

‘WAITING FOR THE COLD TO END’: A QUALITATIVE EXPLORATION OF  
PHOTOVOICE AS A THERAPEUTIC INTERVENTION FOR SURVIVORS OF  
SEXUAL ASSAULT

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A Dissertation  
presented to  
the Faculty of the Graduate School  
at the University of Missouri-Columbia

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In Partial Fulfillment  
of the Requirements for the Degree  
Doctor of Philosophy

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by  
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May 2015

## FACULTY APPROVAL

The undersigned, appointed by the dean of the Graduate School,  
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‘WAITING FOR THE COLD TO END’: A QUALITATIVE  
EXPLORATION OF PHOTOVOICE AS A THERAPEUTIC  
INTERVENTION FOR SURVIVORS OF SEXUAL ASSAULT

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*This dissertation is dedicated to the nine women who bravely shared their stories with me. It took great courage to be so vulnerable, and I have no words to express my gratitude. I would like to also dedicate this dissertation to my daughter, Lennon, for she reminds me that there is goodness in the world, and provides hope for a better future for women and girls.*

## ACKNOWLEDGMENTS

I acknowledge with wholehearted thanks, my doctoral advisor, Dr. Kim Anderson, without whom this dissertation would have never been started, nor completed. This work is only a small representation of my graduate journey, marked by invaluable clinical and research experience. I am indebted to her, and the many other individuals involved in this process.

I would like to also thank my committee for their guidance, and for helping me reach this point in my academic journey. Thank you, University of Missouri Relationship and Sexual Violence Prevention (RSVP) Center, for providing the space and time to do this important and necessary work.

Lastly, I would be remiss if I did not thank my friends and family – most importantly, my wife – for their love and support throughout my graduate education, and this dissertation. I am the woman, and scholar, I am today because of these support networks.

## TABLE OF CONTENTS

Acknowledgements.....	ii
List of Tables.....	vii
List of Figures.....	viii
Abstracts.....	ix
Chapter 1.....	1
Background.....	1
Definition, Prevalence, and Risk Factors.....	3
Definition.....	3
Prevalence.....	4
Risk Factors.....	4
Male Sex Role Socialization.....	4
Involvement in University Greek Life.....	5
Alcohol Consumption.....	5
Media Portrayal of Sexual Assault.....	5
Bio-psycho-social Consequences of Sexual Assault.....	6
Physical Consequences.....	6
Psychological Consequences.....	7
Social Consequences.....	8
Sexual Assault Recovery.....	8
Summary.....	9
Significance of Study.....	10
Purpose of Study and Research Questions.....	10
Dissertation Overview.....	11
Chapter 2.....	12
Literature Review.....	12
Posttraumatic Stress Disorder (PTSD).....	12
PTSD Etiology – Theoretical Assumptions.....	13
Other Psychological Outcomes of Sexual Assault.....	15
Depression.....	15
Self-blame.....	16
Social Learning Theory and Trauma Response.....	17
Behaviorist Principles.....	17
Cognitive Principles.....	22

Systematic Review of Evidence-Based Interventions.....	22
Stress Inoculation Therapy (SIT).....	24
Prolonged Exposure Therapy (PE).....	25
Cognitive Processing Therapy (CPT).....	26
Eye Movement Desensitization and Reprocessing (EMDR).....	26
Supportive Counseling.....	27
Gaps in Treatment Literature for Sexual Assault Survivors.....	28
Posttraumatic Growth.....	29
Introduction of PhotoVoice.....	30
Connecting PhotoVoice to Cognitive and Behavioral Frameworks.....	30
History and Purpose of PhotoVoice.....	31
Theoretical underpinnings of PhotoVoice.....	32
PhotoVoice as a Therapeutic Intervention for Sexual Assault Survivors.....	34
Meaning-making and PhotoVoice.....	35
Narrative Theory and the PhotoVoice Process.....	36
Behaviorism and PhotoVoice.....	38
Conceptual Insights.....	39
Chapter 3.....	42
Research Methods.....	42
Participants.....	42
Informed Consent.....	42
Protection of Human Subjects.....	42
Potential Risks.....	42
Research Design.....	43
Study Research Aims, Questions, and Hypothesis.....	44
Hypothesis.....	44
Sampling Procedure.....	44
Sample.....	44
Intervention Procedure.....	45
Telephone Initial Inquiry.....	45
Pre-screening.....	45
Inclusion criteria.....	46
Orientation.....	46
Focus Groups.....	47
Exhibit Planning Focus Group.....	48
PhotoVoice Exhibits.....	49
Data Collection Procedure.....	50
Recruitment.....	50
Data Collection Points.....	51
Qualitative Instruments.....	51
SHOWeD Instrument.....	51
Individual Interview Instrument.....	52
Quantitative Instruments.....	52
Concept: Posttraumatic Stress Disorder.....	52

Concept: Posttraumatic Growth.....	53
Concept: Positive Rape Attributions.....	54
Analytical Strategy.....	55
Qualitative Analytical Methods.....	55
Coding.....	55
Qualitative Methodological Rigor.....	56
Quantitative Analytical Methods.....	59
Summary.....	59
Chapter 4.....	60
Demographics.....	60
Qualitative Results.....	61
Photo Taking: Exposure to Triggers.....	62
SHOWeD Discussion: Meaning Making and Reauthoring.....	67
Group Process: Relationship Building.....	77
Photo Exhibit: Consciousness Raising.....	83
Summary of Qualitative Results.....	90
Quantitative Results.....	91
Symptoms of PTSD.....	91
Posttraumatic Growth.....	93
Rape Attributions.....	95
Summary.....	96
Chapter 5.....	98
Discussion.....	98
Implications.....	100
Implications for Practice.....	100
Implications for Policy.....	102
Implications for Research.....	103
Limitations.....	104
Conclusion.....	105
References.....	108
Appendices.....	117
Appendix A. Participant Demographics.....	117
Appendix B. Consent Form.....	121
Appendix C. Phone Interview.....	126
Appendix D. Consent with Waiver of Documentation.....	128
Appendix E. Phone Consent Form.....	131
Appendix F. Recruitment.....	132
Appendix G. Individual Interview.....	134
Appendix H. Posttraumatic Stress Disorder Checklist for Civilians (PCL-C).....	135
Appendix I Posttraumatic Growth Inventory (PTGI).....	139
Appendix J. Rape Attribution Questionnaire (RAQ).....	142

Appendix K. Reduced Codes.....144

Vita.....146

## LIST OF TABLES

	PAGE
Table 1. Demographics of Sample.....	61
Table 2. T-test Results Comparing Pretest and Posttest Scores of PCL-C...	93
Table 3. T-test Results Comparing Pretest and Posttest scores for Factor 1: Relating to Others.....	94
Table 4. T-test Results Comparing Pretest and Posttest Scores for Personal strength.....	94
Table 5. T-test Results Comparing Pretest and Posttest Scores for Behavioral Self-blame.....	95
Table 6. T-test Results Comparing Pretest and Posttest Scores for Control Over Recovery.....	96

## LIST OF FIGURES

	PAGE
Figure 1. Theoretical Model of PhotoVoice as a Therapeutic Intervention.....	41
Figure 2. Research Design.....	43
Figure 3. Powerless.....	64
Figure 4. Anxiety Shuttle.....	65
Figure 5. Always Around.....	66
Figure 6. Nothing Lost.....	68
Figure 7. Succulent.....	69
Figure 8. A Word With No Meaning.....	70
Figure 9. Waiting for the Cold to End.....	71
Figure 10. Latina Prayers.....	72
Figure 11. A Moment of Peace.....	73
Figure 12. Objectified.....	74
Figure 13. Invisible.....	75
Figure 14. Under Construction.....	76
Figure 15. Alone.....	77
Figure 16. Time Brings Strength and Healing.....	80
Figure 17. I've Got Your Back.....	81
Figure 18. Petra.....	82
Figure 19. Support.....	83
Figure 20. One of Many Hard Days.....	84
Figure 21. Three Hours of Hell.....	85
Figure 22. Strength.....	87
Figure 23. Vulnerable.....	88
Figure 24. Fearless Leader.....	89
Figure 25. Therapeutic Journey.....	90
Figure 26. Participant's Average PCL-C Scores Over Seven Weeks of PhotoVoice	92
Figure 27. Mean PCL-C Scores Across Seven Weeks of PhotoVoice.....	93

## ABSTRACT

Sexual assault has reached epidemic proportions, and disproportionately affects college-aged women. Posttraumatic Stress Disorder (PTSD) is the most commonly associated mental health disorder associated with sexual assault. There are many scientifically proven successful interventions for treating PTSD among survivors; however, these interventions fail to address posttraumatic growth as a form of recovery. Research states that without posttraumatic growth, symptoms associated with PTSD will continue to surface. This study explored PhotoVoice – a participatory action research method – as a brief therapeutic intervention for survivors of sexual assault. The purpose of this research was to examine how PhotoVoice allowed survivors to grow post-trauma as they reconstructed their identities through a process of cognitive restructuring, exposure, and narrative group work. Nine women participated in PhotoVoice, and each woman was given a camera to photograph images that represented her sexual assault, or healing experiences. They met together three times to discuss their photos. A semi-structured questionnaire was used to guide the discussion. Each group held an exhibit where they displayed their photos and invited attendees. Qualitative results showed that participants were able to confront their triggers through a process of exposure, as well as address their negative distortions through cognitive reframing and meaning-making. The exhibits allowed participants to reclaim control over their self-narratives, as well as educate stakeholders about the traumatic impacts of sexual assault at a Midwestern university. Quantitative results revealed a decrease in symptoms of PTSD, as well as an increase in posttraumatic growth and positive rape attributions.

## CHAPTER 1—INTRODUCTION

### **Background**

In the United States, colleges and universities are facing an epidemic of sexual assault, with approximately 20-25% of college females experiencing rape during their academic tenure (often by someone known to them) (Fischer, Cullen, & Turner, 2000; Krebs et al., 2007). For every 1,000 college women attending university, there are approximately 35 incidents of rape or sexual assault (Krebs et al., 2007). The essence of sexual assault is that you are acted upon against your will. In turn, powerlessness—the experience of being without options—is the hallmark of traumatic experiences (Herman, 1997). In most cases the lasting, major damage caused by rape is emotional and psychological, but for some college women, experiencing sexual assault has lasting impacts on their academic trajectory, including a decline in academic performance, needed time off from school, transfer of schools or departments, or even dropping out of college all together (Loya, 2012). In general, when you factor in medical care, police response, and mental health services, the annual cost of intimate violent crime (e.g., rape, sexual assault, and physical assault) is roughly 127 billion dollars, making it the costliest crime in the United States (U.S.; Miller, Cohen, & Wiersema, 1996).

Experienced with differing frequency and with widely varying severity, the harms caused by trauma diminish and debilitate countless sexual assault survivors' lives. Common problems include substance abuse, self-injury, depression, suicide, violence against others, shame, chronic fear, eating disorders, anxiety, dysfunctional relationships, and physical illness (Campbell, Dworkin, & Cabral, 2009; Chen et al., 2010; Jewkes, Sen, & Garcia-Moreno, 2002; Silverman, Raj, Mucci, & Hathaway, 2001; Tomasula,

Anderson, Littleton, & Riley-Tillman, 2012; Yuan, Koss & Stone, 2006). Furthermore, sexual assault experiences may lead to chronic psychological distress (i.e., PTSD, social avoidance, traumatic distress). Sexual assault survivors who develop posttraumatic stress disorder (PTSD) are at further risk for increased suicide attempts, hospitalizations, and substance abuse (Silverman, Raj, Mucci, & Hathaway, 2001). These problems are all associated with an increased use of health/mental health resources (Campbell, Dworkin, & Cabral, 2009). Consequently, as a result of experiencing sexual assault, college females may exhibit significant impairment in their bio-psycho-social functioning if not addressed in mental health treatment or in their natural environment.

Two standard types of cognitive-behavioral treatments exist for clinicians to use with clients who suffer from PTSD: exposure procedures and anxiety management training (Bisson et al., 2007; Regehr, Ramona, Dennis, Pitts, & Saini, 2013). Interventions incorporating both behavioral and cognitive techniques are considered “the gold standard” to treating symptoms of PTSD among sexual assault survivors, yet research suggests that many women do not fully respond to these treatments as symptoms continue to resurface over time (Leiner, Kearns, Jackson, Astin, & Rothbaum, 2012). In addition, these interventions are not specifically designed to foster posttraumatic growth and empowerment. In other words, they may reduce post-trauma symptoms in the short-run, but not necessarily impact one’s sense of power in regard to their recovery and, ultimately, their lives. Furthermore, there is limited focus beyond the individual treatment modality in cognitive and behavioral interventions with minimal, if any, focus on oppression and its consequences (e.g., powerlessness). Yet, group work is shown to

reduce symptoms of PTSD while increasing social connection and power for female survivors of sexual assault (Schnurr et al., 2003).

This study's primary aim is to explore the use of PhotoVoice as a therapeutic intervention with college females, ages 18 to 34, who are survivors of sexual assault/rape and are symptomatic for PTSD. The methods of PhotoVoice (e.g., picture-taking of social injustices, group collaboration and exhibits with key stakeholders to affect social change) offer strategies of empowerment at a personal level (changing patterns of thinking, behaving and feeling), interpersonal level (managing their relationships more effectively), and societal/organizational level (affecting system change) to improve sexual assault survivors' lives and contribute to their overall recovery and growth (Wang, 1999; Wang & Burris, 1997).

### **Definition, Prevalence and Risk Factors**

#### **Definition**

Sexual assault is commonly defined as any type of sexual contact or behavior that occurs without the explicit consent of the recipient. It includes forced sodomy, child molestation, incest, fondling, attempted rape, and forced sexual intercourse or contact without consent (United States Department of Justice [USDOJ], 2014). Rape is included within the continuum of sexual assault and is defined by the Federal Bureau of Investigation (FBI) as any penetration with any body part (sexual or non-sexual) perpetrated against a victim without explicit consent (FBI, 2013). For this dissertation, sexual assault is defined as any type of unwanted sexual contact or behavior that occurs without consent from the recipient.

Though incidents of sexual assault and rape disproportionately impact women, males are also victims of these horrific crimes, and often face significant challenges in

seeking services for their trauma. Although sexual violence impacts both genders, this dissertation addresses female survivors' experiences with sexual assault who are students at a public Midwestern University.

### **Prevalence**

In their comprehensive report on the prevalence and incidence of violence against women, Tjaden and Thoennes (2006) state that one out of every six women will experience some sort of rape, or attempted rape, in their lifetime. Black and colleagues (2011) found that 37.4% of female rape victims are between the ages of 18 and 24—the age of most college women—while Gross and colleagues (2006) report 27% of college women experience unwanted sexual contact during their academic tenure. Risk factors for college-aged sexual assault include: 1) negative gender-based social influence (i.e., male sex-role socialization) (Carr & VanDeusen, 2004), 2) involvement in University Greek Life (Tyler, Hoyt, & Whitbeck, 1998), 3) alcohol consumption (Silverman, Raj, Mucci, & Hathaway, 2001), and media portrayal of sexual assault as “stranger danger” (Fisher, Cullen, & Turner, 2000).

### **Risk Factors**

**Male sex role socialization.** When males are socialized to be dominant over females it may involve negative sexual beliefs or even myths about rape that lead to sexual aggression (Carr & VanDeusen, 2004; Rozee & Koss, 2003). In addition, male peer support for campus sexual violence creates the notion that men are entitled to sex, which further exacerbates coercive sexual practices (Carr & VanDeusen, 2004). All male campus groups such as fraternities, or even athletics, are highly concentrated organizations that may provide male support for hyper masculine beliefs that perpetuate

rape myths and sexual aggression (Carr & VanDeusen, 2004). These hypermasculine environments leave many college women vulnerable to rape, as these myths and beliefs about women are commonly accepted and supported by peers and even campus administrators.

**Involvement in University Greek life.** Participating in University Greek life is another risk factor for sexual assault or rape on college campuses, as these organizations are historically known for supporting hyper-masculine beliefs that perpetuate rape myths (Carr & VanDeusen, 2004). Furthermore, when compared to their non-fraternity male counterparts, fraternity men are identified as more likely to commit sexual assaults on college campuses (Tyler, Hoyt, & Whitbeck, 1998) with 10.3% of college sexual assaults occurring in fraternity homes (Black et al., 2011).

**Alcohol consumption.** Alcohol consumption is considered another key risk factor for college-age sexual assaults, with at least 50% of college student sexual assaults being associated with alcohol (Koss & Dinero, 1989) including 90% of college acquaintance rapes (Abbey, 2002). While alcohol consumption should never be used to blame a survivor of sexual assault for their experience, it can serve to disinhibit and lower a woman's detection of risk for sexual aggression (Abbey, 2002; Carr & VanDeusen, 2004).

**Media portrayal of sexual assault as "stranger danger".** The mainstream media portrayal of sexual assault as "stranger danger" is another risk factor for sexual assault, even though we know that it is statistically not the case, as the majority of these crimes are committed by acquaintances (Fisher et al., 2000). A risk factor, consequently, may include believing that one cannot be raped by someone who is known, creating a

false sense of safety with male friends and acquaintances. Fisher and colleagues (2000) found that 90% of college-aged victims reported knowing their perpetrator, suggesting that this person could be a friend, or even an intimate partner. In addition, a study looking at sexual victimization of college-aged women revealed that of the survivors sampled, 60% reported their sexual assault occurred in their residence by someone they knew and trusted (Fisher et al., 2000).

