time and by a woman 19.0% of the time. There were no significant differences in perpetrator by sexual orientation for attempted or completed rape; most had male perpetrators (Balsam et al., 2005). Because the current study focuses on male-perpetrated sexual assaults, we expect heterosexual women to be more likely to report coerced sex than lesbians or bisexual women, and all three groups to be equally likely to report attempted or completed rape.

It is important to understand the potentially different experiences of lesbian, bisexual, and heterosexual women in disclosing assault. For instance, even if the perpetrator is a man, lesbian and bisexual women may fear revealing their sexual orientation to strangers or family who are not aware of it, or might encounter disbelief that sexual violence can happen to lesbians and bisexual women (Balsam et al., 2005, Pitt & Dolan-Soto, 2001; Turell, 1999; Wertheimer, 1990). Although the emotional impact of assault may depend on responses of the victim, reactions of support sources to assault disclosure can have a significant impact on a survivor's recovery as well (Campbell, Ahrens, Sefl, Wasco, & Barnes, 2001; Ullman, 1999). However, when a survivor reaches out for support, formal sources (e.g., medical professionals, police, religious leaders) are likely to assume he or she is heterosexual and might transmit heterosexist biases to survivors (e.g., referring to romantic partners as members of the opposite sex, asking questions about medical history and birth control use), which could increase stress and frustration for the survivor and affect her willingness to disclose (Morris & Balsam, 2003; Orzek, 1989; Pitt & Dolan-Soto, 2001; Wakelin & Long, 2003).

Some lesbian and bisexual women also perceive differential treatment based on their sexual orientation. For example, one study of lesbian, gay, and bisexual adults with mental illnesses found that they were more likely to be dissatisfied with their mental health care than heterosexual respondents (Avery, Hellman, & Sudderth, 2001). Further, in a small community convenience sample of lesbians, only one-third of the participants disclosed their sexual orientation to their health care provider (Lehmann, Lehmann, & Kelly, 1998). Of those who did disclose, 27% felt revealing their sexual orientation had a negative effect on the care they received. These examples illustrate that lesbian and bisexual women sometimes perceive unequal treatment based on their sexual orientation, which may negatively affect survivors' perceptions of support and add an additional layer to the recovery process.

There is scant research examining who lesbians and bisexual women tell about their assaults, and what social reactions they receive from others upon disclosure. Of the respondents in the National Lesbian Health Care Survey who were sexually assaulted, only 35% sought help afterwards, mostly from friends, police, or counselors (Bradford et al., 1994). These respondents were most satisfied with help received from rape crisis centers and women's health centers, and most dissatisfied with help received from clergy, medical professionals, emergency room staff, and police (Bradford et al., 1994). However, in some areas, survivors may be unable to reach out to helpful services because of their unavailability or the victims' lack of knowledge that they exist. An urban community sample of lesbian, gay, and bisexual men and women found that few respondents were aware of rape crisis center services (Sloan & Edmond, 1996), and a sample of lesbian and gay college student sexual assault survivors thought that counseling would be hard to find (Waterman, Dawson, & Bologna, 1989).

Further, when sexual minority survivors do reach out for help, they may receive more blame for the assault from people they go to for support, especially if potential support providers are heterosexual. Experimental rape vignette studies reveal that most observers perceive sexual minority male and female victims to be more blameworthy for their assaults than their heterosexual counterparts (White & Kurpius, 2002), thus reflecting homophobic views of lesbian and bisexual survivors. However, another vignette study manipulated the gender and sexual orientation of sexual assault victims of stranger rape by a male perpetrator (Wakelin & Long, 2003). These authors found that a sample of mainly heterosexual college students attributed more blame to the victim when there was a potential for attraction to the perpetrator (who in this study, was portrayed to be a heterosexual male) (Wakelin & Long, 2003). Thus, victims who could potentially be attracted to the perpetrator (gay men and heterosexual women) were rated to have the highest amount of blame for their sexual assaults, and heterosexual men and lesbian women were blamed the least for their assaults because they were assumed to have no sexual attraction to a heterosexual male (Wakelin & Long, 2003). Following the logic of these results, bisexual men and women may also be more likely to be blamed more for their assaults than lesbians and heterosexual men because of their potential attraction to (heterosexual male) perpetrators.

Further, lesbian and bisexual assault survivors might feel additional blame for the attack because of their sexual orientation. Survivors and the people they tell might feel (sometimes legitimately in the case of hate crimes) that sexual orientation played a role in the attack and therefore place misguided blame on the survivor (Garnets, Herek, & Levy, 1990; Wertheimer, 1990). Aside from the general correlates of self-blame for assault, such as depression and PTSD (Ullman & Brecklin, 2002), increased blame may possibly lead a lesbian or bisexual survivor to question her sexual orientation, depending on where she is in the identification and coming out process (Garnets et al., 1990). This additional stress and blame is another form of revictimization for the survivor.

The culmination of blame for the assault and processing the trauma may impact mental health. Left unaddressed, these feelings can have serious mental health consequences (Frazier, 2003). Of all sexual assault survivors, approximately 46% have a lifetime diagnosis of depression and 27% report symptoms of PTSD (Kilpatrick, Saunders, Veronen, Best, & Von, 1987). There is little research on the etiology of postassault symptoms or levels of self-blame of lesbians and bisexual women (Hughes, Haas, Razzano, Cassidy, & Matthews, 2000). However, in Morris and Balsam's (2003) nationwide study of lesbians, assault (both physical and sexual) significantly predicted current generalized psychological distress. Generally speaking, lesbian, gay, and bisexual adults are similarly likely to experience depression as their heterosexual counterparts (Cochran, Sullivan & Mays, 2003; Hughes et al., 2000), but it is not known if there are differences in rates of postassault depression and PTSD.

THE CURRENT STUDY

Very few previous studies of sexual assault survivors have explicitly examined whether women of different sexual orientations vary in their sexual assault experiences and in their responses to sexual assault. The present study utilizes a diverse community sample of sexual assault survivors to explore differences and similarities in characteristics of assault, disclosure of incidents of sexual assault, social reactions received from support sources, and mental health outcomes, based on self-identified sexual orientation.

