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Abstract

Sexual assault is a prominent issue in society, yet many people remain unaware of the serious effects following sexual assault. Victims who report to legal authorities tend to experience disbelief and blame because of the prevalence of *rape myths*. Due to the severity of the trauma, hormones released by the brain hinder proper brain functioning and can cause a little-known evolutionary response termed tonic immobility (TI). The psychological outcome of sexual assault commonly results in or worsens several psychological conditions, including depression, anxiety, PTSD, and drug and alcohol abuse. Guilt, self-blame, and adverse emotions are accelerated with negative interactions while disclosing to the police, friends, family, or others. Avoiding these emotions is possible with support, affirmation, and helpful resources. By promoting education to the public on these topics, victims can receive support and proper clinical assessment on their way to recovery.

The word trauma can bring several thoughts to mind, including images of injuries in an emergency room, a fatal car crash, or first-hand experience in combat. Trauma typically involves being in shock and nearly in an altered state of mind. It often leaves an imprint that is seemingly impossible to erase. The linguistic derivatives of trauma—from Greek and Latin to be a "psychic wound, unpleasant state experience" with "abnormal stress"—make it the perfect word to describe the aftermath for a victim of sexual assault (Trauma, n.d., para. 1). Those who experience sexual assault have increased chances of developing post-traumatic stress disorder (PTSD), more so than those who experience a different kind of traumatic event (Walsh & Bruce, 2014), yet it is scarcely categorized with the descriptions listed above. When it comes to understanding the mental aftermath of sexual assault, the public is unaware of how detrimental it can be on the victim in the short and long term; it is much more significant than just pressing charges, as commonly believed. Thus, a change in understanding of the effects of sexual assault on victims is necessary to properly aid victims in their recovery.

Victims of sexual assault might need to seek professional help to learn to cope with the immediate effects—and later with the long-term effects—of the trauma they experience. Following a traumatic event, an individual may experience an emotional reaction, such as shock and panic, or an avoidance reaction in which repression and denial take place. If either of these reactions is not properly addressed, a chain of problems may arise and combine into symptoms of psychological disorders. The traumatic influence reaches into other aspects of life and may include the development of emotional instability and dysfunctional social relationships (Heaps, 2000). Difficulty coping with the reactions of traumatic or abusive events, namely sexual assault, may lead to mental issues following the event (Heaps, 2000; Thompson et al., 2003); therefore, positive intervention is necessary to counteract the possible detrimental outcomes.

Sexual assault often results in the development or worsening of psychopathology (in this case, mental illness or psychological impairment), which includes an extensive list of possible disorders: depression, anxiety, PTSD, drug and alcohol abuse, and so forth

(Gokten & Duman, 2016). One study combined results to show that the severity of some disorders increases based upon the specificities of the incident such as full penetration and violence (Bak-Klimek et al., 2014). The foregoing studies demonstrate that psychopathology appears to be a result of experiencing some form of sexual assault, which underscores the psychological effects of sexual assault. As the symptoms form due to unhealthy coping, they progress into complex mental disorders.

Notwithstanding the known psychological effects following sexual assault of any kind, many victims do not report the sexual assault and therefore fail to receive treatment or fail to recover. An altered state of mind from symptoms of PTSD, fear, emotional distress, or the desire for privacy can all result in a victim not reporting the sexual assault (Walsh & Bruce, 2014). The National Crime Victimization Survey (NCVS)'s 2018 statistics show only about 24.9% of crimes dealing with sexual assault were reported to legal authorities, leaving 75.1% of rapes unreported (Morgan & Oudekerk, 2019). The rate of reported sexual assault crimes was 2.7 per 1,000 persons aged 12 and older (Morgan & Oudekerk, 2019). Applying the rate of reporting and per 1,200, an estimated total rate of 10.8 for rape crimes were committed in the US during 2018. Alarmingly low statistics show that few victims of sexual assault report their cases. Few reported cases continue in the process of prosecution (Campbell, 2012). Symptoms following the event, even besides those discussed of trauma, can lead to not reporting (Walsh & Bruce, 2014).