### **Bio-Psycho-Social Consequences of Sexual Assault**

#### **Physical Consequences**

Research suggests that survivors of rape and sexual assault often suffer from a myriad of physical consequences including chronic pain, stomach disorders, headaches, migraines, sexually transmitted infections, and other genital injuries (Campbell, et al., 2002; Coker, Hopenhayn, DeSimone, Bush & Crofford, 2008; Jewkes & Garcia-Morenom 2002). There are over 32,000 rape-related pregnancies every year, with a large majority of these pregnancies existing in women who are in sexually abusive relationships (Holmes, Resnick, Kilpatrick & Best, 1996; McFarlane, Malecha, Watson, et al., 2005). Gynecological problems are common for survivors of sexual assault and rape, which can often lead to life-altering complications if left untreated (e.g., infertility, pelvic inflammatory disease, etc.) (Campbell, et al., 2002; Coker, Hopenhayan, DeSimone, Bush & Crofford, 2008; Jewkes & Garcia-Morenom 2002). Fisher and colleagues (2000) found that a large majority of college sexual assaults result in physical injury (e.g., bruises, black-eye, cuts, scratches, swelling, chipped teeth, etc.). Because many survivors of sexual assault use alcohol and drugs as a way to dissociate from the memory, if used in abundance, these coping techniques may also have lasting physical

consequences for survivors (e.g., liver disease, stomach problems, etc.; Acierno et al., 2010; Silverman, Raj, Mucci, & Hathaway, 2001). Such physical consequences can potentially impact a student's ability to learn and focus in school.

### **Psychological Consequences**

Psychological consequences of rape include: rape-related fears, major depressive episodes, suicide (attempts and completed suicides), shock, denial, self-blame, anxiety, social withdrawal, and nervousness (Campbell, Dworkin & Cabral, 2009; Chen et al., 2010; Frazier, Mortensen & Steward, 2005; Nixon, Resick, & Griffin, 2004; Miller, Markman, & Handley, 2007; Tomasula, Anderson, Littleton & Riley-Tillman, 2012; Yuan, Koss & Stone, 2006). These trauma aftereffects are commonly associated with maladaptive thinking (e.g., self-blame) and coping techniques (e.g., substance abuse), which could potentially put one at risk for re-victimization, and thus re-traumatization (Kilpatrick, Acierno, Resnick, Saunders, & Best, 1997).

Such psychological consequences may linger and lead to PTSD, including symptoms related to re-experiencing the trauma (e.g., flashbacks, nightmares), hypervigilance, emotional numbing, and avoidance of trauma reminders. Posttraumatic Stress Disorder is highly associated with sexual assault survivors (discussed more fully in chapter two) (Campbell et al., 2009; Kilpatrick, Saunders, Amick-McMullan, Best, Veronen, & Resnick, 1989; Zinzow, Resnick, Amstadter, McCauley, Ruggiero, & Kilpatrick, 2010). In addition to PTSD, survivors of sexual assault may experience other psychological consequences such as depression and self-blame.

### **Social Consequences**

The social consequences of rape are also significant. Survivors, who are living with the aftereffects of trauma, tend to decrease their contact with friends and relatives, lessening emotional support from these social networks (Golding, Wilsnack, & Cooper, 2002). Thus, survivors of sexual assault are left feeling isolated, or ostracized because of their experience. This isolation can potentially perpetuate more avoidant behaviors, which exacerbates the psychological impacts of rape, such as PTSD (Golding, Wilsnack, & Cooper, 2002).

### **Sexual Assault Recovery**

Recovery can be defined as a personal process of changing one's beliefs, values, feelings, and goals through finding new meaning in life (Song & Shih, 2010). In the process of recovery, some individuals report personal growth or positive changes beyond their previous level of functioning, a process referred to as posttraumatic growth (PTG). Personal growth in the aftermath of sexual trauma does not imply the absence of pain, but rather recognizes the human capacity of individuals to recover and experience new areas of growth following their struggles to heal from trauma (Tedeschi, Park & Calhoun, 1998)

A central component in the experience of trauma is powerlessness, or the loss of individual power and control (Herman, 1997; Rosenbloom & Williams, 2010). "Traumatic events overwhelm the ordinary systems of care that give people a sense of control, connection, and meaning" (Herman, 1997, p. 32). Although interventions incorporating both behavioral and cognitive techniques are considered "the gold standard" to treating symptoms of PTSD (discussed more fully in chapter two) for sexual assault survivors, these interventions are not specifically designed to foster posttraumatic

growth and empowerment. The methods of PhotoVoice (e.g., picture-taking of social injustices, group collaboration, exhibits with key stakeholders to affect social change) offer strategies of empowerment at a personal level (changing patterns of thinking, behaving and feeling), interpersonal level (managing their relationships more effectively), and societal/organizational level (affecting system change) to improve sexual assault survivors' lives and contribute to their overall recovery and growth (Wang, 1999; Wang & Burris, 1994). An empowerment strategy is as an activity that contributes to “a process of increasing personal, interpersonal, or political power so that an individual can take action to improve their life situations” (Gutierrez, Parsons, & Cox, 1998, p. 45). In terms of PhotoVoice, empowerment encompasses increased self-esteem, increased self-confidence, better critical thinking, and enhanced control (Teti, Pichon, Kabel, Farnan & Binson, 2013).

### **Summary**

Sexual assault occurs on college campuses at epidemic rates, and has lasting effects on survivors' bio-psycho-social functioning (Fisher, et. al, 2000; Krebs et al., 2007; Tjaden & Thonnes, 2006). Posttraumatic stress disorder (PTSD) is one of the primary psychological disorders associated with sexual assault, and it manifests in the form of re-experiencing the trauma, avoidance, and hypervigilance (Lang et al., 2003; Herman, 1997). The symptoms associated with sexual assault—specifically, symptoms of PTSD—can affect a students' academic trajectory (Loya, 2012). Gold standard interventions designed to treat PTSD have cognitive and behavior aspects, yet lack components of posttraumatic growth, which is argued as essential in overall healing and recovery from sexual assault (Leiner et al., 2012; Regehr et al., 2013). Interventions

designed to foster a sense empowerment and posttraumatic growth are necessary for survivors to not only address negative thoughts and feelings associated with their trauma, but also allow survivors to make meaning of their experience, and regain control over their lives, and their recovery. PhotoVoice is a tool designed to increase one's ability to better understand their circumstances, while educating stakeholders and social supports, which can lead to recovery and healing (Teti et al., 2013; Wang, 1999; Wang & Burris, 1994).

### **Significance of study**

The chapter introduced the significance, relevance, and prevalence of sexual assault for female college students. Consequences of sexual assault were presented to highlight the effects on survivors' lives and the need to provide effective interventions to ameliorate symptoms and enhance well-being. Interventions that include multiple intervention modalities, as with PhotoVoice (e.g., group, phototaking, exhibits), have the ability to enhance empowerment and change on personal, intrapersonal, and system levels.

### **Purpose of Study and Research Questions**

The study's primary aim is to explore the use of PhotoVoice as a therapeutic intervention with female survivors of sexual assault, ages 18 to 34, attending a Midwestern University who are symptomatic for PTSD. Qualitative research questions include:

1. What change does PhotoVoice produce in survivors of sexual assault?
2. How does PhotoVoice evoke change for survivors of sexual assault?

The study's secondary aim is to assess psychological change pre- and post- PhotoVoice intervention. The quantitative hypothesis is: PhotoVoice will decrease PTSD symptoms and increase posttraumatic growth and positive rape attributions.

### **Dissertation Overview**

Chapter two addresses this study's theoretical orientation and conceptual framework, etiology of PTSD, as well as evidence-based interventions to reduce post-trauma symptoms. In addition, PhotoVoice and its theoretical underpinnings are presented. Chapter three introduces the research design and questions. Chapter four presents the results and chapter five discusses the implications of the study's findings.

## CHAPTER 2—LITERATURE REVIEW

### **Literature Review**

Posttraumatic Stress Disorder (PTSD) is the most common psychological disorder associated with sexual assault and rape (Dunmore, Clark & Ehlers, 2001; Lang et al., 2003). In fact, rape is more likely to be associated with a PTSD diagnosis than any other trauma, including combat (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995). Research suggests approximately 50% of female survivors of rape report having PTSD (Kessler et. al, 1995). PTSD manifests itself through hypervigilance, avoidance, emotional numbing, and intrusive thoughts. Psychological interventions designed to reduce symptoms of PTSD typically consist of cognitive and behavioral techniques, often utilizing exposure and cognitive reprocessing as a way to reduce triggers and address maladaptive thoughts that hinder recovery. These interventions are considered the gold standard for treating PTSD; however, reduction in symptoms does not necessarily foster posttraumatic growth and empowerment (Leiner et al., 2012).

This literature review explores PTSD, its etiology, and other outcomes associated with trauma recovery, as well as interventions designed to treat PTSD, and the theoretical frameworks that inform these interventions. The concept of posttraumatic growth is introduced, as well as an overview of PhotoVoice and its theoretical underpinnings. Finally, a conceptual model is presented that highlights key constructs and their relations that guide the proposed study.

### **Posttraumatic Stress Disorder (PTSD)**

The Diagnostic and Statistical Manual of Mental Disorders (DSM) defines PTSD as a trauma- or stress-related disorder that results from exposure to an actual, or

threatened death, serious injury, or sexual violation (American Psychiatric Association, 2013). The trigger must cause serious distress or impairment to one's daily living, altering his/her ability to function socially, at work, or in other important areas of functioning.

PTSD is characterized by the appearance of psychological avoidance, emotional numbing, intrusive thoughts, and hyperarousal (American Psychiatric Association, 2013; Herman, 1997). Survivors of sexual assault and rape, who have symptoms of PTSD, tend to relive the event, avoid situations that remind them of the event, and are hyper-vigilant and aroused (Herman, 1997). These symptoms can impact one's ability to fully confront the memories of their assault; thus, further perpetuating the manifestation of traumatic reactions (e.g., anxiety, stress, depression).

**PTSD etiology – theoretical assumptions.** Based on Herman's (1997) theory of trauma and recovery, trauma that leads to PTSD occurs when an individual experiences sudden and unexpected emotional or physical harm. When this happens, survivors often utilize inadequate internal and external coping strategies to manage the intensity of the experience, causing disturbances such as intrusive thoughts and dreams (Herman, 1997). People's reactions to trauma are individualized; their minds and bodies play a significant role in their ability to react and cope with these experiences (Bloom, 1999). Because of the mind-body complexity, to fully understand the human response to trauma is challenging. Consequently, it is also difficult to fully understand the psychological manifestations of sexual assault and rape, particularly when it comes to PTSD (Herman, 1997).

When survivors of sexual assault experience overwhelming stress it often disrupts their internal systems of control and calm, causing them to become easily irritated, “on-edge”, and/or hyper-aroused (Herman, 1997). Survivors then may engage in maladaptive coping habits (e.g., substance use and avoidance) as a way to seek comfort (Bloom, 1999; Herman, 1997). In addition, prolonged stress impacts survivors’ memories. In conditions of normal stress, verbal and non-verbal memories interact in a cohesive way—creating a repertoire of memory in the mind that one can pull from over time (Van der Kolk, Burbridge, & Suzuki, 1997). Survivors of sexual trauma who have prolonged stress and anxiety lose their ability to connect their words with their experience; consequently, creating an inability to recall the memory in an integrated manner (Bloom, 1999; Herman, 1997; Van der Kolk et al., 1997). Such fragmented memory is influenced by visual, olfactory, physical, and kinesthetic sensations associated with the experience. These deeply rooted, and often powerful, sensations can result in intrusive thoughts, or even flashbacks, causing survivors to become hypervigilant, avoidant or dissociative, all symptoms of PTSD (Herman, 1997).

A flashback, or intrusive thought, is a sudden fragment of one’s emotional, un verbalized memory (Bloom, 1999; Herman, 1997). It is common for survivors who are experiencing flashbacks to feel, smell, or even hear events associated with the traumatic event. Individuals who are having flashbacks often describe it as an emotional flood of memories. Even though these thoughts may be vivid and clear, the verbal memory system is inactive due to prolonged hyperarousal and hypervigilance, making it difficult for survivors to articulate their experience, causing them to avoid it all together (Herman, 1997). By avoiding these intrusive thoughts, survivors of trauma become numb to

emotions, or they dissociate from the memory (Bloom, 1999; Herman, 1997; Zoellner, Sacks, & Foa, 2001). Such avoidance makes it difficult for survivors of sexual assault to work through their posttraumatic reactions, because they do not have the opportunity to approach and cope with them over time.

Dissociation is a temporary breakdown in one's ability to see and process the world as it happens around them (Brewin & Holmes, 2003). In non-traumatic events, humans dissociate as a way to do multiple tasks at one time (Bloom, 1999). This behavior is commonly described as being on "auto-pilot." In the case of trauma survivors, dissociation can be described as having an "out-of-body" experience, an altered sense of consciousness (Brewin & Holmes, 2003). Dissociating during traumatic events is one of the stronger predictors of PTSD in survivors of trauma (Brewin & Holmes, 2003). Bloom (1999) argues that trauma survivors use dissociation as a survival technique, protecting themselves from pain and sadness. However, this behavior often leads to emotional numbing, which can impact intimacy in the survivor's present relationships and make it difficult for her or him to establish new ones. Furthermore, even though survivors use emotional numbing as a way to protect themselves, it can also increase vulnerability to future traumatic experiences, as it has been known to disinhibit their protective instincts (Bloom, 1999).

### **Other Psychological Outcomes of Sexual Assault**

In addition to PTSD, survivors of sexual assault and rape exhibit other psychological symptoms such as depression and self-blame (Regehr et al., 2013).

**Depression.** Depression commonly co-occurs with PTSD in sexual assault survivors (Au, Dickstein, Comer, Salters-Pedneault, & Litz, 2013), and is characterized

by prolonged sadness, shame, feelings of guilt, anger, worry, pessimism, indifference, and recurring thoughts of death and suicide (Regehr et al., 2013). Regehr and colleagues (2013) state that immediately following an assault, rates of depression among sexual assault survivors range anywhere from 68% to 74%. Not only is depression a mediator for suicidal thoughts and ideation, it is commonly associated with other co-morbid symptoms such as substance abuse and misuse; it can also exacerbate posttraumatic symptoms, resulting in PTSD (Regehr et al., 2013).

**Self-blame.** Depression can manifest itself through self-blame, as sexual assault survivors blame themselves for the rape and sexual assault committed against them. Along with dissociation, self-blame is a strong mediator for poor psychological well-being and revictimization among sexual assault survivors thereby inhibiting the healing process (Miller, Markman, & Handley, 2007). Janoff-Bulman (1979) proposed two different types of self-blame: behavioral and characterological. Behavioral self-blame involves blaming one's behavior, while characterological self-blame involves blaming the character/self of the individual (Janoff-Bulman, 1979). For example, the survivor who says, "I shouldn't have been at that party," is exhibiting behavioral self-blame, whereas the survivor who believes she is a bad person because of what happened is engaging in characterological self-blame. Because characterological self-blame is stable and inflexible, it is more strongly associated with maladaptive coping, depression, and PTSD (Janoff-Bulman, 1979). Behavioral self-blame is malleable, and can be changed, thus, this form of self-blame is less likely to be strongly associated with posttraumatic symptoms and PTSD (Janoff-Bulman, 1979).

Behavioral and characterological self-blame are both connected to one's ability to recover after a sexual assault. The more flexible nature of behavioral self-blame can actually assist with addressing survivors' shattered assumptions about the world and how they believe they fit into the world (Janoff-Bulman, 1979). Janoff-Bulman (1979) argues that behavioral self-blame helps survivors of sexual assault rebuild a more positive self-image, which could lead to more productive thinking and growth. Survivors can use these attributions to make sense of their event (Janoff-Bulman, 1979). Characterological self-blame, however, is considered detrimental to rebuilding one's shattered assumptions, and is typically associated with most sexual assault survivors' self-blaming strategies.

### **Social Learning Theory and Trauma Response**

In order to treat symptoms of PTSD in survivors of sexual assault, one must gain a better understanding of the trauma response. Next, behaviorist and cognitive principles that explain the trauma response are provided. These principles underpin many successful interventions designed to treat PTSD in survivors of sexual assault.

**Behaviorist principles.** Behaviorism emanates from a school of thought in which behaviors can be measured, changed, trained, because they are acquired through a process of conditioning and are dependent upon the environment (Bandura, 1977; Bandura & Walters, 1963; Pavlov, 1897; Skinner, 1936; Watson, 1913). Classical and operant conditioning are two forms of learning used to explain behaviors, and in this case, can be used to explain and understand survivors' responses to the trauma of sexual assault. The behaviorist framework suggests that fear is developed through a process of classical conditioning and maintained through operant conditioning (Regehr et al., 2013).

***Classical conditioning.*** Classical conditioning is a process that elicits behavior through a stimulus-response relationship (Bandura, 1977). Through this form of conditioning, a subject learns to associate one stimulus with another in order to elicit a reaction. In classical conditioning, a neutral stimulus produces a non-specific response, whereas, an unconditioned stimulus produces an automatic reaction. When coupled together (neutral stimulus and unconditioned stimulus), the neutral stimulus becomes a conditioned stimulus, and this conditioned stimulus eventually elicits a conditioned response. Ivan Pavlov accidentally discovered classical conditioning during his experiment with salivating dogs. Examples of Pavlov's experiment, as well as examples of how classical conditioning is related to sexual assault experiences, are further addressed to better understand the trauma response.

Prior to conditioning, Pavlov would ring a bell in front of a dog, and the dogs would not respond. It was not until the neutral stimulus (sound of the bell) was coupled with an unconditioned stimulus (food) that the dogs would actually react and salivate (unconditioned response). After conditioning, however, Pavlov would ring the bell (conditioned stimulus) causing the dogs to salivate without the presence of food (conditioned response). In this example, the bell served as a neutral stimulus until the dogs learned to associate the bell with food. It was not until Pavlov repeatedly paired the bell with food that the dogs exhibited a conditioned response without the presence of the unconditioned stimulus.