Although our hypotheses did not specifically state the direction of difference between lesbians and bisexual women, we did analyze their data as separate groups to allow for any possible differences in characteristics of assault and postassault outcomes to emerge. Guided by previous research, we expected lesbian and bisexual women to be more likely to seek support from formal sources than informal sources (Bradford et al., 1994). We also expected worse social reactions to assault disclosure for lesbian and bisexual women than heterosexual women (Wakelin & Long, 2003; White & Kurpius, 2002). We expected heterosexual women to be more likely to report coerced sex than lesbians or bisexual women, and all three groups to be equally likely to report attempted or completed rape (Balsam et al., 2005). Finally, we expected similar levels of depression and PTSD between sexual orientation groups, but we also expected that lesbian and bisexual survivors might report higher levels of self-blame for their assaults (Garnets et al., 1990; Wertheimer, 1990). We did not have any specific hypothesis about the survivor's type of relationship with the male offender (e.g., stranger, romantic partner, family member or relative, acquaintance).

METHODS

Sample

This study is a secondary analysis of data from the Women's Life Experiences Study, a study originally designed to explore women's sexual assault by male perpetrators (Ullman, Townsend, Filipas, & Starzynski, 2007). The sample is a diverse group of women in a major Midwestern city and its surrounding area. Three main sources of female sexual assault survivors were targeted: women in the community in general, members of the university community including students, staff, and faculty, and women who sought help from agencies postassault. Fliers were posted around the campuses of urban universities, in places where women congregate (e.g., bookstores), and at local mental health agencies and rape crisis centers. The study was also advertised in local newspapers for a 1-year period. Fliers invited women age 18 or older with unwanted sexual experiences since age 14 to participate in a confidential mail survey. Potential participants called the project office to receive more information about the purpose of the study. Interested women were mailed a packet containing a cover letter, a referral list of community resources, an information sheet explaining the study purpose and informed consent, and a 20-page survey. Participants were sent \$20 after returning the survey. There was a 90% response rate for mailed surveys, resulting in 1,084 completed surveys returned.

The sample was fairly well educated, with most women receiving some college education. The typical respondent was 32 and not currently in school. The sample was ethnically diverse, with 46.7% identifying as African American, 37.2% identifying as White, 6.2% Hispanic, 6.1% mixed racial identity, 2.9% Asian, and 0.9% identifying with another racial category not listed above. Most (77.4%) respondents identified as heterosexual, 5.9% identified as gay/lesbian, 11.0% identified as bisexual, 4.9% respondents were unsure, and .8% had missing data for sexual orientation.

Measures

Demographic Information. Respondents indicated their age, education level (less than 12th grade, high school graduate, some college, or graduate school or beyond), sexual orientation (heterosexual, lesbian, bisexual, or unsure), and race (American Indian or Alaskan

Native, Asian, Black, Hispanic, Pacific Islander, White, or other). Due to empty cells during analysis, education was dichotomized (high school education or less or some college education and beyond) and race was also dichotomized (White or ethnic minority).

Adult Sexual Assault. Categories of adult sexual assault (ASA; completed rape, attempted rape, unwanted sexual contact, and sexual coercion) were assessed with the Sexual Experiences Survey (SES), modified to specifically ask about experiences after age 14 (Koss, Gidycz, & Wisniewski, 1987). This survey has demonstrated good internal consistency reliability (Cronbach's $\alpha = .74$) and correlates with other measures of sexual assault (Koss et al., 1987). All items on the SES referred to a male perpetrator. Highest severity of adult sexual victimization was coded as none, sexual contact, sexual coercion, attempted rape, or completed rape, following Koss and colleagues' (1987) guidelines for coding assault severity. Participants who had multiple assaults were asked to answer questions regarding their "most serious" unwanted sexual experience. Each category of ASA was dichotomized into those who experienced that category (1) and those who did not experience that category (0). For example, respondents who indicated that they experienced sexual coercion were coded 1 for sexual coercion. Additionally, a dummy-coded variable capturing attempted rape (0) or completed rape (1) was created. Respondents also reported their relationship with the offender (stranger, nonromantic acquaintance, first or casual date, romantic partner or husband, or some other family member). Each type of offender relationship was dichotomized into those who were assaulted by that type of offender (1) and those who were not (0). For example, responses indicating that a stranger was the offender were coded as 1 for stranger; nonstrangers were 0. Relationship to the offender was also recoded dichotomously as either: known (nonromantic acquaintance, first or casual date, romantic partner or some other family member) or stranger for analyses.

Assault Disclosure and Social Support Measures. Respondents indicated whether they had disclosed the assault to anyone prior to the study, and indicated from a provided list of support sources who they told. They also indicated how long after the assault they first disclosed (immediately, days after, weeks after, year after, more than a year after) and whether telling made it better (much worse, somewhat worse, no difference, somewhat better, much better). Respondents reported whether they spoke to various informal sources (romantic partner, spouse or lover, parent or stepparent, family member/relative other than parents or a friend) as well as several formal sources (minister, priest or rabbi, psychiatrist or other mental health counselor, medical doctor or any other medical person or emergency room staff, the police, rape crisis center staff; no/yes for each source) and whether each source was helpful (no/yes for each source). Respondents also indicated how satisfied (1 = very unsatisfied, to 4 = very satisfied) they were with support received from a romantic partner, family members, friends, rape crisis center staff/volunteers, mental health professionals, professional helpers (e.g., clergy, physician, police, etc.), and with the overall amount of support they received from all people told.

Social Reactions. Responses that victims received from others when disclosing assault were measured with the Social Reactions Questionnaire (SRQ; Ullman, 2000), a measure of positive and negative social reactions to sexual assault disclosures with good test-retest reliability (Pearson r ranged from .68 to .77), construct validity as shown by factor analysis (α 's were .93 for emotional support/belief, .86 for treat differently, .80 for distraction/discourage talking, .83 for taking control, .84 for tangible aid/information support, .80 for victim blame, and .77 for egocentric reactions), convergent validity with expected correlations of positive and negative social reactions with other social support and psychological

symptom measures, and concurrent validity, assessed by correlating SRQ subscales with corresponding social reactions coded from open-ended data from questions about helpful and unhelpful responses to sexual assault disclosure. The SRQ contains 48 possible reactions comprising several different subscales of both positive (emotional support/belief and tangible aid/support) and negative social reactions (treat differently, take control, victim blame, egocentric responses, and distraction; Ullman, 2000). Respondents indicated the frequency of each reaction received from anyone to whom assault was disclosed using Likert scales ranging from never (0) to always (4). The average number of reactions on the positive reaction subscales and the average number of reactions on the negative reaction subscales were coded into two summary scales.