Despite the onset of shock symptoms, unhealthy coping, and the subsequent development of psychological disorders, many sexual assault victims do not receive clinical assessment and therapy. Referring explicitly to female victims, Greeson et al. (2016) addressed the phenomenon of *rape culture*, or the increasing "victimization of women and girls" combined with a decreasing liability of the men who sexually assault (p. 91). With the increased stigma of victimized women, female assault victims may not take action to receive clinical assessment. Although some survivors of sexual assault do communicate the event to another person or take legal action, the public needs to be made aware of the detrimental effects of sexual

assault and assist survivors, because failure to properly recover from the trauma of sexual assault can lead to chronic, harmful, and long-term mental effects. In this paper, issues with the legal system, immediate neurobiological and psychological effects, and the psychopathological outcome will be addressed, with special focus on adolescent and adult women, to illustrate the necessary changes the public must adopt to avoid these outcomes for such victims.

Issues with the Legal System

The few cases reported to the legal system show little success in prosecution. Case attrition, or the failure to bring the accused to trial or conviction after an arrest, produces a problem in sexual assault. Campbell and colleagues (2012) assessed case attrition in rural to urban areas and found an average of 86% of cases are never referred by the police officer involved in the original reporting, which means a vast majority of reported cases were not charged or referred. In that same research, only 1–5% of cases reached trial and conviction (Campbell, 2012). As previously mentioned, less than 24% of cases are even reported to the police (Morgan & Oudekerk, 2019). These statistics raise the question: What is obstructing the criminal justice system from continuing investigations and prosecutions?

The first answer is that cases of sexual assault do not reach the criminal justice system because sexual assault is not easily defined or understood, especially by the public. *Rape myths*—a term described by Bohner (1998) as "descriptive or perspective beliefs about rape . . . that serve to deny, downplay, or justify sexual violence that men commit against women" (as quoted in Hine & Murphy, 2017, p. 1)—interfere with one's concept of what defines sexual assault. Perceiving what may be a true rape has become a stereotype typically involving a horror scene of a stranger, a weapon, and a dark setting, where the female victim blatantly resists (Hine & Murphy, 2017). The prominent cases that advance in the criminal justice system tend to "[involve] a weapon, full penetration, victim injuries, and crime co-occurrence" (Shaw et al., 2016, p. 447). However, this narrow scope excludes most cases. For example, one study with data collected from approximately 100 hospital emergency departments showed 24.2% of female victims

were raped by a friend or acquaintance (Loder & Robinson, 2020). Additionally, 45.6% of cases occurred within the victim's home, while only 4.0% occurred in the street (Loder & Robinson, 2020). Moreover, blame is focused back to the victim of sexual assault for their actions or behaviors (Greeson et al., 2016; Hine & Murphy, 2017; Shaw et al., 2016). When those in the public misunderstand what sexual assault consists of and consequentially blame the victim, survivors are deterred from pursuing criminal justice and the path to recovery.

As public misunderstanding continues, so does that of those involved in the criminal justice system. Rape myths impede police officers and prosecutors from believing the victims, which ultimately influences the product of reported cases (Hine & Murphy, 2017). The more a situation does not entail typical scenarios upheld in rape myths, the less likely it is that the investigation will continue (Hine & Murphy, 2017; Shaw et al., 2016). Believing that the rape myths extend to those experiencing sexual assault also leads the victimized women to not identify the event as a serious sexual assault (Hine & Murphy, 2017). Thus, rape myths and sexual assault misperceptions interfere both with victims reporting their cases and with the criminal justice system pursuing reported cases. By reckoning the event as not serious enough or not worthy of investigation, the victim forsakes the ordeal with self-blame and without support.

Unfortunately, both reporting and not reporting can be unfavorable for the victim. Primary relating is typically to a close relative or friend before additional disclosure occurs (Greeson et al., 2016). Again, due to misperception, initial contact can be less than supportive, as the victim can consequentially feel doubt, blame, lack of assistance, and so forth (Greeson et al., 2016). Contact with police officers or other officials can result in the same discouraging lack of support (Greeson et al., 2016). While some disclosures are positive and helpful to the victim, the negative experience marked by doubt and blame may result in what is called *secondary victimization*, or "the attitudes, beliefs, and behaviors of social system personnel that victims experience as victim blaming and insensitive" (Campbell, 2012, slide 12). It receives its name from the additional aggravation of the trauma, similar to undergoing yet another sexual assault

(Campbell, 2012). The rape myths and the discouragement from both close relations and police officers cause further damage, self-blaming of the victim, and worse conditions overall. Neither the police officers nor the public are to blame; the lack of understanding regarding the detrimental effects on the victim is to blame for the negative experience. The existence of such harmful experiences post-assault is worthy of attention and alteration.