Survivors of sexual assault often speak about how triggers (e.g., smells, sounds, locations, people) create involuntary reactions that make them recall the incident in the form of a flashback (Foa, Steketee, & Rothbaum, 1989). Prior to experiencing sexual

assault, these triggers, or neutral stimuli, may not have affected the survivor. It is not until these stimuli are coupled with an unconditioned stimulus (e.g., an actual sexual assault experience or threat of harm) that unconditioned responses occur (e.g., fear response, anxiety, or other posttraumatic reactions). After prolonged conditioning to these stimuli, survivors of sexual assault may be triggered by certain smells, locations, or individuals associated with the event. Such stimuli produce overwhelming fear and anxiety (i.e., conditioned response) for survivors of sexual assault and can cause flashbacks.

**Generalization.** In conditioning, stimulus generalization and discrimination can occur, and can impact the ways in which an individual responds to a stimulus.

Generalization is a process by which the person responds to stimuli that closely resembles the original conditioned stimulus. For example, if children were conditioned to fear white stuffed rabbits, they could potentially fear other objects that are similar to the stimulus, such as white teddy bears. For survivors of sexual assault, this type of generalized stimulus could be a trauma trigger that reminds them of the original event, but is not necessarily directly associated with the event itself. For example, a survivor of sexual assault who was assaulted by a male with a beard may begin to fear all men with beards.

**Discrimination.** The other side to generalization is discrimination. Individuals are taught to discriminate between stimuli that are similar and to respond only to specific stimuli. With the Pavlov example, the dogs learned to salivate at the sound of a bell, but not with similar sounds that were not associated with food. For survivors of sexual assault, they often discriminate between stimuli as a way to protect themselves through a

process of avoidance. Discrimination can be useful for survivors of trauma because they can learn to make a distinction between what is and is not a trigger. However, this can also be problematic because this type of distinction can lead to avoidant behaviors, encouraging survivors to evade traumatic memories, thereby, perpetuating traumatic symptoms (Herman, 1997).

***Extinction.*** Extinction is a process by which a reduction of the conditioned response occurs when the conditioned stimulus is repeatedly presented in front of the individual without the presence of the unconditioned stimulus (Bandura & Walters, 1963). In the case of Pavlov, he rang the bell without the presence of food over an extended period of time. After the initial conditioning phase occurred, when the conditioned stimulus was presented alone, the salivation began to decrease. In cases where sexual assault survivors are living with PTSD, conditioning to a severe trauma does not easily become extinct. Individuals with PTSD develop strong associations with the events of their trauma, even when they are physically not in the presence of the traumatic experience or event. Because of this, survivors of sexual assault with PTSD are slow to arrive at a period of extinction to the conditioned stimulus (Milad et al., 2009). However, through a process of extinction, one could argue that with prolonged exposure to triggers, survivors' fear responses may dissipate.

***Operant conditioning.*** Operant conditioning is the process of modifying behavior in which an individual is encouraged to behave in a desired manner through consequences that increase or decrease the probability of the desired behavior (Skinner, 1936).

B. F. Skinner describes operant conditioning as modified behavior through positive and negative reinforcement, or positive and negative punishment. Positive and negative reinforcements are designed to increase a desired behavior, and positive and negative punishments are designed to decrease an undesired behavior. Positive reinforcements are used to favorably reinforce an individual after a desired behavior (e.g., praise, rewards). In contrast, negative reinforcements are characterized as the removal of an undesired outcome after the desired behavior is exhibited. Positive punishment is the use of unfavorable outcomes as a way to reduce an undesired response or behavior, whereas negative punishment can be characterized as the removal of favorable events or outcomes after an undesired behavior occurs.

Perhaps the most applicable form of operant conditioning that can be used to describe posttraumatic response in survivors of sexual assault is negative reinforcement. Survivors of sexual assault exhibit use of negative reinforcement when they employ escape and avoidance techniques as a way to avoid the negative consequences associated with remembering the trauma. For example, a survivor may use substances as a way to “escape” the memory of her assault; thereby, allowing her to avoid the negative consequences of the memory of the trauma (e.g., intrusive thoughts). This type of avoidance can lead to fragmented memory, which increases the likelihood of posttraumatic symptoms such as hypervigilance and flashbacks (Herman, 1997).

Because survivors tend to avoid co-occurring stimuli associated with the traumatic event in an effort to temporarily relieve anxiety, the process of extinction cannot occur. Regehr and colleagues (2013) argue that interventions that incorporate exposure techniques help the survivor separate the stimulus from the response, allowing

them to directly confront the stimulus, rather than avoid it, as a way to successfully reduce traumatic symptoms such as hypervigilance, flashbacks, and avoidance (Regehr et al., 2013).

**Cognitive Principles.** In contrast to behavioral conditioning theories, cognitive theory asserts that emotional reactions are a direct result of how one interprets the event that causes psychological distress (Resick & Schnicke, 1993). This theoretical framework supports interventions that allow trauma survivors to restructure maladaptive thoughts as necessary for healing and recovery post trauma (Regehr et al., 2013). The work of Janoff-Bulman (1979) regarding shattered assumptions is an important framework to use when exploring psychopathology from a cognitive perspective. Shattered assumptions lead to disrupted or maladaptive beliefs about the self, which evokes feelings of guilt and lack of control, which further exacerbates the fear response (Petrak & Hedge, 2003).

Cognitive restructuring is a practice that stems from cognitive theory and focuses on having the survivor target, or reframe, negative patterns of thought that lead to distressed emotional responses (Petrak & Hedge, 2003). When a survivor addresses their dysfunctional thoughts through cognitive restructuring, they are able to reframe these thoughts, and repair any shattered assumptions they may have about the world, others, and themselves, which ultimately impacts their ability to heal in a healthy way (Janoff-Bulman, 1979).

### **Systematic Review of Evidence-Based Interventions**

Regehr and colleagues (2013) conducted a systematic review of the most effective treatments designed to reduce distress post sexual assault (see Regehr et al., 2013, for their report of selection criteria, data collection and analysis). Their review consists of

quasi-experimental (Resick, Jordan, Girelli, Hutter, & Marhoefer-Dvorak, 1988; Resick & Schnicke, 1992) and random control trials (Foa, Rothbaum, Riggs, & Murdock, 1991; Resick, Nishith, Weaver, Astin, & Feuer, 2002; Rothbaum 1997; Rothbaum, Astin, & Marsteller, 2005) of these interventions with data from 246 participants attainable for analysis. Their findings show how the following interventions were more effective than no treatment at all in reducing PTSD at post-treatment independently observed [SMD -1.81 (95% CI -2.90 to -0.72, four studies)] and self-reported [SMD -1.90 (95% CI -2.73 to -1.07, three studies)]: Cognitive Processing Therapy (CPT, two studies total of 80 participants; Resick et al., 2002; Resick & Schnicke, 1992), Stress Inoculation Therapy (SIT, two studies,  $n=26$ , Foa et al. 1991; Resick et al., 1988), Prolonged Exposure Therapy (PE, three studies,  $n=94$ , Foa et al., 1991; Resick et al., 2002; Rothbaum et al., 2005;), Eye Movement Desensitization and Reprocessing (EMDR, 2 studies,  $n=34$ , Rothbaum et al., 2005, Rothbaum, 1997), and Supportive Psychotherapy (SP, one study  $N=12$ ; Foa et al., 1991). In addition, EMDR revealed significant improvements in survivor anxiety compared to the control group (Rothbaum et al., 2005; Rothbaum, 1997).

The most clinically significant interventions for reducing PTSD (primary outcome) were PE, CPT, and EMDR (Regehr et al., 2013). There were slight differences in effect sizes for CPT and PE (SMD -0.04 (-0.95 to 0.87),  $p = 0.93$ ), while EMDR was more effective than CPT (SMD -0.83 (-2.20 to 0.54),  $p = 0.23$ ) and PE (SMD -0.87 (-2.36 to 0.62)  $p = 0.25$ ) (Regehr et al., 2013). Results of this systematic review provide provisional evidence that interventions using cognitive-behavior approaches are related with decreased symptoms of PTSD in victims of sexual assault.

### **Stress Inoculation Training (SIT)**

Stress Inoculation Training (Veronen & Kilpatrick, 1983) was adapted from Meichenbaum's (1974) anxiety management procedures to treat survivors of trauma who exhibited persistent fear. This therapy technique encompasses three elements: 1) psychoeducation, 2) in vivo (real life) exposure, and 3) cognitive behavioral coping strategies (i.e., cognitive restructuring, thought stopping, self-dialogue, and muscle relaxation) (Meichenbaum, 1974; Regehr et al., 2013). Clients also participate in controlled breathing and role-playing of stressful situations with this intervention.

The first session consists of clinicians collecting information regarding clients and their experiences with sexual assault. Because sharing details about an experience with sexual assault is potentially triggering, clinicians teach clients skills of deep breathing when feeling anxious or overwhelmed. The second session begins with psycho-education, where clinicians give a brief explanation of the treatment procedures followed by education regarding fear and anxiety. Sessions three through nine focus on a variety of coping techniques. For example, sessions three and four provide clients with deep muscle relaxation and controlled breathing techniques, and session five provides clients with skills to stop negative thoughts and obsessive thinking. In session six, clients are taught cognitive restructuring techniques, while session seven focuses on guided self-dialogue. In session eight clients are taught covert-modeling techniques—survivors imagine engaging in the behavior and reinforcing it—while finally, in session nine they role-play their new behaviors with their clinicians.

### **Prolonged Exposure Therapy (PE)**

Prolonged Exposure Therapy contains the following elements: psychoeducation regarding trauma and response to trauma, relaxation training, repeated in vivo exposure to stimuli, and repeated imaginal exposure to traumatic memories (Regehr et al., 2013). PE for survivors of sexual assault builds upon flooding techniques—an early treatment used with anxiety disorder patients—and emanates from emotional processing theory and theories of deconditioning (Vickerman & Margolin, 2009). This technique gives clients the skills to correct mistaken cognitive assessments of the traumatic event caused by disorganized memories. For example, some survivors may only remember parts of the event, and these fragmented pieces of memory do not fit in a sequence, creating mistaken evaluations of the event itself (Vickerman & Margolin, 2009). This type of disorganized memory plays a significant role in the pathogenesis of PTSD (Jelinek, Randjbar, Seifert, Kellner, & Moritz, 2009).

PE begins with psychoeducation as a way to normalize feelings and increase understanding of what has happened. Next, PE introduces deep-breathing training, followed by in vivo and imaginal exposure to the memories associated with the assault. In vivo exposure is classified as direct exposure to a feared stimulus, whereas imaginal exposure uses imagery exposure or memories. Imaginal exposure is the primary focus of this therapy technique as clients are asked to relive their assault by verbally describing it (in detail) in the present tense as they imagine the past. Sometimes this happens several times in one session. These sessions are recorded and given back to the client to listen to as homework.

### **Cognitive Reprocessing Therapy (CPT)**

Cognitive Processing Therapy emanates from emotional processing theory and is designed to help survivors identify their “stuck points” while processing the traumatic experience (Resick & Schnicke, 1992, 1993; Vickerman & Margolin, 2009). “Stuck points” are defined as “manifestations of a PTSD sufferer’s unsuccessful attempts to accommodate information related to the trauma into preexisting belief and memory structures” (Vickerman & Margolin, 2009, p. 433). This therapy is characterized by exposure to the client’s own trauma memories, often through writing, reading, and cognitive therapy. The goal is to incorporate the traumatic experience into their preexisting cognitive schemas as a way to decrease avoidance and intrusive thoughts regarding the event.

Survivors are asked to write a detailed description of their experience with, and meaning of, rape or sexual assault. They re-read this narrative between sessions and are then asked to write about the impact of their experience multiple times, as a way to develop a new understanding and meaning of their assault. In the remaining sessions, the clinician uses cognitive restructuring techniques and Socratic questioning to focus on and discuss one of the following themes: safety, trust, power/control, esteem, or intimacy.

### **Eye Movement Desensitization and Reprocessing (EMDR)**

EMDR is designed to treat PTSD through both exposure and cognitive techniques (Shapiro, 1996). For survivors of sexual assault, clients are asked to imagine a scene from their assault and to recite specific words associated with this scene while the clinician moves his/her finger back-and-forth in front of the client in an effort to hypnotize him/her as a way for the survivor to process the memory. This memory processing occurs as the client engages in dual attention to both the memory (internal stimulus) as well as the

clinician's finger (external stimulus) (Shapiro, 1996; Vickerman & Margolin, 2009).

When the client no longer feels anxiety toward the scene exposure, they begin to rehearse a new belief about the memory until it feels true for the client. EMDR has empirical support to successfully reduce PTSD and depression for survivors of sexual assault (Lindsay, 1995; Rothbaum, 1997; Vickerman & Margolin, 2009).

### **Supportive Counseling**

Supportive counseling is widely used by lay professionals in victim crisis centers (Regehr et al., 2013). This model of therapy is largely informed by a feminist framework that recognizes and promotes self-determination and empowerment. This type of intervention recognizes sexual assault as a crime against the self and highlights the importance of understanding societal contributions to the social problems of rape and sexual assault (Bass & Davis, 1992; Solomon & Johnson, 1992). A goal of supportive therapy, and other feminist approaches, is to help the survivor frame the experience as a societal problem rather than an individual problem, which helps reduce guilt from characterological and behavioral self-blame while enhancing empowerment (Regehr et al., 2013).

The prevalence of sexual assault is significant in the U.S., especially among female college students. There are a limited number of treatment options available for sexual assault survivors that have been empirically tested and proven effective with this population. Interventions incorporating both behavioral (exposure) and cognitive (cognitive reframing) techniques are more effective at reducing symptoms of PTSD than any of these techniques alone (Petra & Hedge, 2002). Exposure techniques are considered the gold standard for treating PTSD among trauma survivors; however, these

interventions may not specifically address, or correct, distorted thoughts that can lead to maladaptive coping, which is argued necessary for recovery (Resick & Schnicke, 1992). Furthermore, cognitive interventions that lack exposure components are limited in their ability to help survivors overcome fear, because the very nature of these interventions are not designed to have the client go through the process of extinction.

### **Gaps in the Treatment Literature for Sexual Assault Survivors**

Sexual assault and rape survivors represent a disproportionate number of people living with PTSD (Leiner et al., 2012). While it is important to reduce symptoms of PTSD, we know that many survivors of sexual assault are living with additional post-trauma manifestations (e.g., suicide, substance abuse/misuse). Many women display avoidant behaviors by using alcohol and drugs as a way to self-medicate after trauma; however, women who use drugs and alcohol as a form of self-medication are often excluded from intervention studies because of potential impacts to the integrity of the study (e.g., Type I and II error, risk for self-harm, etc.; Vickerman & Margolin, 2009).

Individual interventions, rather than group modalities, are primarily used in cognitive and behavioral interventions. Yet, group work has shown to reduce symptoms of PTSD while increasing empowerment for female survivors of sexual assault (Schnurr et al., 2003). Group work helps survivors of sexual assault break the silence, and also provides emotional support while survivors make meaning of their experience. The group process also supports exposure and cognitive reprocessing techniques, as it encourages storytelling and narrative work, which research evidence suggests as critical for minority women (Banks-Wallace, 1998). Cognitive-behavioral interventions also have minimal, if any, focus on issues of power relations in regard to sexual assault/rape. Without this

contextual understanding, survivors may continue to believe that they are the reason for their sexual assault, further supporting characterological self-blame, rather than understanding that violence against women is a systemic problem. Their low self-worth or lack of self-efficacy can further perpetuate a cycle of PTSD symptoms for survivors, as they have little faith in their ability to recover (Janoff-Bulman, 1979).

Vickerman and Margolin (2009) report another limitation of the evidence-based treatment literature for sexual assault survivors includes how many of the cognitive-behavioral interventions used with this population do not address posttraumatic growth and empowerment because the primary focus of these interventions is on symptom reduction and avoidance of negative outcomes (Vickerman & Margolin, 2009). However, posttraumatic growth and empowerment are important components of rape-related recovery, and without this, symptoms of PTSD may continue to resurface over time (Vickerman & Margolin, 2009). Attention to these topics could improve existing interventions, or assist in developing new ones (Vickerman & Margolin, 2009).

### **Posttraumatic Growth**

Posttraumatic growth (PTG) can be defined as “the experience of significant positive change arising from the struggle with a major life crisis” (Zoellner & Maercker, 2006, p. 628; Calhoun, Cann, Tedeschi & McMillan, 2000). An example of PTG is reflected in a person who has managed to overcome an experience with sexual assault or rape by finding personal transformation and meaning. PTG highlights the process of something “positively new” that developed in a traumatized person’s life and comes with additional benefits compared to their pre-crisis lives (Zoellner & Maercker, 2006, p. 628). Examples of these new benefits include a different outlook on life, an intensified

connection with others, new life priorities, or a deepened sense of the meaning of life. Frazier and colleagues (2001) found that survivors of sexual assault who exhibited posttraumatic growth over a period of twelve months were more likely to have less emotional distress than participants who did not. The PTG process for survivors is related to how they perceive their struggle with adversity, which opens up pathways for growth (Tedeschi & Calhoun, 2004).

### **Introduction of PhotoVoice**

#### **Connecting PhotoVoice to Cognitive and Behavioral Frameworks**

As indicated by Regehr and colleagues (2013), the most effective interventions for sexual assault survivors embody a cognitive and behavior component, an exposure component, a supportive component, or a combination of the three. PhotoVoice is an intervention that combines all three elements as a way to not only reduce posttraumatic symptoms, but also foster a sense of posttraumatic growth and empowerment.