Psychological Reactions

Depressive Symptoms. Depressive symptomatology was assessed using a 10-item version of the Center for Epidemiologic Studies Depression Scale (CESD-10) developed by Andresen, Malmgren, Carter, and Patrick (1994). Scores on the original 20-item scale CES-D (Radloff, 1977) are highly correlated with the CESD-10 ($r = .97$) (Andresen et al., 1994). The original CES-D has demonstrated good internal consistency reliability (Cronbach's $\alpha = .85$) in the general population (Devins et al., 1988) and correlates highly ($r = .87$) with other measures of depression, including the Beck Depression Inventory (Beck, Ward, Mendelsohn, Mock, & Erbaugh, 1961; Santor, Zuroff, Ramsay, Cervantes, & Palacios, 1995). Respondents rated their mood and functioning on 4-point scales (0 = less than 1 day during the last week, 3 = 5–7 days during the last week). The total score is the sum of the items after reversing two positive mood items, where higher scores indicate greater depressive symptomatology.

Posttraumatic Stress Symptom Severity. Three subscales of the Posttraumatic Stress Disorder Diagnostic Scale (PDS) (numbing/avoidance, reexperiencing/intrusion, and arousal symptoms) were used to assess PTSD symptom severity (Foa, 1995). The PDS measures the severity of PTSD symptoms based on *DSM-IV* diagnostic criteria with 17 items referring to respondents' unwanted sexual experience. Respondents indicated on 4-point scales (0 = not at all to 3 = almost always) how often each symptom had bothered them in the past month. Severity scores were computed by summing responses to all 17 items. The scale has good internal consistency ($\alpha = .92$) and validity with a 79.4% agreement between the PDS and Structural Clinical Interview for the *DSM-IV* Axis I disorders (SCID) PTSD module (PTSD concordance rate of diagnoses, $\kappa = .59$).

Attributions of Blame. Survivors' attributions about why they were assaulted were assessed with the Rape Attribution Questionnaire (RAQ; Frazier, 2003). This instrument consists of five 5-point Likert scales assessing attributions made in the past 30 days for assault. The scale assesses two types of self-blame: behavioral (e.g., I used poor judgment) and characterological (e.g., I am just the victim type), and three types of external blame: chance (e.g., it was just bad luck), rapist (e.g., the rapist thought he could get away with it), and society (e.g., men are taught not to respect women). Previous research evaluating validity and reliability of the RAQ found subscale alpha coefficients ranging from .77 to .89, and test-retest reliability coefficients ranging from .68 to .80 (Frazier, 2002).

Data Analysis Strategy

Data were analyzed using chi-square tests of independence to compare assault experiences and outcomes by sexual orientation (heterosexual, bisexual, lesbian). Multiple

Multivariate Analyses of Covariance (MANCOVAs) were performed to explore differences in social reactions, psychological symptoms, and attributions of blame by sexual orientation. Where appropriate, age, level of education, and race were included as control variables, because all three have been shown to be related to postassault mental health and help-seeking behavior (Ullman & Brecklin, 2002). All analyses utilized .05 probability significance levels, with follow-up tests utilizing modified Bonferroni significance criteria corrections (Keppel, 1991).

RESULTS

Sample Characteristics

Demographic characteristics are displayed in Table 1 for the entire sample ($N = 1,084$) and separately by sexual orientation. Cases where sexual orientation was missing ($n = 9$) or the respondent answered "unsure" ($n = 53$) were excluded from all analyses, bringing the final sample size to 1,022. Data missing for summary scales was imputed using mean substitution, when no more than 20% of data for that scale was missing (Tabachnick & Fidell, 2001).

Experiences of Adult Sexual Assault

A majority of respondents (71.1%) indicated that they experienced completed rape. Sexual coercion was experienced by 9.1% of the sample, 8.2% experienced attempted rape, and

TABLE 1. Demographic Characteristics by Sexual Orientation

	Total $N = 1,022$	Sexual Orientation		
		Heterosexual $n = 839$	Lesbian $n = 64$	Bisexual $n = 119$
Race				
African American	46.7%	40.2%	3.8%	2.8%
American Indian/ Alaskan Native	0.3%	0.2%	0%	0.1%
Asian	2.9%	2.8	0%	0.1%
Latina	6.2%	4.8%	.4%	1.0%
Mixed race/ethnicity	6.1%	5.0%	6.3%	13.9%
Pacific Islander/ Native Hawaiian	0.5%	0.4%	0%	0.1%
White	37.2%	29.9%	1.7%	5.6%
Other	0.1%	0%	0%	.1%
Education				
< High school	14.9%	12.9%	.8%	1.2%
High school grad	15.0%	11.9%	1.2%	2.0%
Some college	39.0%	31.3%	3.1%	4.7%
College grad or beyond	31.1%	25.9%	1.3%	3.9%
Average age	32.47	33.18	30.48	28.55

3.7% experienced unwanted sexual contact. Categorical analysis of assault severity revealed significant differences overall between sexual orientation groups, $\chi^2(8, n = 987) = 10.07, p = .014$. To understand this finding we analyzed each type of assault by sexual orientation, applying a modified Bonferroni correction ($P_{critical} = .02$; Keppel, 1991). Chi-square analyses of sexual contact, sexual coercion, and attempted rape were not significant, but there was a trend for experiencing completed rape, $\chi^2(2, n = 987) = 6.18, p = .05$. Proportionately more heterosexual women (72.6%) experienced completed rape than lesbian (58.7%) or bisexual (67.8%) respondents. Finally, a chi-square analysis comparing attempted and completed rape by sexual orientation group was not significant, $\chi^2(2, n = 914) = 4.6, ns$.