Immediate Neurobiological and Psychological Effects of Sexual Assault

Perhaps the most misunderstood part of sexual assault is the immediate psychological and neurobiological effects from the severe trauma. This trauma begins during the event, not just following the event. The misunderstanding is evident during police interviews; the words and testimonies of victims are incomprehensible, the stories do not coincide, lying seems evident, and behavior is strange (Campbell, 2012). The ultimate solution is to combine the expertise of the criminal justice system with a psychological perspective so that a full explanation may be given (Campbell, 2012). This combination will assist the police and the legal system to understand the victims and promote a relationship between the victims and prosecution.

Adding a psychological perspective would incorporate the understanding of what happens to the brain and the mind during sexual assault. The brain and body are changed during the trauma of sexual assault—changes in both chemicals and functions (see Figure 1 in Appendix)—which can hinder proper memory coding. The amygdala and the hippocampus, brain structures that work to encode memories, are activated at the onset of stress or trauma. The hypothalamus, the pituitary gland, and the adrenal glands (HPA axis) are affected at the onset of stress detected by the hippocampus and amygdala, which trigger a release of several hormones in reaction to the trauma (Campbell, 2012). Catecholamine nuerotransmitters are released and send messages to the limbic system in preparation for fighting or fleeing and change the serotonin and neuroendocrine levels in the brain (Bovin et al., 2008; Campbell, 2012). Catecholamine temporarily deactivates rational thinking by the prefrontal cortex

due to circuit damage. Cortisol is also increased to mediate energy given to the adrenaline responses, along with opiates and oxytocin to prevent pain and negative feelings. The activated opiates that block pain are responsible for impeding emotional reactions as well. With the chemical changes in the brain, memory encoding does not proceed with proper function, but rather is fragmented, disorderly, or missing; however, the fragments can be gradually pieced together to rebuild proper recall of the event (Campbell, 2012).

These changes in overall function lead to more reactions of the brain and body. Without proper encoding, the memory of the traumatic event, in this case sexual assault, is incomprehensible. Recalling events, namely to police officers, is then more difficult than with a brain that is functioning normally. Incomprehensible and unstructured stories about the traumatic event can explain the disbelief of police officers or other individuals as it resembles dishonest and false reporting.

Tonic Immobility

The brain and body can react in more severe ways to the trauma than fragmented memory encoding. The fight-or-flight response is well understood, but adrenaline causes a third response, termed *freeze* (Abrams et al., 2009; Bovin et al., 2008; Campbell, 2012; Niermann et al., 2017; Roelofs, 2017). The freeze response is rigid stillness of the body, which increases awareness and senses in preparation for an attack (Bovin et al., 2008). Cortisol, the previously mentioned hormone, can decrease overall energy in the body, and, according to the research of Campbell (2012), it results in freezing to an extreme state called tonic immobility (TI). Other researchers, however, state that freezing is a preparatory response and not the same as TI, because TI occurs once fighting, fleeing, and freezing are not enough to safely escape a possibly fatal situation (Bovin et al., 2008; Roelofs, 2017). As a response controlled in the autonomic nervous system (Niermann et al., 2017), TI is an "evolutionary adaptive strategy" to escape and/or play dead in the presence of prey (Bovin et al., 2008, p. 402) but is effective at the onset of intense, excessive fear (Abrams et al., 2009; Campbell, 2012). The likeliness of experiencing TI increases

with interpersonal violence and trauma (Abrams et al., 2009). TI is marked by a state of complete paralysis and immobility (Abrams et al., 2009; Bovin et al., 2008; Campbell, 2012), and it has been defined as a "temporary state of motor inhibition" (Abrams et al., 2009, p. 550). The body is literally unable to respond during the attack, which refers not only to moving but also to calling out for help, thinking of how to escape, or producing logical responses (Bovin et al., 2008). The brain also typically transfers into trauma-mode and further blocks rational responses. This completely eliminates the possibility of executing actions of retrospectively desired changes (Campbell, 2012), meaning that even if the victims had wanted to take action, they would not have been able to do so. The brain responds to sexual assault with the reaction of TI because of the high level of trauma involved.