PhotoVoice does this by allowing participants to address negative cognitive distortions, in a safe and supportive environment, as a way to reduce characterological and behavioral self-blame. Furthermore, PhotoVoice helps survivors of sexual assault arrive to a point of extinction, through the process of exposure, in an effort to lessen posttraumatic symptoms such as fear and anxiety. PhotoVoice participants do this by exposing themselves to triggers during their photo-taking process and by group processing. The methods of PhotoVoice (e.g., picture-taking, group processing, exhibits with key stakeholders to affect social change) also offer strategies of empowerment at a personal level (changing patterns of thinking, behaving and feeling), interpersonal level (managing their relationships more effectively), and societal/organizational level

(affecting system change) to improve sexual assault survivors' lives and contribute to their overall recovery and growth (Wang, 1999; Wang & Burris, 1994).

### **History and Purpose of PhotoVoice**

Originally developed by Wang and Burris (1994), the PhotoVoice method is most often used in health education to bring awareness to social injustices that plague marginalized communities. Marginalized and oppressed individuals give voice to their experiences through a specific photographic technique. Participants are given cameras that enable them to record issues and display them in public exhibits (Wang, 1999; Wang & Burris, 1994, 1997). Following the principles of Community-Based Participatory Research (CBPR), photovoice uses images to teach, as it provides evidence of social injustices as well as raise awareness. Since its inception, PhotoVoice has become an empowering tool to connect participants to key stakeholders in the community to create change and opportunities that otherwise would not be available to marginalized groups (Wang, 1999; Wang & Burris, 1997, 1994).

The method uses photos to tell a story; thus, in its original capacity the term, *photo novella*, was coined to describe the work (Wang & Burris, 1994). One primary methodological difference between the two (photo novella and PhotoVoice) exists. While photo novella serves as a tool for sharing a story of a particular person or community, the *PhotoVoice* method helps provide voice to marginalized individuals and has the power to create systemic change (Wang & Burris, 1994).

There are three main goals of PhotoVoice: 1) enable participants to reflect on strengths and concerns regarding the social issue being studied, 2) promote critical dialogue (in large and small group settings) regarding the social issue, and 3) inform

policy by including key stakeholders at photo exhibits (Wang & Burris, 1994, 1997). A review of the literature did not produce any studies of PhotoVoice as a therapeutic intervention, in general, and with survivors of sexual assault, in particular.

### **Theoretical Underpinnings of PhotoVoice**

Photovoice draws from three conceptual frameworks: empowerment education, feminist theory, and documentary photography. These conceptual frameworks support social change initiated at the community level (Wang & Burris, 1994, 1997). These three foci guide researchers to uncover rich and descriptive data about participants and their communities; a context that often cannot be fully captured through quantitative methods.

PhotoVoice uses empowerment education techniques created by Wallerstein and Bernstein (1988) based on Freire's (1970) *Pedagogy of the Oppressed*. This method of education begins with highlighting issues people perceive to be central to their lives (Wang & Burris, 1997). Freire suggests that one way people can begin to critically discuss injustices that plague their community, focusing on the impact of political and social forces, is to do it through visual image, using drawings and photographs to represent reality (Freire, 1970). PhotoVoice involves individuals taking pictures of the environmental concerns or strengths most important to them. Individuals then meet in a group to dialogue about these strengths and concerns as a way to identify needs of their community. These needs are then presented by participants to community stakeholders and serve as a catalyst for community change. According to Wang and Burris (1994), participants become advocates for their communities and often this type of advocacy leads to much needed policy shifts.

PhotoVoice is also grounded within feminist theory. Feminist theory identifies male bias and its influence on research, particularly, participatory research. In this regard, feminist theory seeks to transform one's thought process in a way that increases awareness and appreciation of women's roles as researchers and advocates (Wang & Burris, 1994). Images can be used to teach and influence change within a community, especially in regards to violence where societal norms and practices often silence victims. Because almost everyone can learn to use a camera, this method becomes extremely powerful for oppressed individuals (e.g., women, children, people who cannot read or write) giving them the opportunity to share their voice (Wang & Burris, 1997). This method also views participants as experts of their own worlds who have knowledge that professionals, and people who do not identify with that community, often lack.

Documentary photography is used as a method to portray social issues and concerns through a range of visual styles and genres (Wang & Burris, 1997). Wang and Burris (1997) describe documentary photography as a form of "social conscience presented in visual imagery" (p. 371). Documentary photography provides vulnerable people with the opportunity to express their stories and perceptions of their world, and PhotoVoice places the control in the hands of these people. The PhotoVoice method gives cameras to individuals who may not have access to such a tool as a way to actively participate regarding social issues in their community (Wang & Burris, 1997). One example of an influential piece of documentary photography conducted by Roy Stryker, the chief of the Historical Section of the Depression-era U.S. Farm Security Administration, captured the impact of improper land use on rural poverty (Wang &

Burris, 1997). Stryker stated that documentary photography is “the things to be said in the language of pictures” (Raeburn, 2006, p. 328).

### **Photovoice as a Therapeutic Intervention for Sexual Assault Survivors**

Even though PhotoVoice has historically been used as a needs assessment tool designed to help researchers and participants better understand a social issue, it has therapeutic qualities (Wang, 1996; Wang & Burris, 1994; Wang, 1996, 1997). For example, the very nature of participating in a group dialogue about an important shared experience (e.g., sexual assault and rape) helps foster a sense of support and camaraderie (Wang, 1999; Wang & Burris, 1994, 1997). The process of sharing your photos with members of a group, and other people outside of the group, stimulates dialogue about experiences that often have been denied, dismissed or devalued by others (Teti, Murray, Johnson, & Binson, 2012; Wang, 1999).

Picture sharing can be used to help transform policy by creating critical dialogue about social inequalities that affect the issue being studied (in this case, sexual assault and the cultural influence on the issue) for self and others. Consciousness-raising dialogue can help survivors identify and address dysfunctional thoughts regarding their experience, hopefully ameliorating characterological and behavioral self-blame. Sharing their pictures with members of the group, and other support networks, can potentially help strengthen relationships, not to mention break the silence regarding the social issue.

**Meaning-making and PhotoVoice.** PhotoVoice assists participants to tell their stories while exploring the meaning of these stories through sharing their images. Constructivist Self-Development Theory (CSDT) postulates that as humans we create realities regarding our experiences, and for survivors of violence, some make meaning of

their trauma (Lee & Greene, 1999). Constructivist Self-Development Theory focuses mainly on the impact trauma has on a survivor's sense of self (McCann & Pearlman, 1992). The methods of PhotoVoice allow survivors to process their trauma in a way where they have total control over how it, and their sense of self, is constructed rather than their trauma defining them or their experience (McCann & Pearlman, 1992).

According to CSDT, cognitive schemas are important concepts to address during this process of self-discovery (McCann & Pearlman, 1992). Each survivor's experience is unique and individual, including differing ideas—or schemas—about the self, such as vulnerability, shame, strength, healing, or a combination of these. Through methods such as PhotoVoice, survivors may reclaim their identities by telling and retelling their story allowing for individual and group meaning-making (Teti, Murray, Johnson, & Binson, 2012; Lee & Greene, 1999; Meichenbaum & Fitzpatrick, 1993). They may redefine themselves despite their victimization (Norman, 2000). Survivors cannot change the past, but they can influence how they interpret their present and future selves. They can choose whether or not their trauma will become a focal point of their re-claimed identities (Anderson, 2010).

Survivors of sexual assault need opportunities to define their experience, and to gain a clear sense of who they were, who they are now, and who they plan to become. For some, defining a sense of self is a lifelong task that requires self-exploration along with exposure to life's trials and tribulations. CSDT framework suggests that survivors who engage in self-exploration, as a way to further develop a sense of their true self, can increase tolerance to the effects of their trauma (McCann & Pearlman, 1992).

PhotoVoice allows participants to explore their experience through photo sharing and group support. Participants can explore their experiences, triggers, and the perceptions of self through a creative and expressive form of documentary photography. All of this aligns with recommendations for self-discovery from a CSDT framework (McCann & Pearlman, 1992). CSDT suggests that in order to resolve disrupted schemas (e.g., safety, trust, esteem, power, and intimacy) one must gently challenge them, as in the group experience where they are safe to discuss their thoughts, feelings and vulnerabilities (McCann & Pearlman, 1992). Allowing survivors the time and space to process, elaborate on their memories, and organize their thoughts surrounding the event, allows them to approach rather avoid their traumatic experiences (Brewin, Gregory, Lipton, & Burgess, 2010; Ehlers & Clark, 2000; Simon, Feiring, & McElroy, 2010). Consequently, survivors then have the tools and support to construct a more adaptive meaning of the event (Ehlers & Clark, 2000; Janoff-Bulman, 1992).

**Narrative theory and the PhotoVoice process.** The use of narrative methods allows survivors of sexual assault the opportunity to re-construct their sense of self through re-counting their trauma in a way to make meaning of their horrific experiences (Norman, 2000). Norman (2000) postulates that victims of trauma who are able to find meaning in their event, viewing themselves as survivors fare better than those who dwell on themselves as victims, blaming others for their experience, and taking negative views of their event.

In addition to the storytelling component of PhotoVoice, the intervention helps survivors explore self and identity while also exploring the memory of the trauma (Wang 1999, 1997; Wang & Burris, 1994). Photos taken of our experiences and ourselves

represent a story of who we were, who we are as individuals now, and who we plan to become. This helps shape the survivor's dominant story about herself, which is consistent with narrative theory (Anderson, 2010; Simon, Feiring, & McElroy, 2010). When a woman is sexually assaulted, much of her dominant story is shaped by the experience.

Survivors of sexual assault should have choice in the construction of their sense of self, or their identity (Anderson, 2010; Docherty & McColl, 2003). Traumatic events are often defined by the circumstances of the trauma, by the perpetrator, or by society. This can further perpetuate feelings of low self-esteem and self-worth, which impacts one's ability to cope and heal after experiencing sexual assault. When survivors share their story, they begin to integrate their experience into their self-identity through a process of re-storying or re-authoring. This can serve as a pinnacle point for survivors' recovery as they begin to re-claim their identity.

Re-storying is a process by which survivors of sexual assault begin working through their trauma in order to alleviate traumatic symptoms associated with their experience (Simon, Feiring, & McElroy, 2010). This process is necessary and important in order for them to better understand their experience with adversity (Anderson, 2010). The process of PhotoVoice, including the exhibit, helps the participant recreate her dominant story (re-storying) and is symbolic of her re-entering the world as a survivor.

Exploring survivors' narratives enhances opportunity for understanding the complexities and intersectionality of sexual violence (Bhuvaneshwar & Shafer, 2004). Furthermore, using documentary photography techniques, similar to those found in PhotoVoice, as a way for survivors to explore their experience with sexual assault enhances the therapeutic options available to them, by allowing them the opportunity to

actively participate in construction of their re-claimed identity. Once survivors realize they have the opportunity to re-construct their self-narrative and control the way it is told, they can start to impact the meaning of their past. They will begin the process of re-claiming their identity: redefining who they were, who they are now, and who they wish to become (Anderson, 2010).

**Behaviorism and PhotoVoice.** According to behaviorism, the process of extinction is important to reduce fear, anxiety, and flashbacks and may occur through prolonged exposure to conditioned stimuli (i.e., triggers, smells, sounds, locations, etc.) without the presence of the unconditioned stimulus (i.e., the actual assault itself or the perpetrator of the assault). In PhotoVoice, participants are asked to document their lives as a survivor of sexual assault. They do this by confronting their triggers through a photo-taking process, as well as re-exposing themselves to the triggers during the focus group discussion. Throughout the PhotoVoice process, participants are continually revisiting their photos, thus consistently confronting their triggers (conditioned stimulus), until eventually a process of extinction can occur.

Because survivors of sexual assault have strong associations to their traumatic experiences, producing significant posttraumatic reactions, it is imperative that prolonged exposure to conditioned stimuli is done in a safe and supportive way. PhotoVoice allows participants complete control over what they photograph and discuss during a focus group. As a facilitator, it is important to encourage survivors to directly confront their triggers in order for the process of extinction to occur. In addition, the supportive dynamic of the group process allows participants to safely re-expose themselves to the triggers as well as reframe any negative thoughts.

### **Conceptual Insights**

According to Herman's theory of trauma (1997), survivors of sexual assault experience a range of posttraumatic symptoms that make it difficult for them to function in their everyday lives. These symptoms include avoidance, dissociation, fear, hypervigilance, and emotional numbing. In addition, prior to experiencing sexual assault, survivors are connected to a pre-trauma sense of self, involving healthy assumptions about their identity, other people, and the world. Janoff-Bulman (1979) states that when a person experiences sexual trauma their assumptions about themselves, people, and the world are most often shattered. These shattered assumptions greatly influence self-blame and also cause survivors to use avoidance as a way to protect themselves from the traumatic experience.

Survivors of sexual assault are conditioned to respond to triggers, and these behaviors are then maintained through a process of operant conditioning. For example, survivors of sexual assault may develop intense fear responses when exposed to certain triggers associated with their event. In addition, they may use avoidance, or generalization, as a way to protect themselves from the emotional memories of the event. However, through a process of extinction, survivors can, and will, begin to see a reduction in the overall fear response.

PhotoVoice allows survivors to reconstruct their identities through a process of cognitive reframing. PhotoVoice helps participants explore how they view themselves and how they wish to be seen by others in the future (Wang, 1994). The photos not only represent triggers for survivors, but also they reveal values, thoughts, attitudes, and feelings regarding themselves. Having physical artifacts (i.e., the photos) to talk about an

important issue or experience helps break the verbal barrier for some who struggle with sharing their experiences. Furthermore, involvement in PhotoVoice helps foster a sense of self-worth and empowerment for participants as they take pride in their photos, share them with others, and raise awareness (Wang, 1994).

A conceptual model of PhotoVoice as a therapeutic intervention for survivors of sexual assault is provided that draws from the professional literature presented in this chapter (see Figure 1). This model presents the trauma response as well as an understanding of PhotoVoice as a therapeutic intervention. Finally, the model reveals both proximal and distal outcomes of PhotoVoice as a therapeutic intervention for survivors of sexual assault.

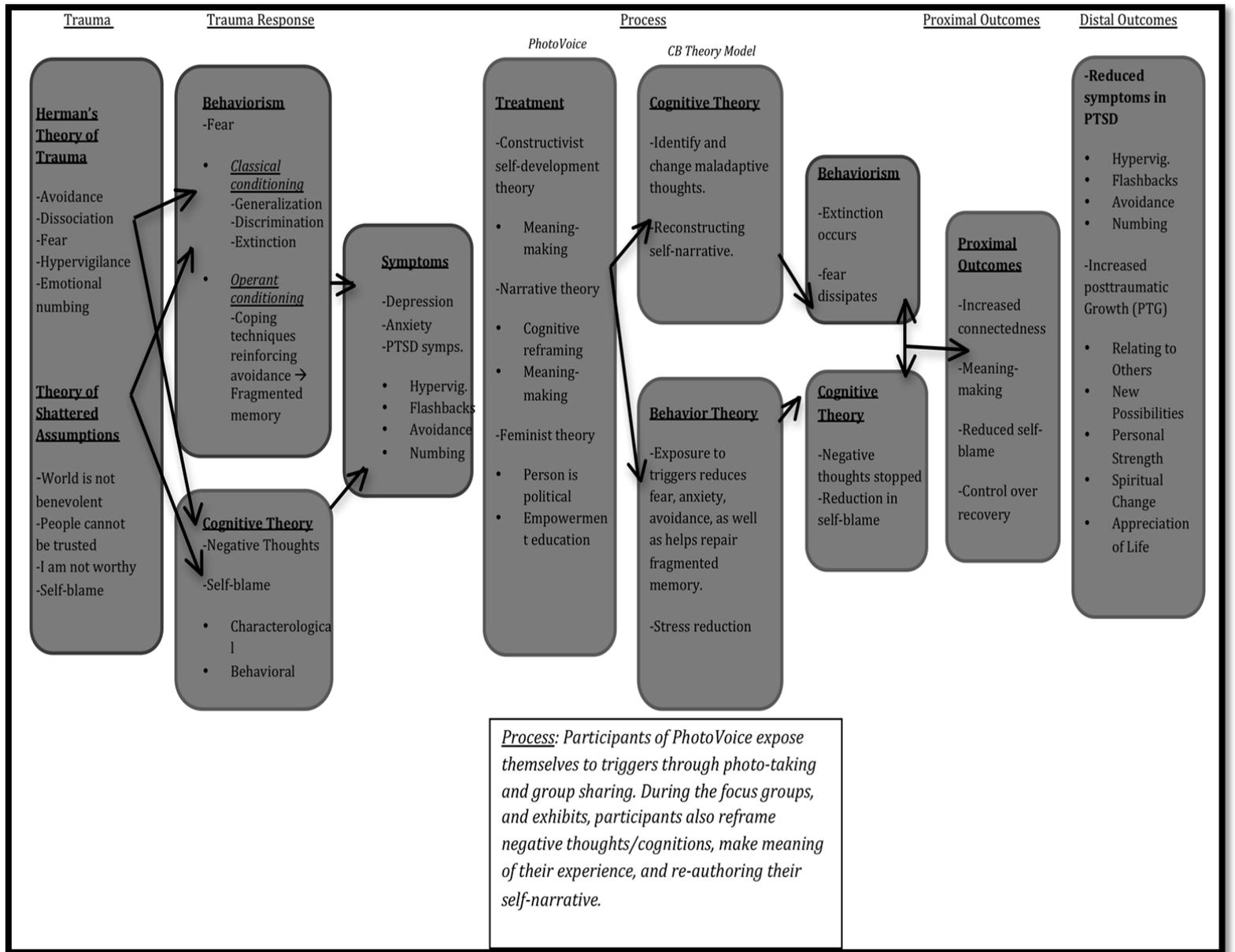


Figure 1. Theoretical Model of PhotoVoice as a Therapeutic Intervention.