Most (79.3%) women in this study knew their offenders (44.7% acquaintance, 22.3% romantic partner, 12.3% family member or relative). The remaining 20.6% of the sample were assaulted by a stranger. Chi-square analyses of the victim-offender relationship revealed significant differences overall between sexual orientation groups, $\chi^2(2, n = 892) = 16.77, p = .01$. To understand these differences, we analyzed each type of relationship to the offender separately by sexual orientation, applying a modified Bonferroni correction (Keppel, 1991). Chi-square analyses of family member offenders by sexual orientation revealed significant differences ($\chi^2(2, n = 892) = 13.56, p < .001$) showing that proportionately more lesbians (27.1%) had offenders who were relatives than bisexual (13.9%) or heterosexual (10.9%) respondents. There were no significant differences for other types of offenders (acquaintance, romantic partner, or stranger) by sexual orientation. Additionally, there were no significant differences by sexual orientation when a dichotomous variable representing assault by a stranger versus assault by a known man was analyzed, $\chi^2(2, n = 892) = .19, ns$.

Assault Disclosure

Chi-square analyses of sexual orientation and assault disclosure variables did not reveal significant differences. Women of different sexual orientations did not differ significantly by whether they had ever disclosed the assault to anyone prior to the survey ($\chi^2(2, n = 934) = 2.91, ns$), how long after the experience they disclosed ($\chi^2(2, n = 741) = 10.42, ns$) or in their perceptions of whether or not disclosure made things better or worse overall, $\chi^2(2, n = 740) = 9.67, ns$.

Disclosure to and Helpfulness of Formal Support Sources

Most women (60.3%) told a formal support source about the assault. Chi-square analyses comparing the number of women who disclosed to any formal support source (e.g., mental health professional, religious personnel, medical personnel, police, or rape crisis center staff) by sexual orientation revealed significant differences, $\chi^2(2, n = 741) = 6.30, p = .04$. More bisexual women (71.4%) told a formal source than did lesbians (63.3%) or heterosexual women (58.2%). Each formal support source was analyzed separately by sexual orientation using a modified Bonferroni correction (Keppel, 1991). Almost half of all respondents spoke with a psychiatrist or mental health counselor (46.1%), and there were significant differences by sexual orientation, $\chi^2(2, n = 736) = 11.79, p = .003$. More bisexual women (60.2%) talked with a psychologist, psychiatrist, or mental health professional than did lesbians (55.1%) or heterosexual women (43.0%). There were no significant differences by sexual orientation in disclosure to clergy, medical personnel, police, or rape crisis centers, perhaps because few women told these sources (10.4%, 17.4%, 13.6%, and 15.4%, respectively).

Of the women disclosing to formal sources (doctor, emergency room staff, or medical personnel), there were differences in perceived helpfulness of those sources by sexual orientation, $\chi^2(2, n = 191) = 7.735, p = .02$. Most lesbians found the doctor/other medical person/ER staff helpful (71.4%), and more than half of heterosexual women found them helpful (64.2%). However, only 37.9% of bisexual women found this formal source helpful. There were no differences by sexual orientation in perceived helpfulness of clergy, mental health professionals, police, or rape crisis center staff. In general, most women found these sources helpful (74.0% found clergy helpful, 74.6% found mental health professionals helpful, and 79.1% found rape crisis center staff helpful) with the exception of police, who just over half of women found to be helpful (52.4%).

Disclosure to and Helpfulness of Informal Support Sources

There were no significant differences by sexual orientation in telling any informal source (romantic partner, parents, other family members, or friends) ($\chi^2(2, n = 745) = .02, ns$), perhaps because almost all women disclosing assault (97.4%) told an informal source. Analyzing each type of informal support separately, there were significant differences by sexual orientation in telling a romantic partner about the experience, $\chi^2(2, n = 739) = 7.58, p = .02$. More bisexual women (76.5%) told a romantic partner than did lesbian (65.3%) or heterosexual women (62.2%). There were no additional differences by sexual orientation in telling a parent or stepparent, other family member/relative, or a friend. Finally, there were no differences in perceived helpfulness of these informal sources.

Social Reactions to Assault Disclosure

Next we analyzed differences in the social reactions received from social support sources by sexual orientation. A MANCOVA predicting the average number of positive and negative social reactions by sexual orientation was performed controlling for age, level of education, and race, factors found to influence attitudes about sexual assault (Nagel, Matsuo, McIntyre, & Morrison, 2005). Due to the unequal sample sizes between groups, Pillai's Trace was used to test for significance. There was a significant multivariate effect of sexual

TABLE 2. SRQ Subscales Means and Standard Deviations by Sexual Orientation

SRQ Subscale Average Number of Responses	Sexual Orientation								
	Heterosexual			Lesbian			Bisexual		
	<i>M</i>	<i>SD</i>	<i>N</i>	<i>M</i>	<i>SD</i>	<i>N</i>	<i>M</i>	<i>SD</i>	<i>N</i>
Total positive	2.06	.83	583	2.22	.87	46	1.82	.76	94
Emotional support	2.36	.86	554	2.61	.87	38	2.09	.86	91
Aid/informational	1.16	1.00	554	1.42	1.13	38	.98	.93	91
Total negative	1.01	.65	583	.89	.56	46	1.09	.67	94
Controlling	.93	.74	554	.68	.67	38	1.04	.71	91
Distraction	1.24	.82	554	1.00	.70	38	1.28	.84	91
Treat differently/ stigmatize	.82	.83	554	.57	.65	38	1.00	.91	91
Egocentric	1.23	.97	554	1.46	.98	38	1.22	.88	91
Blaming	.71	.87	554	.49	.61	38	.84	1.01	91

orientation and education on the total number of positive and negative reactions (Pillai's Trace $F(4, 1434) = 3.01, p = .018, F(2, 716) = 16.53, p < .001$, respectively). At the univariate level, sexual orientation was significantly related to the average number of positive social reactions, after applying the modified Bonferroni correction ($F(2, 717) = 2.99, p = .01$), with bisexuals receiving the fewest positive social reactions to disclosure ($M = 1.82$). Education was significantly related to the average number of positive reactions ($F(1, 717) = 19.09, p < .001$), with more educated women receiving fewer positive reactions ($M = 1.92, SD = .79$) than women with a high school degree or less ($M = 2.23, SD = .86$). Education was also significantly related to the average number of negative reactions ($F(1, 717) = 4.93, p = .001$), with more educated women receiving fewer negative reactions ($M = .97, SD = .64$) than women with a high school degree or less ($M = 1.22, SD = .71$). Table 2 displays the average number of positive and negative social reactions received by sexual orientation.