Some victims of sexual assault may experience TI, and such an experience can lead to worsening psychological conditions. Primarily, victims whose bodies respond with TI regain their logical thinking and rationalize multiple options of what could have occurred differently during the assault, leading to the eventual development of guilt (Abrams et al., 2009). Guilt converts to self-blame that triggers psychological disorders (Bovin et al., 2008) and is heightened with negative experiences related to disclosure to authorities (Greeson et al., 2016). Furthermore, TI and the accompanying neurobiological effects can enable PTSD symptoms, especially anxiety (Abrams et al., 2009; Bovin et al., 2008; Niermann et al., 2017; Roelofs, 2017). The explained neurobiological disruption behind TI may worsen the guilt, self-blame, and symptoms of PTSD. Therefore, psychopathological damage can increase during the trauma of sexual assault and exacerbate the need for seeking clinical help or therapy.

Reactions to Trauma and Acute Stress Disorder

While the body is reacting to the traumatic event, the brain causes other immediate reactions that are also detrimental to the mental health of victims (see Figure 1). Abrupt emotional reactions may include shock, panic, fear, sadness, grief, and/or anger. On the other hand, the avoidance reaction suppresses or denies the emotions in an

attempt to numb the mental pain. Typically, the victim experiences one or the other or starts emotional and turns to numbing the emotions. Both reactions lead to intrusion of horrific memories, images, or distress. Due to the intensity of trauma resulting from sexual assault, the emotional reaction can progress into terror, frantic behavior, confusion, and exhaustion; avoidance reactions can progress into maladaptation, emotional numbing, and withdrawal; and intrusion can progress to guilt, shame, despair, memory issues, obsessive thoughts, and compulsive repetitions. These progressions impair victims emotionally. Due to greater impairment, it is difficult to confide the details of the event to an individual, which then further delays healthy coping. If the immediate psychological reactions are not interrupted or if healthy coping remains blocked, victims are more susceptible to severe psychopathology (Heaps, 2000).

Long-Term Psychopathological Outcome

Psychopathology can develop from unhealthy coping from the neurobiological and psychological responses. For those who experience these responses following sexual assault, immediate assistance may not be easily attainable and the psychological effects from the trauma often lead to foregoing proper treatment. This causes a chain reaction, leading to developing psychological disorders (Heaps, 2000), all of which appear to be more prominent among those who have experienced sexual assault (Thompson et al., 2003). PTSD, borderline personality disorder, somatoform disorders, and dissociative and conversion disorder are considered to be connected regulation of trauma and emotions (del Río-Casanova et al., 2016). Emotional regulation, a byproduct of trauma previously discussed, connects the trauma to psychopathology (del Río-Casanova et al., 2016). If the assault involves more violence, the victim is subsequently more sensitive to developing psychopathology, as are those who are abused by a person with a familiar relationship (Gokten & Duman, 2016). The effects of sexual assault are not allotted to the timeframe of the event, nor even to a period of a few weeks; these disorders are complex and may require long-term clinical assessment for improvement.

Serious mental disorders are not the ultimate fate of all survivors of sexual assault, however. Personality factors and previous experience of extreme stress may support healthy coping skills, which can then continue as one copes with the distress and trauma of sexual assault (Regher & Marziali, 1999). Positive attachments and other advantages of a functional family life aid in developing healthy coping skills under stress, whereas familial dysfunction is typically detrimental to coping skills and personality factors (Regher & Marziali, 1999). Nevertheless, experiencing sexual assault appears to increase the possibility of mental disorders.

In order to avoid the development of mental disorders, coping skills are vital to recovery after sexual assault, but the stress can be excessive and can transcend the scope of self-help. Healthy coping skills start with approaching the intruding distress, followed by reflection and a coherent resolution (Heaps, 2000). The victim's first cry for help is not always successful, as established previously, and the healthy coping skills may be unattainable (Heaps, 2000). Suppressing the emotional and avoidance reactions may lead to unhealthy coping (Heaps, 2000); therefore, urgent assistance should be available to the victim to promote recovery and repress psychopathology.

Post-Traumatic Stress Disorder

Trauma is commonly followed by the onset of PTSD given the neurobiology of sexual assault, but the likelihood of developing it is higher for victims of sexual assault—more so than other forms of traumatic events (Walsh & Bruce, 2014). Elements of sexual assault promote PTSD, especially the following: severity, physical injury, number of occurrences, self-blame, and avoidance coping (Ullman et al., 2007). Related to TI, symptoms of PTSD such as anxiety and flashbacks are heightened from the trauma of sexual assault (Abrams et al., 2009; Bovin et al., 2008); in fact, symptoms of TI resemble those of PTSD (Bovin et al., 2008). The reoccurrence of symptoms increases chances of a diagnosis of PTSD, while avoidance decreases chances (Walsh & Bruce, 2014). The symptoms of PTSD occur nearly instantaneously and persist until clinical assistance can reverse the progression of the disorder.