## CHAPTER 3—RESEARCH METHOD

### Research Methods

#### Participants

Participants ( $N = 9$ ) were female college students, ages 18-24, who had experienced a sexual assault and were symptomatic for Posttraumatic Stress Disorder (PTSD). Sexual assault experiences included childhood sexual abuse ( $n = 4$ ), child sexual abuse and adult rape ( $n = 4$ ), adult rape only ( $n = 4$ ), polyvictimization (adult rape and domestic assault ( $n = 1$ ), and multiple sexual assaults ( $n = 5$ ). (See Appendix A – Participant Demographics Form).

#### Informed Consent

**Protection of human subjects.** Institutional review board approval was received on October 31, 2013. A confidential master list of identifying information was kept separate from study materials in a locked file cabinet in the Rape and Sexual Violence Prevention Center (RSVP) coordinator's office. Participants were assigned a code for all study materials. All non-identifying data (e.g., transcripts, completed instruments, etc.) was stored on the researcher's password protected computer or in her locked file cabinet at the RSVP center. The IRB approved consent form (see Appendix B – Consent Form) informed participants of their rights and responsibilities (e.g., voluntary status, withdrawal without penalty).

**Potential risks.** While the research study was expected to have positive outcomes for those involved, a potential risk to participants was increased emotional distress or discomfort. The following protocols (in addition to the informed consent) helped to

increase participants' comfort levels: 1) treat participants with respect and dignity including respect for their ability to make decisions regarding their participation, 2) encourage participants to have control of the pace and direction of the interview, including choice in declining to answer questions, and 3) emphasize their participation is voluntary and they may terminate at any time during the research process.

Though some discomfort regarding discussion about their experience with sexual assault was expected, no participants felt like the topic caused too much distress to prevent them from participating. No one dropped out of the study. All interested participants, including women who did not meet criteria for the study, received information on MU support resources including: RSVP center, Student Health Center, Student Counseling Center, and Psychological Services Clinic.

### Research Design

A mixed-methods research design was used. A single-system multiple base-line was employed. Treatment conditions for each group were staggered to ensure that changes were due to the actual PhotoVoice intervention, rather than chance. Stable baselines were captured for each participant in each group. See Figure two below for research design.

Group #	Jan.		Feb.		Mar.		Apr.		May	
1	O <sub>1</sub>	O <sub>1</sub>	X	O <sub>2</sub>						
2		O <sub>1</sub>	O <sub>1</sub>	X	O <sub>2</sub>					
3			O <sub>1</sub>	O <sub>1</sub>	X	O <sub>2</sub>				

Figure 2<sup>1</sup>. Research Design.

<sup>1</sup> O<sub>1</sub>: Represent pre-test measures. All participants were required to complete initial pre-screening measures to ensure they met criteria. This took place during the pre-screening meeting, as well as they were asked to complete an additional set of pre-test measures after the orientation. X: Represents the PhotoVoice intervention.

O<sub>2</sub>: Represents the post-test measures. All participants completed post-test measures at the following times: after focus group 1, after focus group 2, after the exhibit planning meeting, after the exhibit, and a one-month follow-up.

In addition to the multiple baseline design, qualitative inquiry and the method of thematic analysis was used. All focus group discussions, exhibit planning meetings, and individual interviews were recorded and transcribed verbatim by the researcher. In addition to transcripts, all photos taken by participants were collected and included in the analysis process.

### **Study Research Aims, Questions, and Hypothesis**

The study's primary aim was to explore the use of PhotoVoice as a therapeutic intervention with female survivors of sexual assault, ages 18-34, attending a Midwestern University who were symptomatic for PTSD. Qualitative research questions included:

1. What change does PhotoVoice produce in survivors of sexual assault?
2. How does PhotoVoice evoke change for survivors of sexual assault?

The study's secondary aim was to assess psychological change pre- and post- PhotoVoice intervention. The quantitative hypothesis was:

**Hypothesis** PhotoVoice will decrease PTSD symptoms and increase posttraumatic growth and positive rape attributions.

### **Sampling Procedure**

**Sample.** A purposive sampling method was used: females enrolled in a Midwestern University who had experienced sexual assault and were symptomatic for Posttraumatic Stress Disorder. A total of 20 women inquired about the study, 12 participated in the pre-screening, and nine met participation eligibility criteria and signed written consents. Participants who met study criteria were assigned to groups after participating in the initial pre-screening.

Recruitment occurred between October 2013 and February 2014. Although a multi-pronged recruitment strategy was used, study enrollment was low, perhaps due to the sensitivity of the topic and the time commitment associated with the intervention. The initial group had four participants, the second group had three, and the final group had two participants.

### **Intervention Procedure**

**Telephone initial inquiry.** During recruitment, individuals who inquired about the PhotoVoice intervention were read a script via telephone (see Appendix C – Phone Interview) that detailed the intervention protocol, as well as an informed consent with waiver of documentation to participate in a pre-screening (see Appendix D – Consent with Waiver of Documentation). Telephone contacts were conducted by the study researcher and took place at least 24-48 hours after initial inquiry. If the participant agreed to verbally consent to participate in a pre-screening, the study researcher scheduled a pre-screening meeting with key study personnel.

**Pre-screening.** All individuals who met eligibility criteria and verbally agreed to participate in a pre-screening, met with Jennifer Shearrin, BSW, a key study personnel approved by RSVP (Note: Jennifer Shearin was also conducting a study through RSVP and Dr. Anderson was overseeing her and the researcher's projects. They met weekly for nine months for research meetings). Potential participants were asked to complete the Posttraumatic Stress Checklist-Civilian version (PCL-C), a demographics form, and a written consent form. All pre-screening meetings were conducted at the University of Missouri Women's Center counseling room. If participants did not meet criteria for the study ( $n = 3$ ), they were provided additional campus resources from the University of

Missouri Counseling Center, the University of Missouri Student Health Center, the Relationship and Sexual Violence Prevention (RSVP) Center, and other community resources (e.g., psychological services screening clinic).

**Inclusion criteria.** Female participants were defined as college enrolled women between the ages of 18-34, who had experienced a sexual assault and were symptomatic for PTSD. While this project has an age range and gender specification, violent crimes such as sexual assault, impact women and men of varying ages. These specifications were set in order to control for similar groups.

Sexual assault was defined as any kind of sexual contact that occurred without the explicit consent of the recipient, including: sexual threats, attempted rape, and completed rape (United States Department of Justice [USDOJ], 2014). Symptomatic for PTSD was defined as  $\geq 44$  on the PCL-C. The clinical cut-off score used for sexual assault survivors (Norris & Hamblen, 2003).

**Orientation.** Participants who met study criteria were assigned to groups and given a brief orientation detailing how to take photos, what to photograph, and the intervention protocol. During the orientation, the researcher taught participants how to use the cameras, explained the project rules and guidelines, showed the participants how to take pictures, and provided time to practice taking pictures. There was also a discussion about photograph meaning—how their photos could relate to their life as a survivor of sexual assault—and areas of focus for participants. If participants wanted to take pictures of other individuals, they were informed that permission must be given to the photographer prior to the photo taking. The researcher gave each participant an IRB-

approved permission form to gain consent from individuals they wished to feature in photographs (see Appendix E – Photo Consent Form).

The researcher suggested the following possible focus areas: powerlessness, shame and guilt, distrust, strength, healing, memories, and triggers. The researcher also asked participants to share any other focus areas they felt were appropriate. All participants agreed that these focus areas were enough to begin the process.

**Focus groups.** There were a total of nine focus groups (3 x 2 SHOWed groups + 3 exhibit planning focus groups).

After the orientation, participants were given approximately one week to take photographs of images they felt pertained to their life as a survivor of sexual assault. After this week of photo taking, they met together at the RSVP Center for a focus group. The focus groups were held at the RSVP Center, with the exception of group three; their focus group meetings were held in the Women's Center Counseling Room due to space conflicts at the RSVP Center. The researcher brought a laptop computer to download digital photos for group members to see. The focus group sessions included both individual presentation of photos (within the group setting) and group discussion that was facilitated by the researcher using the SHOWed method.

SHOWed was developed for PhotoVoice by Wang and Burris (1994) and is a five-question semi-structured format. It allows participants to frame their stories in a safe way, as well as encourage them to take a critical stance on what it means to be a survivor of sexual assault. The acronym SHOWed is: 1) What do you **S**ee here? 2) What is really **H**appening here? 3) How does this relate to **O**ur lives? 4) **W**hy does this situation, concern, or strength exist? 5) What can we **D**o about it?

Participants were asked to pick two to four photographs they felt best represented their experience with sexual assault to describe during the focus groups. Each participant was allotted a specific amount of time (20-25 minutes) to present the photos of their choice to the group. During the individual presentations, the researcher directed the SHOWeD questions to the participant, and also asked questions that addressed what they were thinking when they took the picture, and what the photo indicated about their experience as a survivor. Next, the discussion was opened up to the group, where the facilitator asked them questions regarding their reactions to the photo, the similarities and differences between group members' experiences, and how the photo addressed the problems or needs of the collective group. Each focus group was two to two and a half hours long.

**Exhibit planning focus group.** The exhibit planning meeting/focus group, was structured similarly to the SHOWeD focus groups, in that participants had a final opportunity to share one (1) photo using SHOWeD questioning; however, they were also asked to plan their invitation-only group exhibits during this time. Each group planned their exhibit together. They decided on an exhibit location, what photos to display (about 15-20 photos total per exhibit), and an exhibit invitation list. Examples of exhibit attendees included university officials (e.g., the Chancellor and Vice Chancellor of the University of Missouri), key stakeholders (e.g., members of the Office of Student Conduct, the Director of Student Affairs at the University of Missouri, investigators from the University of Missouri Police Department, etc.), family members, significant others, friends and roommates. Participants were intentional about who they invited, and each group had an opportunity to write an invitation (i.e., e-mail invitation) that would be sent

to the list of attendees by the researcher. The researcher also sent the e-mail invitation to participants so they could personally share the invite with friends, family, or other supportive persons to attend.

**PhotoVoice exhibits.** Each participant was given the option to agree to participate in the invitation-only group exhibit. If they consented, individuals were involved in all decision-making regarding photos and narratives that would be on display. This was done to ensure that the participatory nature of PhotoVoice was intact and for protection of participant language and perspective. Participants were also given a choice if they wanted to use a pseudonym or no name for photo authorship. Participants did not have to share any information or photographs that they did not want to share. All participants chose to participate in their group's invitation-only PhotoVoice exhibits.

In addition, the researcher organized a public exhibit in the Spring of 2014. It was held during the RSVP Center's annual Sexual Assault Awareness Month (SAAM) programming. Participants were asked to invite friends and family to this exhibit; however, it was not mandatory for the participants to attend. Five total participants attended the large group exhibit.

***Exhibit location and setup.*** All invitation-only group exhibits were held at the RSVP Center. The public exhibit was held in the lower level lounge of the University of Missouri Student Center outside the RSVP Center office. Key quotes from participants were selected to describe their photos, which were put in photo frames and displayed on easels borrowed from the University of Missouri Department of Student Life. Exhibits

were one to two hours in length. Participants were available to answer any questions the exhibit attendees had.

### **Data Collection Procedure**

**Recruitment.** Recruitment occurred through the RSVP Center's social media outlets (Facebook and Twitter), the RSVP Center's e-mail listservs, as well as MU Info, an information distribution system that reaches all University of Missouri students, staff, and faculty (see Appendix F – Recruitment). The researcher scheduled social media posts using an online social media scheduler called Hootsuite. Social media posts were scheduled strategically to meet peak social media traffic hours (e.g., Thursday evening between 11:00 p.m. - 2:00 a.m., Friday mornings between 8:00 a.m. – 12:00 p.m., Saturday evening between 11:00 p.m. - 2:00 a.m., and Sunday mornings between 8:00 a.m. - 12 p.m.). In addition to social media, the study researcher sent e-mails to all RSVP Center listservs, including the RSVP Center Peer Educators, the RSVP Center outreach group, and a list of contacts who previously utilized RSVP crisis intervention and case management services. Interested participants were asked to contact the study researcher via e-mail to schedule a phone interview. During the phone interview participants were read a brief description of the study protocol and the consent with waiver of documentation to participate in a pre-screening. The study researcher collected all consent with waiver of documentation forms. After Jennifer Shearrin completed the pre-screening with participants, all written consents and measures were brought to the study researcher and stored in locked file cabinets in the RSVP office.

**Data collection points.** Participants underwent a series of data collection points (one pre-screening, one orientation, two SHOWeD focus groups, one exhibit planning meeting, one exhibit, and an individual interview):

1. Pre-screening (quantitative data collection point)
2. Orientation (quantitative data collection point)
3. Focus group one (quantitative and qualitative data collection point)
4. Focus group two (quantitative and qualitative data collection point)
5. Exhibit design meeting (quantitative and qualitative data collection point)
6. Exhibit
7. Individual interview (quantitative and qualitative data collection point)
8. One month follow-up (quantitative data collection point)

### **Qualitative Instruments**

The primary aim of the study was to explore PhotoVoice as a therapeutic intervention with sexual assault survivors. The qualitative instruments were designed to gather information to address the research questions of the study.

**SHOWeD instrument.** SHOWeD is part of the PhotoVoice intervention but it also provided rich text for qualitative analysis. The researcher used SHOWeD to help participants identify key aspects of the photo that related to their experience with sexual assault (e.g., triggers, strengths, weaknesses, etc.). In addition, SHOWeD allowed participants to share their story with other group members, creating fruitful dialogue regarding sexual assault experience from survivors' perspectives.

**Individual interview instrument.** Upon completion of focus groups, exhibit planning meetings, and exhibits, the researcher conducted individual interviews to further discuss each participant's experience with PhotoVoice as a brief therapeutic intervention. (see Appendix G – Individual Interview). The interview instrument included asking about changes that occurred related to PTSD symptoms, PTG, and positive rape attributions. In addition, the researcher asked participants to share what they perceived to be the most meaningful part of PhotoVoice. The researcher then asked participants to discuss any needs, priorities, or challenges they experienced throughout the intervention and how the intervention facilitated change.

### **Quantitative Instruments**

The secondary aim of the study was to measure the effect PhotoVoice had on participant PTSD symptomology, PTG, and rape attributions. (Note: due to this study's small sample size, reliability tests were not conducted on quantitative instruments.)

**Concept: posttraumatic stress disorder (see Appendix H – PCL-C).** The Posttraumatic Stress Disorder Checklist (Weathers et al., 1991) is one of the more commonly used measures to assess PTSD symptomology among the military population (PCL-M), civilians (PCL-C), and among individuals who have experienced specific traumas (PCL-S). For this study,  $\geq 44$  was the clinical cut-off score for PTSD symptomology.

The PCL-C is a 17-item self-report measure that is closely aligned with the DSM-IV diagnosis of PTSD (i.e., symptoms are captured in three different clusters: re-experiencing, avoidance, and emotional numbing; Wilkins, Lang, & Norman, 2011). Respondents were given paper copies of the PCL-C, and were asked to self-report the

degree to which they were bothered by PTSD symptoms in the past month, using a Likert scale [1 (not at all) to 5 (extremely)]. Total scores may range from 17-85.

***Test-retest reliability and internal consistency.*** Wilkins and colleagues (2011) revealed that the PCL-C has acceptable test-retest reliability. This analysis showed higher reliability when the PCL-C was administered using a computer, with lower reliability found in paper formats. Because of access, time constraints, and limited funding, a paper of the PCL-C was administered for this study.

Wilkins and colleagues (2011) report an internal consistency of .75 or above, in 14 of the 72 studies, when the measure was administered with the following mixed samples: military, women with substance abuse disorders, women treated for breast cancer, adults who have suffered from traumas resulting in the loss of limbs, and female undergraduates.

**Concept: posttraumatic growth (see Appendix I – PTGI).** The Posttraumatic Growth Inventory (PTGI) (Tedeschi & Calhoun, 1996, 1998) is a 21-item measure designed to capture significant positive change (posttraumatic growth) that individuals may experience after negative life events such as sexual assault, loss of a loved one, or other highly traumatic events (Tedeschi & Calhoun, 1996, 1998). Each of the items on the PTGI is rated on a 6-point Likert scale ranging from 0 (I did not experience this change as a result of my crisis) to 5 (I experienced this change to a very great degree as a result of my crisis). Overall scores range between 0-105.

Despite the overwhelming evidence that traumatic events produce serious mental and physical health consequences, there is a body of literature that suggests survivors may be transformed by their experiences, including sexual assault and rape survivors

(Tedeschi & Calhoun, 1996, 1998; Veronen & Kilpatrick, 1983). The PTGI is designed to measure this transformation, by capturing a survivor's perceived change in self, changes in relationships with others, and a changed philosophy of life, which all aligns closely with the work of Janoff-Bulman (1989) and the theory of shattered assumptions. This is why the PTGI was chosen to measure PTG among survivors of sexual assault who participated in this intervention.

***Test-retest reliability and internal consistency.*** The PTGI has acceptable test-retest reliability ( $r = .71$ ), and strong internal consistency, with an overall Chronbach's alpha of .90 (Tedeschi & Calhoun, 1996, 1998). The PTGI can be used to reveal a total PTG score, or it can be used to reveal scores for 5 subscales: Relating to Others (7 items; alpha=.85), New Possibilities (5 items; alpha=.84), Personal Strength (4 items; alpha=.72), Spiritual Change (2 items; alpha=.85), and Appreciation of Life (3 items; alpha=.67). When used with a sample of female sexual assault survivors, Cronbach's alpha for the PTGI was .94, with subscales ranging between .78 to .85 (Grubaugh & Resick, 2007).

**Concept: positive rape attributions (see Appendix J – RAQ).** The Rape Attribution Questionnaire (RAQ) was used to measure participants' beliefs about why the assault occurred through five different attributions: behavioral self-blame, characterological self-blame, blaming the rapist, blaming society, and blaming chance (Frazier, 2003). There are five items for each of these attributions. The RAQ assesses three aspects of control for survivors: control over the recovery process (present control), taking precautions to avoid re-victimization (future control), and perceived likelihood of future assaults (Frazier, 2003). This scale was tested with a sample of sexual assault

survivors (not specifically college-aged), and the mean alphas for each of these subscales are as follows: present control = .81; future control = .70; future likelihood = .83.