Mental Health Outcomes

Because depression and PTSD can be comorbid (Stein & Kennedy, 2001), and because depression and PTSD symptom scores were significantly correlated ($r = .53$), we ran a MANCOVA predicting these two mental health outcomes from sexual orientation while controlling for age, education level, and race. Sexual orientation, education, and race significantly predicted levels of depression and PTSD at the multivariate level (Pillai's Trace $F(4, 1790) = 2.66, p = .03, F(2, 894) = 11.11, p < .001, F(2, 894) = 3.11, p = .05$, respectively). At the univariate level, sexual orientation significantly predicted depressive symptoms ($F(2, 895) = 4.67, p = .01$), after applying a modified Bonferroni correction, and there was a trend for sexual orientation to predict PTSD, $F(2, 895) = 3.11, p = .05$. Table 3 displays the means and standard deviations of depression and PTSD symptomatology by sexual orientation, level of education, and race. Bisexual women had more depressive symptoms and higher levels of PTSD than lesbians or heterosexuals. Finally, women with lower levels of education or ethnic minority membership had significantly higher levels of PTSD ($F(1, 895) = 17.74, p = .02, F(1, 895) = 6.19, p = .01$, respectively) than women with more education and White women. Lower levels of education were also associated with higher depression scores, ($F(1, 895) = 15.89, p = .02$) than were higher levels of education.

Attributions of Blame

A MANCOVA using sexual orientation to predict the five attributions of blame (behavioral, characterological, chance, rapist, and society), while controlling for age, education, and race, was not significant at the multivariate or univariate level for any of the subscales, Pillai's Trace $F(10, 1752) = 1.23, ns$. However, the covariates age and education were significant predictors of blame (Pillai's Trace $F(5, 875) = 15.73, p < .001, F(5, 875) = 9.24, p < .001$, respectively). Less educational attainment significantly predicted higher characterological self-blame ($F(1, 879) = 7.78, p = .005$), higher attribution of blame to chance ($F(1, 879) = 13.38, p < .001$), and less blame attributed to society ($F(1, 879) = 9.55, p = .002$) than for women with more education. Table 3 displays the means and standard deviations of each type of blame by sexual orientation group, race, and education. Age significantly predicted blaming chance ($F(1, 879) = 11.52, p = .001$), rapist blame ($F(1, 879) = 61.05, p < .001$), and societal blame, $F(1, 879) = 15.27, p < .001$. Older women were more likely than younger women to blame chance ($r = .118, p < .01$), the rapist ($r = .261, p < .01$), and society ($r = .119, p < .01$) for their assault.

TABLE 3. Mental Health and Attribution Means and Standard Deviations by Sexual Orientation, Race, and Education

	Mental Health				Type of Blame									
	Depression		PTSD		Behavioral		Characterological		Chance		Rapist		Society	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
Sexual orientation														
Straight	10.86	5.14	18.28	12.38	16.65	5.23	12.82	4.53	14.39	4.42	17.73	4.59	15.71	4.81
Lesbian	11.04	4.81	19.54	12.01	15.70	5.28	12.05	5.29	14.70	4.50	17.84	4.71	15.55	5.31
Bisexual	12.51	4.76	20.77	12.41	16.87	5.68	13.62	4.94	14.38	4.44	17.95	4.43	16.52	4.61
Race														
Ethnic minority	11.28	5.17	19.85	12.38	16.29	5.32	12.87	4.80	14.61	4.57	17.99	4.48	15.35	4.91
White	10.69	4.96	16.84	12.28	17.19	5.26	13.12	4.40	14.03	4.20	17.38	4.70	16.45	4.60
Education														
High school grad or less	12.07	4.71	22.04	12.29	16.30	5.06	13.55	4.98	15.39	4.60	18.36	4.39	14.82	4.78
Some college and beyond	10.62	5.21	17.24	12.15	16.75	5.46	12.54	4.48	12.98	4.30	17.51	4.65	16.19	4.82

DISCUSSION

The aim of this study was to explore similarities and differences in unwanted male-perpetrated sexual experiences of lesbian, bisexual, and heterosexual adult women using a diverse community sample. Previous research indicates that sexual assault is approximately as common in the lesbian and bisexual female population as in the heterosexual female population (Balsam et al., 2005; Bradford et al., 1994; Descamps et al., 2000; Grundlach, 1977; Hughes et al., 2001; Morris & Balsam, 2003; Pitt & Dolan-Soto, 2001; Scheer et al., 2003), and that most assaults are perpetrated by men (Balsam et al., 2005; Bradford et al., 1994; Brand & Kidd, 1986; Moore & Waterman, 1999; Morris & Balsam, 2003). However, little research has explored women's postassault experiences by sexual orientation, and even fewer studies have examined differences between lesbian and bisexual women. Therefore, this study analyzed these subgroups separately to better understand the relationships between sexual orientation and experiences of male-perpetrated sexual assault, assault disclosure, helpfulness of support sources, social reactions received, and mental health outcomes.

We began by examining trends in characteristics of unwanted sexual assault. Although there is a trend in studies of sexual assault to examine the dichotomy between completed rape and noncompleted rape (Ullman, 1997; Ullman & Siegel, 1993), the current study showed that such distinctions do not necessarily capture the differing experiences of sexual assault by sexual orientation. Overall, a chi-square analysis of the types of "unwanted sexual experiences" measured (e.g., sexual coercion, sexual contact, attempted rape, completed rape) by sexual orientation was significant. "Traditional" analyses of completed rape (only that category) versus noncompleted rape (all other categories) did not reveal significant differences by sexual orientation because most women (76.8%) in this study experienced completed rape. However, analysis of only the women who experienced completed rape revealed differences by sexual orientation group. Specifically, there was a trend for more heterosexual women to experience completed rape than for lesbian or bisexual women, contrary to our hypothesis. These findings are inconsistent with previous research and could be an artifact of the way the questions about assault were asked: Participants were to reference their most serious experience of sex when they did not want it. The women in prior studies were reporting on lifetime prevalence of assault, not one specific incident (Balsam et al., 2005; Brand & Kidd, 1986; Scheer et al., 2003). These results suggest a trend for heterosexual women to experience completed rape as their most serious experience of unwanted sex more often than lesbian or bisexual women might. Perhaps lesbian and bisexual women find other elements of sexual assault, not captured in this survey, to be more serious or important (e.g., noncompleted sexual assaults that are part of hate crimes). It is important for future research to focus on the potentially different implications of types of assault by sexual orientation, and to understand the larger context in which those assaults are occurring.