Although PTSD is not unavoidable in cases of sexual assault and is a serious issue, it can be effectively treated. Along with studies indicating PTSD is an inevitable outcome are contrary studies that show how quickly symptoms of PTSD can subside (Regher & Marziali, 1999). The issue following the event is still prominent, because the symptomatology of PTSD remains chronic for women who do not see results of quick improvement (Regher & Marziali, 1999). Even so, PTSD symptoms are 6–7 times more common for those who have experienced trauma of sexual assault, whether in childhood, adulthood, or both (Thompson et al., 2003). The symptoms of arousal and avoidance were respectively 2–3 times higher for victims of sexual trauma that those with other forms of trauma (Thompson et al., 2003). Recovery from PTSD is possible for victims of sexual assault, yet for some, the symptoms may still be present and require clinical assessment for proper coping.

Other Disorders

Psychological disorders tend to occur simultaneously, which is referred to as comorbidity; disorders following sexual assault are no exception. The psychological impact of sexual assault brings many problems, including the possibility of depression, alcohol abuse or dependence, and more (Walsh & Bruce, 2014). Heaps (2000) outlines the possible outcome of disorders from sexual assault once aspects of healthy coping are blocked: sleep problems, anxiety, depression, psychosomatic disorders, and personality difficulties. This list is not all-inclusive but rather includes some of the singular and comorbid possibilities (Heaps, 2000). The neurobiology and psychology of sexual assault is complex and so is the psychopathological effect on the victims, so the resulting disorders commonly intertwine a web of comorbidity.

"I Believe You"

For those who choose to report or disclose a sexual assault, victims can experience difficulties with both loved ones and the legal system, which may lead to self-blame. A university campus study showed that individuals who tend to accept rape myths are less likely to offer support or aid in obtaining resources than their counterparts with

feminist ideals (Holland et al., 2020). Frequently, upon hearing that the victim didn't try to fight back, that they did not think through the situation, or that the story is incomprehensible, one tends to not believe the victim (Campbell, 2012; Shaw et al., 2016). The self-blame worsens into more detrimental psychopathology if left unattended (Bovin et al., 2008). Negative responses from any person can cause further detriment to the victim.

If the initial response at disclosure were positive, many harmful mental disorders could be avoided or properly treated. This is the hope and the purpose of the "Start by Believing" campaign. In essence, the campaign educates the public on how to respond to victims in the moment of disclosure ("What to Say," n.d.). "Start by Believing" gives four simple tips to the public for avoiding worsening the situation and ultimately avoiding second victimization ("What to Say," n.d.). The first tip is implied from the name of the campaign: start by believing, which means not reacting with doubt or blame but rather replying with "I believe you" ("What to Say," n.d.). The following tips instruct on giving supportive responses, avoid asking why, and assist in seeking help ("What to Say," n.d.). By applying the principles of this initiative, the public can help a victim of sexual assault if the detrimental effects are generally known. Greeson et al. (2016) examined adolescent and adult female survivors to show that the majority disclosed the sexual assault to a family member or friend. The disclosure is where recovery may begin, and it depends upon the individual being informed and aware. Understanding the immediate reactions of the brain and mind and knowing the possible outcomes of mental disorders can prevent the development of long-term issues and aid in facilitating recovery following sexual assault.

Conclusion

Unbeknownst to most of society, a victim of sexual assault experiences many negative outcomes from their trauma. At the detection of danger, the body releases hormones and activates the autonomic nervous system, while causing increased anxiety, loss of rational thinking, and inability to form coherent memories (Campbell, 2012; Niermann et al., 2017). Immediately following the event and its

neurobiological effects are emotional or avoidance reactions from the extreme trauma (Heaps, 2000). These outcomes may escalate into long-term mental disorders (Heaps, 2000). Neurobiological and psychological reactions of sexual assault are not commonly known but are a prominent factor of the long-term mental health of victims.