### **Analytical Strategy**

**Qualitative analytical methods.** Qualitative data included verbatim transcripts of focus group ( $n=9$ ) and individual interviews ( $n=9$ ) resulting in 159 pages of transcription. Additional data included 81 photos.

After each interview was transcribed, the researcher compared the text to the digital recordings to ensure accuracy. The researcher used a thematic analysis approach to analyze qualitative data. This type of analysis allows the researcher to examine, pinpoint, and record similarities within the data in order to later organize them into themes (Braun & Clarke, 2006). Themes are patterns found across the data set that are directly associated with the research questions and become categories for analysis (Fereday & Muir-Cochrane, 2008).

**Coding.** The process of thematic analysis began with the researcher familiarizing herself with the data through conducting and transcribing the sessions. Prior to reviewing the transcripts, the researcher generated a list of initial codes (e.g., control over recovery, re-authoring narrative, triggers) as they related to the research questions (Braun & Clarke, 2006). Using a constant comparative method, the researcher went back and forth between the phases of analysis; tagging labels to the data set based on the specific research questions and condensed larger data sets into smaller units, or categories (Braun & Clarke, 2006). In-vivo coding (participants' terminology) was also used in this reduction phase.

The researcher reduced thirty-nine codes (see Appendix K – Reduced Codes) into four over-arching themes of how PhotoVoice evoked change in survivors of sexual assault. In addition, one theme (posttraumatic growth) was derived from the qualitative data to reveal how the intervention produced change in themselves as a result of their participation in the intervention. Data analysis was conducted using a constant comparative method (CCM); a qualitative procedure that identifies and extracts significant statements from in-depth, semi-structured interview transcripts to be conceptualized and reconstructed in new ways (Glaser & Strauss, 1967). This method allowed the researcher to generate themes that, along with substantive codes, categories, and their properties, encompassed as much behavioral variation as possible (Glaser & Strauss, 1967).

**Qualitative methodological rigor.** Qualitative analysis requires the researcher to reduce data that reflects participants' experiences with sexual assault and their perceptions of PhotoVoice as a therapeutic intervention (Erlandson et al., 1993). The researcher, therefore, employed the following to insure methodological rigor: credibility, transferability, dependability, conformability, and reflexivity (Anderson, 2010; Steedman, 1991; Lincoln & Guba, 1985).

**Credibility.** Credibility required the researcher to realistically portray the data in a way that credibly accounted for participant perspective. This occurred through member (participant) checking, as the researcher provided the participants with preliminary and final qualitative results to ensure the data accurately reflected their perspectives. This ensured that the researcher reconstructed participant stories truthfully, in order to better understand phenomena from their perspective.

***Transferability.*** This criterion refers to the degree to which the results of this study can be generalized or transferred to other contexts or other respondents (Lincoln & Guba, 1985). Transferability can be enhanced by thoroughly describing the context of the research and the assumptions that were central to the research findings. The researcher maintained detailed descriptions of participants' accounts in an effort for readers to make decisions regarding application of data findings to other contexts and respondents. Sampling criteria also helped foster transferability within this study, as there were a range of responses and experiences from women who experienced sexual assault. The purposive sampling technique allowed participants to provide unique, rich context and perspective. The researcher could then document unique themes among this data for transferability.

***Dependability.*** Dependability accounts for the ever-changing conditions of this qualitative study, and ensures that the findings would be similar if replicated with another population of people with a similar context (Lincoln & Guba, 1985). There were changes in the research design after a refined understanding of the participants' needs and perspectives were obtained. For example, the original protocol called for only two SHOWeD sessions per group; however, after the first group completed their two sessions, they requested that an additional SHOWeD session occur during their exhibit-planning meeting. During this time participants shared more photos about their experience, and revealed more data about where they saw their healing going in the future. Any changes to the research design were reviewed by Dr. Anderson to ensure dependability.

***Confirmability.*** Confirmability refers to the degree to which the results of a study are confirmed, or substantiated by others (Lincoln & Guba, 1985). Research conclusions

are to be traced back to original data sources as described earlier in this chapter. The researcher used triangulation to ensure confirmability. Triangulation is the use of more than one method of data collection to answer the research question. This study used mixed-methods, where both quantitative and qualitative data were collected. In addition, there were multiple ways in which qualitative data were collected (e.g., focus groups, photos, individual interviews). All data was triangulated to ensure confirmability. Through weekly meetings (with Dr. Anderson and Jennifer Shearin), the researcher also remained in constant communication with other members of the research team to discuss any personal thoughts or reactions to the research process. These discussions further supported that findings from this study were a direct product of the inquiry rather than biases of the researcher and/or research team.

***Reflexivity.*** Finally, to ensure rigor, the researcher reflected on how her own similarities and differences with the participants, and her own worldview and perspectives, may have impacted the data collection and analysis. The researcher considers gender-based violence to be an important topic, both personally and professionally. Like the participants, she is a female survivor of gender-based violence, and has five years of experience working as victim/survivor advocate. She used her experiences and knowledge to create a safe space for participants to share their own stories with images and discussions – which contributed to rich data about women’s lives. Violence is difficult to discuss and the PhotoVoice meetings were held at the University, the overall site of many participants’ assaults or legal processes. No participants said that the researcher’s facilitation or the group format prevented them from sharing; however, it is possible that women were tentative or fearful to discuss some aspects of their

experiences. Given the researcher's experience and knowledge about survivors' experiences, she was open to seeing both challenging and positive aspects of women's lives in the data, and thus the final themes included various aspects of women's resilience as well as painful aspects of their assault.

**Quantitative analytical methods.** A two-tailed paired sample t-test compares the dependent measure of a single sample under two treatment conditions (pre-and post-test); it was chosen for this study to determine whether there were significant changes in symptoms of PTSD, PTG and rape attributions that occurred as a result of the PhotoVoice intervention.

All quantitative data were entered into Microsoft Excel and analyzed using the Analysis Toolpak in Microsoft Excel. Measures containing negatively worded items were reverse coded prior to analysis in Excel. To control for Type I error, all analyses were conducted at an alpha level of .05.

### **Summary**

The purpose of this chapter was to explain the mixed-method research design used in this study. Because the study is primarily qualitative and emergent in nature, having a specific set of methods and procedures supports the overall framework of the study and, ultimately, enhances study rigor. This design promotes the integrity of the research, and will be by the researcher to inform larger treatment trials in the future.

## CHAPTER 4—RESULTS

### **Demographics**

Table 1 presents descriptive information about the study participants' race/ethnicity, level of education or status in school, age, as well as information regarding their experience with rape, intimate partner violence, and stalking. Also presented are the variation of sexual assault experiences (multiple exposures to sexual assault, or sexual assault accompanied with intimate partner violence and stalking), and their service utilization (e.g., case management from the Relationship and Sexual Violence Prevention (RSVP) Center, University Counseling Center, and community counseling services)

Most participants identified as Caucasian ( $n = 6$ ), undergraduate student survivors of sexual assault, who experienced rape while attending college, and knew their perpetrator. Two women identified as Latina, while one woman identified as a black woman. Prior involvement with the RSVP Center was not a criterion for participation in PhotoVoice; however, some participants used crisis intervention and case management services from the RSVP Center. Furthermore, many of the participants had not used counseling services before (either from the university, or from a community counseling agency or service).

Table 1. Demographics of Sample			
<i>Demographics of Sample</i>			
Variable		Frequency	Percentage
<b>Race/Ethnicity:</b>	<i>Black</i>	<i>n = 1</i>	11.11%
	<i>Caucasian/White</i>	<i>n = 6</i>	66.67%
	<i>Latina/Hispanic</i>	<i>n = 2</i>	22.22%
<b>Status in School:</b>	<i>Undergraduate</i>	<i>n = 8</i>	88.89%
	<i>Graduate</i>	<i>n = 1</i>	11.11%
<b>Assaulted While at College:</b>	<i>Yes</i>	<i>n = 6</i>	66.67%
	<i>No</i>	<i>n = 3</i>	33.33%
<b>Multiple Rape Experiences:</b>	<i>Yes</i>	<i>n = 5</i>	55.56%
	<i>No</i>	<i>n = 3</i>	33.33%
<b>Relationship to Perpetrator:</b>	<i>Aquaintance</i>	<i>n = 7</i>	77.78%
	<i>Stranger</i>	<i>n = 2</i>	22.22%
<b>Childhood Sexual Abuse:</b>	<i>Yes</i>	<i>n = 4</i>	44.44%
	<i>No</i>	<i>n = 5</i>	55.56%
<b>Previous RSVP Client:</b>	<i>Yes</i>	<i>n = 4</i>	44.44%
	<i>No</i>	<i>n = 5</i>	55.56%
<b>Utilized Counseling During PV:</b>	<i>Yes</i>	<i>n = 4</i>	44.44%
	<i>No</i>	<i>n = 5</i>	55.56%

### Qualitative Results

The primary aim of this study was to explore the use of PhotoVoice as a therapeutic intervention for female survivors of sexual assault enrolled at the University of Missouri who met criteria for Posttraumatic Stress Disorder. The qualitative research questions were: 1) What change did PhotoVoice produce in survivors of sexual assault? 2) How did PhotoVoice evoke change? The first research question was answered more

specifically in the quantitative analysis, but it is supported by qualitative thematic analysis regarding essential aspects of posttraumatic growth, including enhanced control over their recovery process and, ultimately, their lives.

For the second research question, thematic analysis revealed four essential themes regarding how PhotoVoice evoked change. First, picture taking exposed participants to their triggers; the process allowed them to lessen associated emotional reactions (e.g., fear) and integrate fragmented memories of their trauma.

Secondly, the SHOWeD discussion facilitated re-authoring of their self-narratives from vulnerability to ones of strength through making meaning of their experiences. Thirdly, the group process provided support and encouragement to explore post-trauma interpersonal relationships and uncover positive and negative support networks. Finally, the private (invitation-only) and public (open to campus) exhibits encouraged consciousness raising and an improved sense of empowerment.

As research question one is addressed more fully in the quantitative section, this section will address the four themes that emerged to answer research question two.

### **Picture-Taking: Exposure to Triggers**

Before involvement in the PhotoVoice project, participants discussed avoiding their triggers as a way to cope with their sexual assault. They expressed how trigger exposure produced emotional reactions such as anxiety, hypervigilance, and flashbacks. The photo-taking process of PhotoVoice allowed participants to approach their triggers with choice and control and, thus, lessened overwhelming associated feelings and emotions. They chose what triggers to capture (e.g., locations of the assault, the University conduct hearing room) and how they would be represented. In addition,

participants processed their trigger exposure in a safe group format. This allowed for additional desensitization as they reported on their triggers and reactions along with processing with other participants about their exposure experiences. Finally, participants were able to better understand the connection of their triggers and post-trauma reactions such as anxiety and extreme hypervigilance. Next are examples of what participants expressed regarding their triggers.

Participant number 004 was sexually assaulted in a fraternity house at her university. Passing this area of campus created significant anxiety and shame for her, and as a result, she used avoidance as a way to overcome this anxiety. This avoidance caused her to repress the memory, pushing it back into her mind, allowing traumatic symptoms to continue to manifest without dealing with them. Participant 004 said that PhotoVoice exposed her to the trigger and encouraged her to express her thoughts and feelings about the event, which began the process of her dealing with her memories of the trauma. In describing the picture of the fraternity house (See Figure 3, Powerless) she said, “This is where I was raped, in a fraternity. Pretty cliché, I know. I blame myself for not fighting back...this house represents weakness. It’s one of the many triggers I have, and that’s a constant struggle for me.”

She continued to note, “It’s going to be a part of my everyday life...I have to convince myself that [not fighting back] was the way my body wanted to deal with the trauma.” Based on group discussion and observations, it appeared that this exposure helped Participant 004 to lessen her feelings of self-blame and shame, allowing her to go through this area of campus feeling less upset and anxious by the memories of the assault.



*Figure 3. Powerless.*

Similarly, Participant 006 described feelings of anxiety post-trauma. She explained that the University bus triggered these anxious feelings and, therefore, she avoided riding the bus. Consequently, she chose to photograph the bus as one of her triggers. In describing the photo titled, “Anxiety Shuttle” (see Figure 4), she expressed, “If the bus is not full, I’m ok. But I don’t know if it is going to get full.” She continued to note that this uncertainty caused anxiety, which usually sent her into a panic attack. She said, “When the bus gets full, I can’t get my space. All of a sudden I feel like I need to leave. It’s like a shuttle that keeps me closed in.” She went on to report,

the photo of the bus is symbolic of how I didn’t want to be touched...every time I get on the bus, I don’t want to be touched, but I am...touch has become evil to me. I don’t want anybody touching me. My space has been invaded, and I don’t want it invaded again.



*Figure 4. Anxiety Shuttle.*

Participant 006 discussed how photographing and talking about the bus, helped her to better understand the trigger's effects and allowed an avenue for her to lessen her associated anxiety.

Participants 001 and 007 photographed objects and people that triggered traumatic memories of their assault, causing reactions such as nightmares and anxiety. In describing her first photo, Participant 001 said, "I am still a young woman, and young women always go through stuff like this...my photos will talk about [my experience], or remind me of the experience." She described a photo of a bottle of lotion and how it is symbolic of her experience. She explained that the scent of the lotion triggers traumatic memories of the event. She said, "it was my favorite fragrance...when he assaulted me, he came up and surprised me. I can feel him and hear him tell me that I smelled good." She continued, "it is still hard for me to wear the lotion...I tried to take it back, it's my favorite fragrance. I shouldn't have to stop wearing it." Participant 001 is still reminded of her assault when she wears the lotion; however, she described being able to wear it with less triggered emotions of the event.

Participant 007 described how military uniforms trigger traumatic reactions. Her assailant was in the military, and the site of a man in uniform she reports, “is very triggering for [her].” She described her photo titled, “Always Around” (see Figure 5) and continued, “I had a very skewed, frightened perception of anything military.”



*Figure 5.* Always Around.

She expressed that the photo was symbolic of her fear of military personnel. She explained that the photo reminds her of how she feels constantly surrounded by people in uniform, noting how this hypervigilance created significant anxiety for her. Participant 007 said that she is working toward being comfortable with being around military personnel without feeling anxious.

In confronting triggers, participants addressed posttraumatic reactions associated with the memory (e.g., anxiety, hypervigilance). The women did this by directly confronting their triggers through photo taking and discussing these photos in a safe

group format. This exposure laid the foundation for them to make meaning of their sexual assault, as they continued to discuss their photos in the SHOWeD focus groups.

### **SHOWeD Discussion: Meaning Making and Reauthoring**

Answering and processing the SHOWeD questions within a group format allowed participants to share their photos while also witnessing (and commenting) on those of others. In doing so, participants further processed their sexual assault experiences, along with making meaning (e.g., gaining insight and understanding) of their associated suffering and healing. For some, they reported how they gained meaning by recognizing that sharing their experiences may help other survivors. For others, making meaning of their sexual assault experiences allowed them to revise (or replace) trauma-influenced elements of their self-narratives (e.g., questioning belief systems, revising belief systems). Next, examples of participants' making meaning experiences are provided, including gained insights and transformed perceptions of their trauma allowing for a re-authoring of their self-narratives.

Participant 009 shared with the group her experience of being sexually assaulted by her boyfriend. She explained that her boyfriend was Mormon and requested that she conform to his religious beliefs. She said, "I put aside my religious beliefs to accommodate him." In describing a photo of a book (see Figure 6, Nothing Lost), she expressed that the book served as the foundation for her current religious beliefs, because at the time, her boyfriend was Mormon, and pressured her into that religion.



*Figure 6. Nothing Lost.*

She has since explored other religions after her experiences with sexual assault.

Participant 009 continued to note that the book reminds her of her experience, but also helps her “get back to who [she] was and pick up where [she] left off.”

Participant 009 also presented a picture of a garden, titled “Succulent” (see Figure 7) to represent her healing and transformation process. In describing the photo she expressed:

I’m always developing and transforming into something that can look different even though it came from the same foundation. I have trouble reconciling with how much these past events have shaped me, and how okay I am with that as who I am. That’s the gray area I see in plants. It’s hard to tell if they look the same, or different...the sapling [of a plant] is part of who they are now, but you can’t see it.



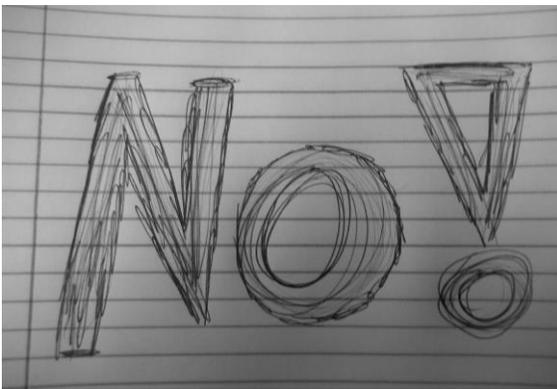
*Figure 7. Succulent.*

She further explained how plants are symbolic of her experience and her survivorship. She said, “her experience is part of who she is, but most people cannot see it.” She continued to express how succulents are symbolic of her healing:

Succulents are different from most flowers. You can break them open, like aloe, and they can actually do things like treat burns. Sometimes, they produce flowers, which is rare. They transform so much...you can take old parts and recycle them into something bigger...I can take how [my rape] shaped me as a person and build it into something bigger, or better.