Similar to the type of assault, the relationship between the survivor and the offender is also often dichotomized as assault by a stranger or assault by someone the victim knew (Ullman & Siegel, 1993). These analyses revealed no significant differences by sexual orientation because most women (79.4%) knew their attackers. However, more detailed examination of the relationship to the offender (e.g., stranger, acquaintance, romantic partner, family member/relative) by sexual orientation revealed that more lesbians were assaulted by a family member or relative than were the other two groups. Perhaps this finding reflects the high rates of childhood sexual assault experienced by lesbian and bisexual

women (Balsam et al., 2005), given that "adult" experiences of assault in this study were those that happened after age 14. Other studies use age 18 as a cutoff point for adulthood (e.g., Balsam et al., 2005) or just use the term "childhood" to allow respondents to decide their own cutoff for adulthood (e.g., Descamps et al., 2000). However, Morris and Balsam (2003) did find that 6.5% of adult sexual assaults of lesbians and bisexual women over the age of 18 were perpetrated by a male relative. We do not know definitively if the relative-perpetrated assaults are part of a longer history of childhood sexual assault and therefore cannot draw strong conclusions from this finding. However, it does highlight the need for future research to take a more nuanced view of the victim-offender relationship to shed light on the context of sexual assault.

There were no differences by sexual orientation in the length of time it took women to disclose the assault or in their appraisals of whether disclosing made things better or worse overall. However, as predicted there were differences in disclosure to formal sources by sexual orientation. Bisexual women were more likely to disclose to formal support sources than heterosexual or lesbian women, partially supporting our hypothesis. Specifically, bisexual women were more likely to tell a psychiatrist or mental health counselor. Perhaps because bisexual women told more formal sources in general they were more likely to speak with a mental health professional. However, of the women who told mental health professionals, there were no differences by sexual orientation in the perceived helpfulness of this source; most found them to be helpful. Of women who told medical personnel, bisexual women and lesbians found telling them to be less helpful than did heterosexual women. This result supports previous research findings that lesbian, gay, and bisexual populations perceive less helpful care from medical professionals (Bradford et al., 1994; Lehman et al., 1998).

Almost all of the women in this study told informal support sources about their assaults. However, bisexual women were the most likely to tell a romantic partner about the experience in comparison to heterosexual women and lesbians. There were no differences by sexual orientation in the perceived helpfulness of telling any informal support source. This finding has implications for the sexual identity development process. Lesbian and bisexual women may not have told some members of their social support networks about their sexual orientation, and must be careful to utilize allies who will be supportive. However, perhaps women in this urban sample had large enough support networks where they could tell a romantic partner, friend, or family members about the assault. Women in circumstances less tolerant of lesbian and bisexual women might have a harder time finding sources of informal support.

Social reactions received from support sources (both formal and informal) differed by sexual orientation as predicted. Bisexual women received the fewest positive reactions to their assault disclosures, partially supporting our hypothesis. They were also the least likely to find doctors, medical personnel, and emergency room staff helpful. Therefore, it appears that the support sources bisexual women disclose to are not responding in a supportive manner. Perhaps receiving fewer positive reactions from support sources leads bisexual women to tell more sources in search of positive support, which would account for their telling more formal sources about the assault than did lesbians or heterosexual women. Future research should focus on the needs of bisexual assault survivors to understand what reactions they receive that are unhelpful, why they receive those reactions, and how to promote positive reactions to them.

Significant differences between sexual orientation groups were also found with regard to psychological symptoms. In this sample, bisexual women had more symptoms of

depression and PTSD than did lesbians or heterosexual women, contrary to our hypothesis. Caution must be used in interpreting these results, because causality cannot be determined from this study. However, generally the rates of depression and PTSD in nonassaulted lesbian, gay, and bisexual populations are similar to those of heterosexual populations (Hughes et al., 2000). The intersection of sexual assault and sexual orientation will have obvious negative effects on mental health if one's sexual orientation is perceived as a cause of the assault (Descamps et al., 2000), a factor not addressed by this study. The mental health status of bisexual women in this sample is additionally worrisome because they were the most likely to tell mental health professionals and romantic partners but received the most negative responses to disclosure. More research is needed on the relationship between social reactions received from support sources and mental health outcomes after sexual assault, especially for bisexual women.

Contrary to our hypothesis, there were no differences by sexual orientation in the amount of self-blame, although there were differences by education and age, similar to previous research findings (Burt, 1980; Nagel et al., 2005). This study asked participants to focus on their most severe unwanted sexual experience, and a majority experienced completed rape (74%). Some research shows that women who experience more severe sexual assaults blame themselves less and the perpetrator more for the assault (Fisher, Daigle, Cullen, & Turner, 2003; Ullman et al., 2007). This finding should be replicated with another sample of lesbian and bisexual women, with specific attention paid to different types of assault.

This study highlights some distinctions in the male-perpetrated sexual assaults in a community sample of lesbian, bisexual, and heterosexual women. However, there are several limitations. First, we only inquired about men's sexual aggression against women. Assault also occurs between women, but was not captured by this study. Additionally, recent research shows that surveys about sexual assault using the SES do not always capture all the forms of unwanted sexual experiences (Abbey, BeShears, Clinton-Sherrod, & McAuslan, 2004; Testa, VanZile-Tamsen, Livingston, & Koss, 2004). Future researchers should examine female-perpetrated assaults and simultaneously modify the SES to capture other forms of unwanted sexual experiences and test the reliability of the modified instrument (Waldner-Haugrud, 1999).