The combination of neurobiological, emotional, and social pressures often leads victims to fail to report. While each individual may have their own reasons for not reporting, research has shown that reasons can stem from the psychological damage of the trauma (Walsh & Bruce, 2014). Roughly one fourth of sexual assault victims report the crime to the police, and an even smaller fraction of those reports continue in the legal system (Campbell, 2012; Morgan & Oudekerk, 2019). Rape myths remain an impediment to reporting because an act of sexual assault that does not match the myths are not considered seriously (Greeson et al., 2016; Hine & Murphy, 2017; Shaw et al., 2016). Additionally, the neurobiology that inhibit coherent memories and the ability to react leaves room for blaming the victim for lying about it and not escaping. Many factors can play a role in failure to report, but properly understanding the effects of sexual assault may help victims report and at least receive treatment.

Along with being unaware of the effects of sexual assault on victim, one may not know how to help a victim and effectively facilitate recovery. Responding with belief and support, seeking professional help, and avoiding blaming questions can aid in victims' recovery ("What to Say," n.d.). Extreme mental disorders may not be the fate for each victim. Nevertheless, not all victims receive the help they need or the support from those around them. Exacerbation of the trauma can be replaced with healing by understanding the possible effects and believing the victims of sexual assault.

References

Abrams, M. P., Hons, B. A., Carleton, R. N., Taylor, S., & Asmundson, G. J. G. (2009). Human tonic immobility: Measurement and correlates. *Depression and Anxiety*, 26(6), 550–556.

Bak-Klimek, A., Karatzias, T., Elliott, L., Campbell, J., Pugh, R., & Laybourn, P. (2014). Nature of child sexual abuse and psychopathology in adult

survivors: Results from a clinical sample in Scotland. *Journal of Psychiatric and Mental Health Nursing, 21*(6), 550–557.

Bovin, M. J., Jager-Hyman, S., Gold, S. D., Marx, B. P., & Sloan, D. M. (2008). Tonic immobility mediates the influence of peritraumatic fear and perceived inescapability on posttraumatic stress symptom severity among sexual assault survivors. *Journal of Traumatic Stress, 21*(4), 402–409.

Campbell, R. (2012). *Neurobiology of sexual assault* [PowerPoint slides]. Retrieved from https://nij.gov/multimedia/presenter/presenter-campbell/Pages/welcome.aspx

del Ro-Casanova, L., Gonzlez, A., Pramo, M., Van Dijkea, A., & Brenlla, J. (2016). Emotion regulation strategies in trauma-related disorders: Pathways linking neurobiology and clinical manifestations. *Reviews in the Neurosciences*, 27(4), 385–395.

Gokten, E. S., & Duman, N. S. (2016). Factors influencing the development of psychiatric disorders in the victims of sexual abuse: A study on Turkish children. *Children and Youth Services Review, 69*, 49–55.

Greeson, M. R., Campbell, R., & Fehler-Cabral, G. (2016). 'Nobody deserves this': Adolescent sexual assault victims' perceptions of disbelief and victim blame from police. *Journal of Community Psychology*, 44(1), 90–110.

Heaps, R. A. (2000). *Understanding and coping with painful, traumatic, or hurtful events.* Paper presented at the annual Utah State Mental Health Convention, Provo, UT.

Hine, B., & Murphy, A. (2017). The impact of victim-perpetrator relationship, reputation and initial point of resistance on officers' responsibility and authenticity ratings towards hypothetical rape cases. *Journal of Criminal Justice*, 49, 1–13.

Holland, K. J., Gustafson, A. M., Cortina, L. M., & Cipriano, A. E. (2020). Supporting survivors: The role of rape myths and feminism in university resident assistants' response to sexual assault disclosure scenarios. *Sex Roles, 82*, 206–218.

Loder, R. T., & Robsinson, T. P. (2020). The demographics of patients presenting for sexual assault to US emergency departments. *Journal of Forensic and Legal Medicine, 69*, 1–13.

Morgan, R. E., & Oudekerk, B. A. (2019). Crime victimization, 2018. *Bureau of Justice Statistics, NCJ 253043*, 1–37.

Niermann, H. C., Figner, B., & Roelofs, K. (2017). Individual differences in defensive stress-responses: The potential relevance for psychopathology. *Current Opinion in Behavioral Sciences, 14*, 94–101.

Regehr, C., & Marziali, E. (1999). Response to sexual assault: A relational perspective. *Journal of Nervous and Mental Disease, 187*(10), 618–623.