A member of the Armed Forces sexually, Participant 006 was sexually assaulted during military training. When discussing this assault with the group she described the

experience as the ultimate betrayal. She drew a picture of the word ‘No’, photographed it, and described it during the SHOWeD focus groups. She titled the photo, “A Word with No Meaning” (see Figure 8) and expressed how this photo is symbolic of her lack of a voice. In describing the photo, she explained to the group that she told her perpetrator ‘no’ several times before he forced himself upon her. She said, “the word ‘no’ holds no weight or meaning...it didn’t mean ‘no’ when it happened. Does it now? Do I have a voice?”



*Figure 8. A Word With No Meaning.*

Participant 006 explained that PhotoVoice allowed her to not only reach out for help, but also helped her find her voice, thus, reducing anxiety and helping her to heal. She said, “Participating in PhotoVoice allowed me to find my voice. It helped reduce my anxiety, and gave me strength. Every day I feel better. Stronger.” When asked about her healing, Participant 006 described a tree in winter, relating the picture of the tree to herself and her healing process. She titled the photo, “Waiting for the Cold to End” (see Figure 9). In describing the photo, she expressed, “I look at the trees and I feel like they’ve been stripped of something. While it’s alive inside, it seems so dead outside.” In relating the tree to her healing, Participant 006 expressed:

I feel like with the right sunlight, water, and time, the leaves will come back. I feel like the tree in winter right now. I've been stripped of my courage, trust, my voice...I feel like with the right [care] things will become greener, better.



*Figure 9.* Waiting for the Cold to End.

Participant 008 was assaulted by an acquaintance in her graduate program resulting in significant anxiety, including frequent nightmares. She expressed that she used prayer as a way to help her cope and overcome her trauma symptoms. In the photo titled, “Latina Prayers” (see Figure 10) participant 008 reported:

[After my assault] I fell into a depression. My partner bought candles, and I wrote out what I was praying for, and what I wanted [to come out of my student conduct process]... We placed it under one of the candles and prayed. When all else failed, I just prayed. When I felt too exhausted to pray, my partner would pray with me.

PhotoVoice also gave Participant 008 the space to share how her healing is a constant changing process. She used a photo of the ocean to help convey the ebb and flow of her healing process and her ability to regain control of her life. She titled the



*Figure 10.* Latina Prayers.

photo, “A Moment of Peace” (see Figure 11):

The ocean is a big part of me grounding myself. It’s symbolic of my healing because it’s so ever changing. Every time I go to the beach, it looks the same in some ways, but pieces of it are still so different. That’s how I feel about my

healing process. It is changing all the time...I still take comfort in the fact that I am always going to be healing, just like the ocean will always be there.



*Figure 11. A Moment of Peace.*

Participant 005 was sexually assaulted three times. She describes how the color (red) of her hair had something to do with each of the assaults. She said, “Each time [I was assaulted] had something to do with my hair. For some reason, people have a weird obsession with red heads.” She told her PhotoVoice group that the color of her hair was something she used to love about herself as a child, stating that it “made [her] feel unique, and special.” Because of her sexual assault experiences, the one thing she loved about herself quickly became something she hated. She shared a photo titled, “Objectified” (see Figure 12) and expressed:

I feel like an object...like a car decal, or a spoiler on the back of a car. It makes me feel like [my hair] is a feature about me. I feel like guys pick me out and I do not have a choice in it.



*Figure 12.* Objectified.

Participant 005 continued to explain that as a way to regain control over herself, and her recovery, she cut off all of her hair. She noted how liberating this was.

Participant 005 also expressed how she views herself as invisible to others. In a transparent photo of herself titled, “Invisible,” (see Figure 13) she expressed that being invisible is a source of safety for her, yet it also is a negative in that people do not view her as “a whole person.” In describing her photo she said,

[being invisible] is symbolic of how I feel about my presence in other people’s lives...I felt very invisible in high school. I never got much attention. It was so normal to me. When I came to college, that’s when people first started to notice me and I didn’t handle it well...Guys see through [me], they don’t see me as a

whole person. They just see me as a figure. They don't see your cares, your emotions, your wants. You just become an object.

When asked how she feels about not being fully seen, Participant 005 stated,

“Sometimes I am more comfortable with being invisible.”



*Figure 13. Invisible.*

Participant 007 was assaulted by an acquaintance. In describing her experience with the group, she explained that because she knew the person, she felt betrayed and unsafe. She discussed her thoughts on healing and growth and used a photo of a construction site to help express her journey toward recovery. She titled the photo, “Under Construction” (see Figure 14) and said, “I’m rebuilding who I am, rebuilding my life around this thing that happened.” Because her assault was perpetrated by an acquaintance, she explained how the fence around the construction site was symbolic of how she feels about letting people into her life since her rape:

The fence is symbolic of how sometimes I have this fence around me. I'm okay with the people who are inside my walls, because I have invited them in. Other days, I have this fence around me, and I just want to get through the day. I want tomorrow to come...some days a lot of building happens. A lot of growth happens. A lot of good things happen that make it easier for me to not have nightmares. There are still days where a couple of bricks have to come down, and things have to be replaced and fixed. It's a constant building process.



*Figure 14.* Under Construction.

Participant 004 photographed the steps of a sorority house where she initially accepted help after the sexual assault. In a photo titled, "Alone," (see Figure 15) she

states how “[these steps] bring everything back. [They’re symbolic of] how I said out loud what had happened to me for the first time, and accepted help from [an EMT].” She continued to note, “[the EMT] kept telling me to keep my eyes open. He didn’t understand that I wanted to die. I didn’t want to face what had just happened to me.”



*Figure 15. Alone.*

She expressed how now she sees the incredible strength it took for her to not only accept help, but to continue on in life.

### **Group Process: Relationship Building**

Participants expressed how the group process in PhotoVoice allowed them to meet other women who experienced sexual assault, summoning a support system they did

not have prior to participating in the intervention. They discussed how through viewing others' photos and processing those as a group helped them gain additional insight on how each of their sexual assault experiences was unique to the individual, yet there were similarities in how they were affected and coped with their adversities. Participants reported how this helped them to "normalize" their experiences while the support of others allowed them to connect their personal strength. For some, meeting and connecting with other survivors of sexual assault was their primary motivation for participating in PhotoVoice as a therapeutic intervention.

Next, transcript excerpts from focus groups and individual interviews are presented regarding enhanced relationship building as a result of the PhotoVoice process.

[the most meaningful part of the intervention] was meeting the other girls, because I haven't been able to talk to anybody who's been through the same thing...just hearing their stories was huge. [PhotoVoice showed me] that there's a lot of similarities between my experience, and [other group members'] experience...just the way it's affected us, and what we think about the assault, and how we've dealt with it. (Participant 004)

The group meetings were meaningful because not only did I get to see the pictures from the other people, but I got to hear their story...while they had a similar [experience to mine], each one of us had a different story to tell. (Participant 007)

Participant 006 also talked about the group connection, "I think just being able to show up each week and talk to other members, and share photos and stories [was meaningful]. We all grew together as a group." She continued to express how her group members plan to remain in contact with one another after PhotoVoice. Participant 008

also expressed the benefits of connecting with others, “being in a group, sharing [our stories], was meaningful because it was hard for me, at times, to open up. But, then, I felt safe to do that...I felt honored to be in [their] presence, sharing [stories].”

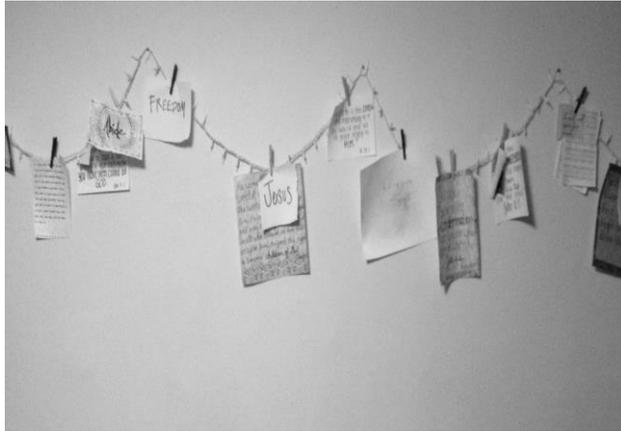
In addition to the PhotoVoice group process providing a supportive network for participants, it also allowed them to explore the effects of their trauma on their informal support networks. For example, some women cited improved relationships while others cited more closed off ones and a reluctance to meet new people, or interact with friends and family.

Participant 003 expressed having feelings of self-blame and guilt for not intervening during the sexual assault. Due to the intensity of these feelings, she struggled to reach out to friends and family members for support. In fact, she explained that she waited several months to share her story with her mother as she feared her reaction, “I didn’t want anyone to know I was raped. It took me two and a half months to tell my mom.” Over time, she disclosed to her family because, “[I realized] that it doesn’t have to be a shameful event. It changed who I am, but it doesn’t make me a bad person.”

Participant 003 reported that PhotoVoice participation allowed her to feel comfortable sharing her story with others. As a result, Participant 003 got involved with her university’s campus sexual and domestic violence resource and prevention center, serving on a task force to end sexual assault. Furthermore, she is involved in an outreach and education program as a way to bring awareness about sexual assault on campus.

Participant 003 also talked about how she wanted to use her experience to help others. She became involved with a campus ministry at her university, and she shared her story with another survivor during a meeting one evening. She took a photo of a wall, and

titled it “Time Brings Strength and Healing,” (see Figure 16) to represent these experiences. She expressed, “It felt really good to talk about my life and not be an emotional wreck at the end of the night. I was able to just go home, and get some sleep.”



*Figure 16.* Time Brings Strength and Healing.

Participants 006, 007 and 008 discussed developing relationships with animal companions as a way to help them heal. Participant 006 took a photograph, titled, “I’ve Got Your Back” (see Figure 17), of her dog’s service patch and expressed how having her dog impacted her recovery by making it “be okay with going places.” She continued to note how training the dog has allowed her to “heal” and described the dog as her “little leash to pull me back on track.”



*Figure 17. I've Got Your Back.*

Participant 007 was empowered by Participant 006's photo sharing of her dog, and decided to train her dog as an emotional support animal with the guidance of Participant 006. This encouraged them to remain in contact with one another even after PhotoVoice ended. Similarly, Participant 008 took a picture of her cat and titled the photo, "Petra" (see Figure 18). In describing Petra, she talked about having the cat as an emotional support animal:

She makes me happy. When I have days that I don't want to get up, she will come lick my face. We take care of each other. Petra [her cat] is symbolic of everything I've gone through...Coming to college was a struggle for me. I would volunteer at the Humane Society, but leave feeling so drained...It made me feel empowered that I took the initiative to do this. To accomplish something like [participating in PhotoVoice].



*Figure 18. Petra.*

Participant 007 spoke about how her relationship changed with her partner after she told him about her sexual assault experience. She photographed a bench, and titled the photo, “Support” (see Figure 19) to represent telling him and how it positively impacted their relationship:

This photo is symbolic of the first time I had to share my story with a significant other. It was one of the hardest things I had to tell him...The conversation ended up bringing us really close, but it was scary at the same time. I contacted him

when I decided to do this project. I told him I would appreciate it if he came when we exhibit the photos. He was such a prevalent person in keeping me from blaming myself.



*Figure 19.* Support.

### **Photo Exhibit: Consciousness Raising**

Participants were connected to each other throughout their PhotoVoice journey, which continued to be enhanced when it came to planning their exhibits and viewing the photos as a whole collection. Initial exhibits were invitation-only and specific to each group. As the women were aware of other groups participating in PhotoVoice, they wanted the opportunity to meet one another and share their photos in a collective exhibit during the University's sexual assault awareness month. The exhibit process was not only empowering for them, but also raised consciousness for the attendees.

For participants who were sexually assaulted on campus, a primary goal for their PhotoVoice participation was to share their stories via a public photo exhibit with specific campus stakeholders and officials who were directly involved in the student judicial process. Participants 003, 004, and 009 discussed the barriers they faced to

obtaining justice and took photos representing their campus' student conduct hearing, and how this process negatively affected their healing and growth.

Participant 003 photographed a picture of a coffee cup to describe how her sexual assault had caused her many sleepless nights, and as a result, impacted her ability to maintain focus on her schoolwork. She titled the photo, "One of Many Hard Days" (see Figure 20). She explained that she fears running into her perpetrator on campus. She said, "I remember thinking I would see him all over campus...I was just on high alert looking for him. I hate this feeling and wish it would go away for good." She said that she chose this particular photo to include in the exhibit because she wanted campus officials to understand how fear of contact with her perpetrator impacted her ability to focus on her coursework, and as a result, impacted her grades and daily life as a student at her university.



*Figure 20.* One of Many Hard Days.

Participant 003 photographed a chair, (see Figure 21, Three Hours of Hell) to represent seeing her perpetrator for the first time at the student conduct hearing:

This chair represents the first time I saw him since I had come back to Mizzou. It was right before the [student conduct] hearing. I remember being afraid to look, but wanted to look. Wanting him to see my anger, and my pain, and make him realize what he had done...Looking at this photo, I can still see him sitting there.

It represents a whole layer of pain and frustration that the student conduct process gave me.

Participant 003 said that she chose this photo to include in the exhibit in an effort to educate stakeholders involved in the university's student judicial process.



*Figure 21. Three Hours of Hell*

She later discovered that Participant 004 had a similar experience with the student conduct process, and was motivated to use her pictures as a way to help campus officials better understand survivors' healing challenges.

Similar to Participant 003, Participant 004 spent months advocating for herself during the campus student conduct process. After the student conduct committee made a

motion to expel the perpetrator, administrators from the university overturned the committee's decision, allowing the assailant to come back to campus. Participant 004 photographed the room where her student conduct hearing took place. She chose to include the photo in the exhibit in an effort to show the student conduct committee, and other campus officials, how she felt about the decision, and how it impacted her growth and healing. She titled the photo, "Strength" (see Figure 22) and expressed:

It took so much strength for me to go into that room and it feels like I didn't accomplish much. I think the part that makes me angriest is that the [a university administrator] found him guilty but didn't think that was enough to expel him. What would've been enough? What will [administrators] tell the next girl he rapes? I bet you he has raped someone since me. He has the perfect environment for it, being in a fraternity with all those parties. He's probably done it again, and that girl is afraid to tell anyone. The fact that this happened to me doesn't say anything about me as a person. What I did with what happened says everything. I tried to remove a rapist from our campus, and while I didn't succeed, what I did was brave. I didn't know how strong I was until being strong was the only choice I had.



*Figure 22. Strength.*

Participant 004 also photographed a picture of the campus sidewalk as a way to express her thoughts about safety on campus. She titled the photo, “Vulnerable” (see Figure 23) and said, “I felt vulnerable in this picture...like I felt the night I was raped.” She chose to include the picture in the exhibit in order to convey how allowing the perpetrator to return to campus makes her feel vulnerable and unsafe. She continued to note, “Walking around campus I’m constantly in fear that I will run into the man that did this to me. It will always be in the back of my head as a possibility I cannot change.”



*Figure 23. Vulnerable.*

Participant 004 stated that she was motivated to participate in PhotoVoice because she could share her photos publicly as a way to raise awareness about survivors' experiences with student conduct hearings and hopefully positively influence policy at the university.

Participant 009 used the PhotoVoice exhibit as a way to show her support system how helpful they were during her student judicial process. She was allowed to bring her academic advisor into the hearing as an advocate and emotional support. In a photo titled, "Fearless Leader" (see Figure 24) she expressed how her advisor's support helped her through this process:

Those are my advisor's hands. During my committee meeting she held my hand the whole time we were [in the hearing]. The only time she let go was to get up and go to the bathroom. She held onto my hand the whole time. It was really powerful to me because I felt so weak in there...She was my strength. I didn't

have anybody else. I describe it as my fearless leader by my side. She's what got me through. I think my experience would have been worse had I not felt validated by her in some way. But the moment I told her, she suited up and got ready for battle with me. She never left my side. I feel connected to her...like she was feeling what I was feeling.



*Figure 24.* Fearless Leader.

Participant 009 hoped that this photo helped demonstrate to campus stakeholders how important emotional support is for survivors undergoing the student judicial process. Participant 009 also photographed a photo of her therapist's office to help educate campus stakeholders of the value of therapeutic supports for survivors of sexual assault. In a photo titled, "Therapeutic Journey" (see Figure 25) she stated:

I felt comfortable to disclose what happened, and felt fortunate to have her [therapist] as support...I feel very safe with her. I am so thankful to have her. She gently pushes me to go certain places that are hard for me to go to.



*Figure 25. Therapeutic Journey.*

Participant 009 also used methods of PhotoVoice, including the exhibit, as a way to better understand her identity as a survivor, particularly as someone working in the sexual assault field. She reported:

I've been doing this work for years, I understand it intellectually. Being on the other end was really difficult. [My therapist and I] have been working on that...what it means for me as a person, a woman of color, a scholar, and now a survivor.

### **Summary of Qualitative Results**

In summary, qualitative data revealed four themes related to how PhotoVoice evoked change in survivors of sexual assault. The photo-taking process exposed participants to triggers, which desensitized them to the traumatic memories of their sexual assault, and allowed them to integrate their fragmented memories of the trauma. The SHOWeD focus groups encouraged critical dialogue regarding their sexual assault

experience and healing, which facilitated meaning-making and allowed participants to re-author their self-narratives. Furthermore, the SHOWeD groups provided a safe and supportive environment for participants, and encouraged them to explore their pre- and post-trauma relationships, revealing positive and negative supports. Lastly, the exhibits encouraged consciousness raising, and facilitated empowerment for participants.

Qualitative data also revealed expressions regarding participants' sexual assault experiences, and their thoughts on healing and growth, posttrauma. The women expressed thoughts and feelings about their posttraumatic reactions (e.g., fear, nightmares, and avoidance), and how they overcame these reactions. These expressions are consistent with symptoms of PTSD, which were captured for each participant, over time, using the Posttraumatic Stress Disorder Checklist for Civilians (PCL-C) (Weathers et al., 1993). In addition, the women expressed thoughts and feelings about posttraumatic growth and healing; specifically, taking control over how, and to whom their story is told, and making meaning of their experience, including developing new relationships posttrauma.