Unlike most previous studies of sexual orientation and sexual assault, we did not assess lifetime rates of assault. Instead, women who were assaulted multiple times were asked to recall only the most serious experience of unwanted sex, limiting the types of assault measured to those considered more severe. However, we do not know what criteria participants used to categorize the "most severe" assault (if multiply assaulted) or how those criteria might differ by sexual orientation.

Finally, this study used a convenience sample of women, many of whom came from lower socioeconomic backgrounds, so it is unknown if these results would generalize to a more representative sample. Only a small number of lesbians were included in this study, and therefore caution must be taken when interpreting the findings. Although difficult and time-consuming, we recommend that future research attempt to contact a random sample of women, with care taken to oversample lesbian and bisexual women, to draw more generalizable conclusions (Waldner-Haugrud, 1999).

Lesbians, bisexual, and heterosexual women appear to have many common experiences after they are sexually assaulted by a man. Most disclose their assaults to another person, within the same amount of time, and feel that disclosing did not make things worse. Almost all women tell their romantic partner, family, or friends about the assault,

and perceive them to be similarly helpful. Their rates of depression after the assault are similar, and they do not attribute blame differently according to sexual orientation. In this study, most women blamed the rapist.

There also appear to be some important differences between the sexual assault experiences of lesbian, heterosexual, and bisexual women. This study highlights the need for additional research on the post-sexual assault experiences of lesbian and bisexual women. It is important for future research to consider how sexual orientation may affect the interpretations of sexual assault by survivors and their support networks. For example, qualitative research with lesbians and bisexual assault survivors might shed light on the intersections they see between sexual orientation, experiences of sexual assault, and assault disclosure. This study's findings also highlight a need for professionals who see sexually assaulted women to be sensitive to issues of sexual orientation and to take care that their actions are perceived as supportive in the healing process.

REFERENCES

- Abbey, A., BeShears, R., Clinton-Sherrod, A., & McAuslan, P. (2004). Similarities and differences in women's sexual assault experiences based on tactics used by the perpetrator. *Psychology of Women Quarterly*, *28*, 323–332.
- Andresen, E. M., Malmgren, J. A., Carter, W. B., & Patrick, D. L. (1994). Screening for depression in well older adults: Evaluation of a short form of the CES-D. *American Journal of Preventive Medicine*, *10*, 77–84.
- Avery, A., Hellman, R., & Sudderth, L. (2001). Satisfaction with mental health services among sexual minorities with major mental illness. *American Journal of Public Health*, *91*, 990–991.
- Balsam, K., Rothblum, E., & Beauchaine, T. (2005). Victimization over the life span: A comparison of lesbian, gay, bisexual and heterosexual siblings. *Journal of Counseling and Clinical Psychology*, *73*, 477–487.
- Basile, K. (2005). Sexual violence in the lives of girls and women. In K. Kendall-Tackett (Ed.), *Handbook of women, stress and trauma* (pp. 101–122). New York: Brunner-Routledge.
- Beck, A., Ward, C., Mendelsohn, M., Mock, J., & Erbaugh, J. (1961). An inventory for measuring depression. *Archives of General Psychiatry*, *4*, 561–571.
- Bradford, J., Ryan, C., & Rothblum, E. (1994). National Lesbian Health Care Survey: Implications for mental health care. *Journal of Consulting and Clinical Psychology*, *62*, 228–242.
- Brand, P., & Kidd, A. (1986). Frequency of physical aggression in heterosexual and female homosexual dyads. *Psychological Reports*, *59*, 1307–1313.
- Burt, M. R. (1980). Cultural myths and support for rape. *Journal of Personality and Social Psychology*, *38*, 217–230.
- Campbell, R., Ahrens, C., Seftl, T., Wasco, S., & Barnes, H. (2001). Social reactions to rape victims: Healing and hurtful effects on psychological and physical health outcomes. *Violence and Victims*, *16*, 287–302.
- Cochran, S., Sullivan, J., & Mays, V. (2003). Prevalence of mental disorders, psychological distress and mental health services use among lesbian, gay and bisexual adults in the United States. *Journal of Consulting and Clinical Psychology*, *71*, 53–61.
- Descamps, M., Rothblum, E., Bradford, J., & Ryan, C. (2000). Mental health impact of child sexual abuse, rape, intimate partner violence and hate crimes in the National Lesbian Health Care Survey. *Journal of Gay and Lesbian Social Services*, *11*, 27–55.
- Devins, G., Orne, C., Costello, C., Binik, Y., Fizzel, B., Stam, H., et al. (1988). Measuring depressive symptoms in illness populations: Psychometric properties of the Center for Epidemiologic Studies Depression (CES-D) scale. *Psychology and Health*, *2*, 139–156.