Roelofs, K. (2017). Freeze for action: Neurobiological mechanisms in animal

and human freezing. *Philosophical Transactions of the Royal Society B: Biological Sciences*, 372(1718).

Shaw, J., Campbell, R., & Cain, D. (2016). The view from inside the system: How police explain their response to sexual assault. *American Journal of Community Psychology*, *58*(3–4), 446–462.

Start by Believing. (n.d.). *What to Say*. Retrieved from http://www.startbybelieving.org

Thompson, K. M., Crosby, R. D., Wonderlich, S. A., Mitchell, J. E., Redlin, J., Demuth, G., . . . Haseltine, B. (2003). Psychopathology and sexual trauma in childhood and adulthood. *Journal of Traumatic Stress*, *16*(1), 35–38. https://doi.org/1022007327077

Trauma. (n.d.). In *Online Etymology Dictionary*. Retrieved from https://www.etymonline.com/word/trauma

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(1), 23–37. https://doi.org/10.1111/j.1471-6402.2007.00328.x

Walsh, R. M., & Bruce, S. E. (2014). Reporting decisions after sexual assault: The impact of mental health variables. *Psychological Trauma: Theory, Research, Practice, and Policy*, *6*(6), 691-699. https://doi.org/10.1037/a0036592

Appendix

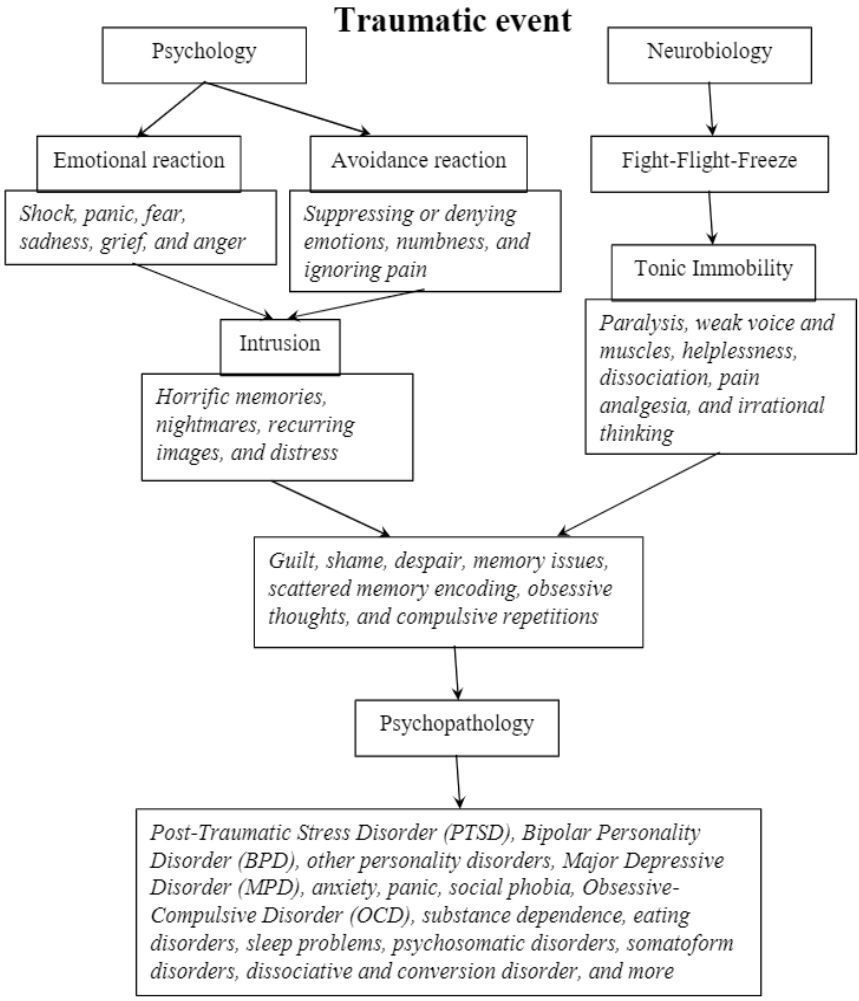

Figure 1. Flow chart of trauma leading to psychopathology. This figure maps out the psychological and neurobiological effects as they advance to psychopathology. Adapted from Abrams et al. (2009); Campbell (2012); del Río-Casanova et al. (2016); Heaps (2000); and Walsh & Bruce (2014).