- Fisher, B. S., Daigle, L. E., Cullen, F. T., & Turner, M. G. (2003). Acknowledging sexual victimization as rape: Results from a national-level study. *Justice Quarterly, 20*, 535–574.
- Foa, E. B. (1995). *Posttraumatic Stress Diagnostic Scale Manual*. Minneapolis, MN: National Computer Systems.
- Frazier, P. A. (2002). *Rape Attribution Questionnaire*. Unpublished manuscript. University of Minnesota.
- Frazier, P. A. (2003). Perceived control and distress following sexual assault: A longitudinal test of a new model. *Journal of Personality and Social Psychology, 84*, 1257–1269.
- Garnets, L., Herek, G., & Levy, B. (1990). Violence and victimization of lesbians and gay men. *Journal of Interpersonal Violence, 5*, 366–383.
- Grundlach, R. (1977). Sexual molestation and rape reported by homosexual and heterosexual women. *Journal of Homosexuality, 2*, 367–384.
- Hughes, T., Haas, A., Razzano, L., Cassidy, R., & Matthews, A. (2000). Comparing lesbians' and heterosexual women's mental health: A multi-site survey. *Journal of Gay & Lesbian Social Services, 11*, 57–76.
- Hughes, T., Johnson, T., & Wilsnack, S. (2001). Sexual assault and alcohol abuse: A comparison of lesbians and heterosexual women. *Journal of Substance Abuse, 13*, 515–532.
- Keppel, G. (1991). *Design and analysis* (3rd ed.). Upper Saddle River, NY: Pearson-Prentice Hall.
- Kilpatrick, D., Saunders, B., Veronen, L., Best, C., & Von, J. (1987). Criminal victimization: Lifetime prevalence, reporting to police, and psychological impact. *Crime and Delinquency, 33*, 479–489.
- Koss, M. P., Gidycz, C. A., & Wisniewski, N. (1987). The scope of rape: Incidence and prevalence of sexual aggression and victimization in a national sample of higher education students. *Journal of Consulting and Clinical Psychology, 55*, 162–170.
- Lehmann, J., Lehmann, C., & Kelly, P. (1998). Development and health care needs of lesbians. *Journal of Women's Health, 7*, 379–387.
- Moore, C., & Waterman, C. (1999). Predicting self-protection against sexual assault in dating relationships among heterosexual men and women, gay men, lesbians, and bisexuals. *Journal of College Student Development, 40*, 132–140.
- Morris, J. F., & Balsam, K. F. (2003). Lesbian and bisexual women's experiences of victimization: Mental health, revictimization, and sexual identity development. *Journal of Lesbian Studies, 7*(4), 67–85.
- Nagel, B., Matsuo, H., McIntyre, K. P., & Morrison, N. (2005). Attitudes towards victims of rape: Effects of gender, race, religion, and social class. *Journal of Interpersonal Violence, 20*, 725–737.
- Orzek, A. (1989). The lesbian victim of sexual assault: Special considerations for the mental health professional. *Women & Therapy, 8*, 107–117.
- Pitt, E., & Dolan-Soto, D. (2001). Clinical considerations in working with victims of same-sex domestic violence. *Journal of the Gay and Lesbian Medical Association, 5*, 163–169.
- Radloff, L. (1977). The CES-D scale: A self-report depression scale for research in the general population. *Applied Psychological Measurement, 1*, 385–401.
- Raphael, J. (2004). *Listening to Olivia: Violence, poverty, and prostitution*. Boston, MA: Northeastern University Press.
- Russell, D., & Bolen, R. (2000). *The epidemic of rape and child sexual abuse in the United States*. Thousand Oaks, CA: Sage Publications.
- Santor, D., Zuroff, D., Ramsay, J., Cervantes, P., & Palacios, J. (1995). Examining scale discriminability in the BDI and CES-D as a function of depressive severity. *Psychological Assessment, 7*, 131–139.
- Scheer, S., Parks, C., McFarland, W., Page-Shafer, K., Delgado, V., Ruiz, J., et al. (2003). Self-reported sexual identity, sexual behaviors and health risks: Examples from a population-based survey of young women. *Journal of Lesbian Studies, 7*, 69–83.
- Sloan, L., & Edmond, T. (1996). Shifting the focus: Recognizing the needs of lesbian and gay survivors of sexual violence. *Journal of Gay and Lesbian Studies, 5*, 33–52.

- Stein, M., & Kennedy, C. (2001). Major depressive and PTSD co morbidity in female victims of intimate partner violence. *Journal of Affective Disorders, 66*, 133–138.
- Tabachnick, B., & Fidell, L. (2001). *Using multivariate statistics* (4th ed.). Needham Heights, MA: Allyn & Bacon.
- Testa, M., VanZile-Tamsen, C., Livingston, J., & Koss, M. (2004). Assessing women's experiences of sexual aggression using the Sexual Experiences Survey: Evidence for validity and implications for research. *Psychology of Women Quarterly, 28*, 256–265.
- Tjaden, P., & Thoennes, N. (2000). *Full report of the prevalence, incidence, and consequences of intimate partner violence against women: Findings from the National Violence Against Women Survey*. Report for grant 93-IJ-CX-0012, funded by the National Institute of Justice and the Centers for Disease Control and Prevention. Washington, DC: National Institute of Justice.
- Turell, S. (1999). Seeking help for same-sex relationship abuses. *Journal of Gay and Lesbian Social Services, 10*, 35–49.
- Ullman, S. (1997). Review and critique of empirical studies of rape avoidance. *Criminal Justice and Behavior, 24*, 177–204.
- Ullman, S. (1999). Social support and recovery from sexual assault: A review. *Aggression and Violent Behavior: A Review Journal, 4*, 343–358.
- Ullman, S. (2000). Psychometric characteristics of the Social Reactions Questionnaire: A measure of reactions to sexual assault victims. *Psychology of Women Quarterly, 24*, 169–183.
- Ullman, S., & Brecklin, L. R. (2002). Sexual assault history, PTSD, and mental health service seeking in a national sample of women. *Journal of Community Psychology, 30*, 261–279.
- Ullman, S., & Siegel, J. (1993). Victim-offender relationship and sexual assault. *Violence and Victims, 8*, 121–134.
- Ullman, S. E., Townsend, S. M., Filipas, H. H., & Starzynski, L. L. (2007). Structural models of the relations of assault severity, social support, avoidance coping, self-blame, and PTSD among sexual assault survivors. *Psychology of Women Quarterly, 31*, 23–37.
- Wakelin, A., & Long, K. (2003). Effects of victim gender and sexuality on attributions of blame to rape victims. *Sex Roles, 49*, 477–487.
- Waldner-Haugrud, L. (1999). Sexual coercion in lesbian and gay relationships: A review and a critique. *Aggression and Violent Behavior, 4*, 139–149.
- Waterman, C., Dawson, L., & Bologna, M. (1989). Sexual coercion in gay male and lesbian relationships: Predictors and implications for support services. *The Journal of Sex Research, 26*, 118–124.
- Wertheimer, D. (1990). Treatment and service interventions for lesbian and gay male crime victims. *Journal of Interpersonal Violence, 5*, 384–400.
- White, B., & Kurpius, K. (2002). Effects of victim sex and sexual orientation on perceptions of rape. *Sex Roles, 46*, 191–200.

Acknowledgments. This research was supported by NIAAA grant #AA13455 to Sarah Ullman. We thank Henrietta Filipas, Stephanie Townsend, and Kelly Kinnison for assistance with data collection and Tonda Hughes for helpful comments on an earlier version of this article.

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