### **Quantitative Results**

A two-tailed paired sample t-test was conducted to measure the impact of PhotoVoice on symptoms of Posttraumatic Stress Disorder (PTSD), Posttraumatic Growth (PTG), and rape attributions (behavioral self-blame and control over recovery). All results were analyzed at an alpha of .05 ( $p < .05$ ).

#### **Symptoms of PTSD**

All participants began the intervention highly triggered, with high individual PCL-C scores at pretest; however, these scores decreased at posttest (see Figure 26). In

addition, the trend across the sample also revealed high PCL-C scores at pretest with a decline in PCL-C scores at posttest (see Figure 27). As reflected in table 2, participants reported a significant decrease in the number of symptoms at posttest compared to pretest. The estimated average effect size of PhotoVoice on total PCL-C scores was large (ES = -1.66; Cohen, 1988).

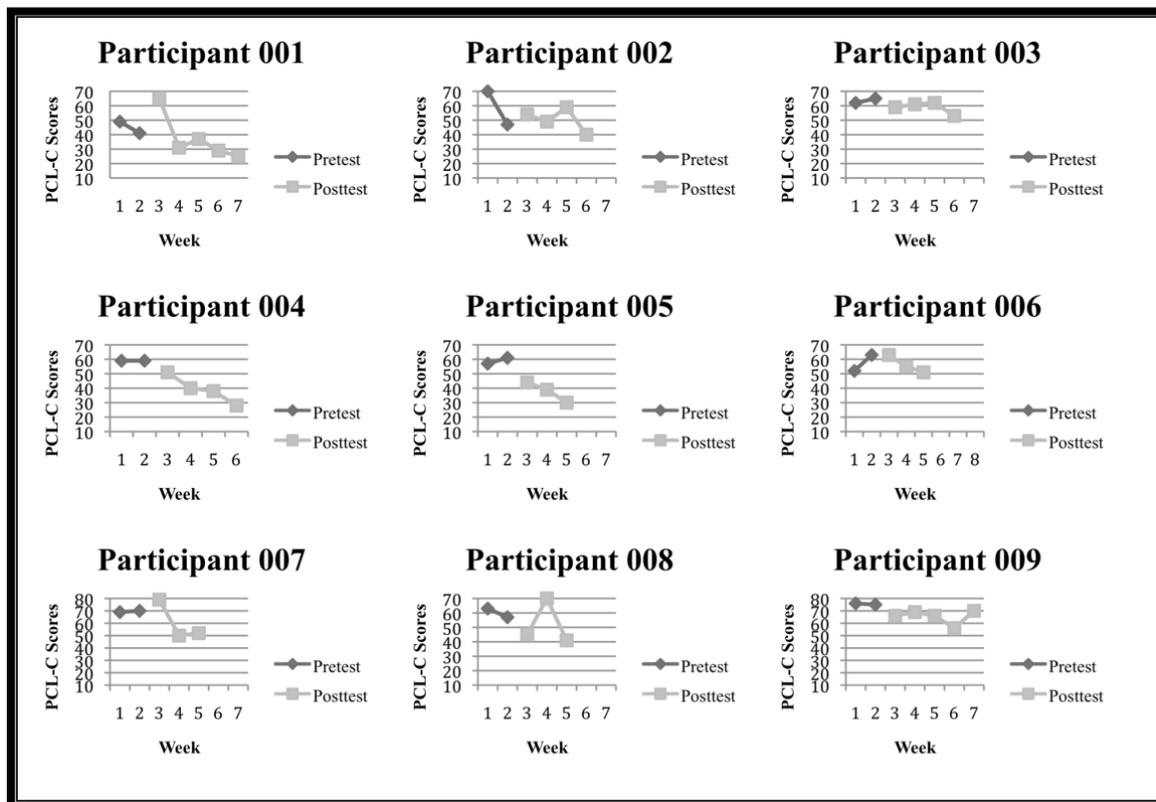


Figure 26. Participant's PCL-C Scores Over the Course of PhotoVoice.

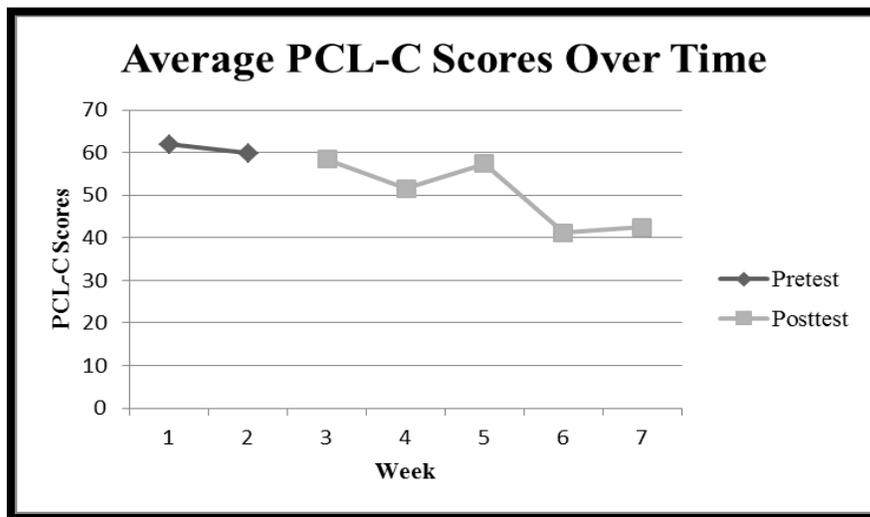


Figure 27. Mean PCL-C Scores Across Seven Weeks of PhotoVoice

Time	N	Mean	SD	t-stat	t-crit	Df	P	Decision
Pretest	9	61.89	8.75	4.59	2.3	8	0.002	Reject
Posttest	9	47.33	11.91					

### Posttraumatic Growth

The Posttraumatic Growth Inventory (PGTI) was used to measure participants' posttraumatic growth (PTG) pre- and post-intervention. There are five factors (relating to others, new possibilities, personal strength, spiritual change, and appreciation of life, respectively) of the PGTI. Results show significant impacts on factors 1 (relating to others) and 3 (personal strength).

Table 3 reveals a significant increase in participants' factor one (relating to others) scores of the PGTI. The estimated average effect of PhotoVoice on participants relating to others was large (ES = 1.05, Cohen, 1988).

Table 3								
<i>t-test Results Comparing Pretest and Posttest Scores for Factor 1:Relating to Others</i>								
<b>Time</b>	<b>N</b>	<b>Mean</b>	<b>SD</b>	<b>t-stat</b>	<b>t-crit</b>	<b>Df</b>	<b>p</b>	<b>Decision</b>
Pretest	9	15.56	8.53	-3.15	2.31	8	0.013	Reject
Posttest	9	24.56	8.35					

Table 4 reveals a significant impact on participants' factor three (personal strength) scores of the PGTI. The estimated average effect of PhotoVoice on participants relating to others was large ( $ES = 1.01$ , Cohen, 1988).

Table 4								
<i>t-test Results Comparing Pretest and Posttest Scores for Personal Strength</i>								
<b>Time</b>	<b>N</b>	<b>Mean</b>	<b>SD</b>	<b>t-stat</b>	<b>t-crit</b>	<b>df</b>	<b>p</b>	<b>Decision</b>
Pretest	9	13.56	4.28	-3.53815	2.306	8	0.0076	Reject
Posttest	9	17.89	1.62					

Results revealed a non-significant impact of the intervention posttest scores for factors two ( $M = 18.44$ ,  $SD = 4.22$ ,  $p = .081$ ; new possibilities), four ( $M = 6.11$ ,  $SD = 4.68$ ,  $p = .681$ ; spiritual change), and five ( $M = 11$ ,  $SD = 2.40$ ,  $p = .101$ ; new appreciation of life). However, as the data are triangulated, qualitative findings suggest that PhotoVoice, particularly SHOWed discussions, has in fact helped participants make meaning of their experience, which allowed them to develop a heightened appreciation of life. In addition, participants discussed the potential for new possibilities, specifically noting how they can use their experience with sexual assault to help other survivors. Finally, one participant described joining a campus ministry (spiritual change), and using it as a platform to share her story with other women in the ministry. These differences in findings further supports the value of rich, qualitative data.

## Rape Attributions

The Rape Attribution Questionnaire (RAQ) captured participants' rape attributions at the beginning and end of the intervention. There are five attributions on the RAQ (behavioral self-blame, rapist blame, control over recovery, future likelihood, and future control, respectively).

Table 5 reveals a significant decrease in participants' behavioral self-blame at posttest and Table 6 reveals a significant increase in participants' control over recovery at posttest. The estimated average effect of PhotoVoice on these attributions indicates PhotoVoice had a large effect on participants' behavioral self-blame ( $ES = 1.20$ , Cohen, 1988) and control over recovery ( $ES = -1.13$ , Cohen, 1988).

Table 5 <i>t-test Results Comparing Pretest and Posttest Scores for Behavioral Self-blame</i>								
Time	N	Mean	SD	t-stat	t-crit	df	p	Decision
Pretest	9	4.09	1.01	2.63	2.31	8	0.03	Reject
Posttest	9	2.87	1.02					

Table 6 <i>t-test Results Comparing Pretest and Posttest Scores for Control Over Recovery</i>								
Time	N	Mean	SD	t-stat	t-crit	df	p	Decision
Pretest	9	3.64	1.03	-2.81	1.86	8	0.011	Reject
Posttest	9	4.38	1.3					

Results indicate that PhotoVoice had a non-significant impact on the following posttest attributions: rapist blame and future control ( $M = 3.13$ ,  $SD = 1.30$ ,  $p = 0.30$ ;  $M = 4.27$ ,  $SD = 0.45$ ,  $p = 0.31$ , respectively). However, qualitative data showed that

participants began the process of shifting the blame to their rapist, but it is unclear as to whether PhotoVoice had an impact on this shift. In addition, photographing, discussing, and displaying their photos in an exhibit encouraged participants to reclaim control over how and to whom their story was told, as well as increased participants' control over whether or not they felt they have control over the possibility of being sexually assaulted in the future (future control).

Non-significant results were also calculated for participants' future likelihood ( $M = 2.56$ ,  $SD = 0.91$ ,  $p = 0.48$ ). Future likelihood captures whether or not participants believe they will be raped again. Though these posttest results are statistically non-significant, a slight increase in the overall average for each attribution at posttest was calculated, when compared to their pretest average. In other words, across the sample there was a non-significant increase in women believing they can be raped again, yet they also believed they had some level of control over whether or not it could happen again in the future.

### **Summary**

Results of this study show that PhotoVoice has a significant impact on participants' posttraumatic growth (PTG) and healing. Research findings revealed that PhotoVoice decreased participants' individual and overall PCL-C scores, suggesting a positive impact on one's PTSD symptomology. Non-significant quantitative results related to some subscales on the Posttraumatic Growth Inventory (PTGI) and the Rape Attribution Questionnaire (RAQ) does not necessarily mean the PhotoVoice intervention did not affect these factors. Qualitative findings suggests otherwise, as participants discussed how their experience with assault and healing, helped them

consider new possibilities that ultimately led to a new appreciation of life, as well as an increase in spiritual growth (all factors of the PGTI). In addition, they discussed their process of shifting the blame to their perpetrator, which is central in reducing self-blame, as well as taking control over their recovery (which includes control over the future likelihood of another sexual assault occurring).

## CHAPTER 5—DISCUSSION

### Discussion

PhotoVoice is a community based participatory action research method (CBPR) that explores social issues impacting marginalized communities. A careful review of the literature indicated that PhotoVoice had yet to be tested as a therapeutic intervention with survivors of sexual assault. Instead, it is most commonly used as an assessment tool in the fields of health education and public health, and more recently within the social work profession. Prior to this dissertation, the researcher used PhotoVoice as a needs assessment tool in many different capacities, including a study to explore health inequalities, as well as other water-related challenges, that impacted the community of Santiago, Honduras. In addition, she also assisted a PhotoVoice study that explored healthcare stigma associated with men living with HIV/AIDS in rural Missouri. Across these experiences, the researcher discovered that PhotoVoice had similar therapeutic qualities to those found in the gold standard treatments for treating Posttraumatic Stress Disorder (PTSD). Specifically, PhotoVoice utilizes cognitive reframing to help participants explore and make-meaning of their experiences, as well as exposure components (through photo-taking) and group work. Thus, this study piloted the use of PhotoVoice as group, exposure-based therapeutic intervention with survivors of sexual assault.

As highlighted in Figure 1. “Theoretical Model of PhotoVoice as a Therapeutic Intervention” (see pg. 41), the cognitive-behavioral conceptual framework suggests that fear is developed through exposure to a conditioned stimulus (classical conditioning), and maintained by reinforcing the reactions to this stimulus (operant conditioning)

(Bandura & Walters, 1963; Pavlov, 1897; Skinner, 1936; Watson, 1913). Cognitive theory can also be used to explain survivors' development of self-blame; specifically, the cognitive distortions that perpetuate behavioral and characterological self-blame. (Janoff-Bulman, 1979; Petrak & Hedge, 2002; Resick & Schnicke, 1993). Evidence-based interventions used with survivors of sexual assault to treat fear, and symptoms of PTSD, encompass cognitive and behavioral techniques such as cognitive reframing and exposure to the traumatic memories of the event (Regehr et al., 2013). After implementing PhotoVoice as a therapeutic intervention, results indicate that though cognitive reframing and exposure affect proximal outcomes (increased connectedness, meaning-making, reduced self-blame, and control over recovery) it is by way of these outcomes that posttraumatic symptoms decrease, and posttraumatic growth increases. In addition, these outcomes increase positive rape attributions.

In the current study, the methods of PhotoVoice (e.g., picture-taking, SHOWeD focus groups) allowed participants to expose themselves to their triggers (e.g., location of the sexual assault, or images and objects that remind them of their experience) as a way to lessen the traumatic impact of these memories. In addition, the SHOWeD focus groups facilitated re-authoring of their self-narratives from vulnerability to ones of strength through making meaning of their experiences. Thirdly, the group process provided support and encouragement to explore post-trauma interpersonal relationships and uncover positive and negative support networks. Finally, the private (invitation-only) and public (open to campus) exhibits encouraged consciousness raising. As a result, PhotoVoice as an intervention was effective in reducing participants' PTSD symptomology while increasing posttraumatic growth (particularly relating to others and

personal strength) and positive rape attributions (decreasing behavioral self-blame and increasing control over recovery). Consistent with theories of trauma, posttraumatic growth, and narrative, this study revealed how influential survivor exploration of their own experience, including exposure to triggers, can be on one's healing and recovery.

### **Implications**

**Implications for practice.** The PhotoVoice process offers clients strategies of empowerment at a personal level (changing patterns of thinking, behaving and feeling), interpersonal level (managing their relationships more effectively), and societal/organizational level (affecting system change) to improve their overall recovery and growth. Consistent with social work practice, PhotoVoice as an intervention utilizes a person-in-environment conceptual framework at micro, mezzo, and macro levels. For example, this study allowed participants to explore their traumas, environmental stressors (such as triggers), as well as encourage them to use their stories as a way to inform the community, and shift policy around sexual assault. Furthermore, practitioners can use PhotoVoice to gain an understanding of a community's unmet needs and activate community members as change agents to address the issues explored. The PhotoVoice intervention can be implemented by trained clinicians, as well as crisis advocates (depending on the level of need of clients), and other lay people to affect change on individual, organization, and community levels.

PhotoVoice could also be utilized in therapy on an individual client basis. Because PhotoVoice is commonly used as a needs assessment tool, it is designed to gather facts and stories about the social issue being studied (Wang & Burris, 1997; Wang & Burris, 1994; Wang, 1996). Social workers and other helping professionals can use the

tool with individual clients, in an assessment capacity, to help better understand a client's perspective, as well as build rapport with the client. This could possibly reduce the power dynamic between clinician and client, and also allow the client to creatively express their thoughts, feelings, and experiences. PhotoVoice could be used in conjunction with other interventions such as Trauma Focused Cognitive Behavior Therapy (TF-CBT), Narrative Exposure Therapy (NET), and other evidence-based interventions with cognitive and behavior components to enhance the trauma narrative component. This research has yet to be conducted, making the case for more studies measuring the efficacy of PhotoVoice as a supplementary intervention.

PhotoVoice may be used as a method in family therapy as well as it can help family members to better understand a loved one's experience with sexual assault, or other traumas. For instance, the survivor could show the family photos related to her life as a sexual assault survivor, and family members could discuss them regarding their process of understanding and dealing with this experience as a supporter.

PhotoVoice is a highly flexible method that can be adapted for specific goals (e.g., needs assessments, program evaluation, and group support) based on the agency purpose. PhotoVoice allows participants to provide evidence – in the form of pictures – of the social issue being studied. This provides vulnerable populations the opportunity for an alternative means of expression, as their voices are often silenced as a result of institutional oppression. This equitable and flexible method can thus be used with a variety of marginalized populations (Wang, 1999; Wang & Burris, 1994). When presenting these research findings at national conferences (National Association of Social Workers [NASW], Society for Social Work Research [SSWR]), the following were

mentioned by attendees as possible study populations: clients who experience/are experiencing death, grief, or loss; suicidal youth and adults; patients living with chronic pain; patients with chronic illness; military survivors of sexual assault, combat trauma, or other military related traumas; youth living with depression, or depressive symptoms; and people who are homeless, or living in transitional living programs. All of these populations have either directly experienced a trauma, or have the potential to be traumatized by their situation (i.e., homelessness).

**Implications for policy.** The PhotoVoice method has significant implications for policy. Most notably, PhotoVoice has the ability to inform, or even shift policy regarding the issue being studied (Wang & Burris, 1997; Wang & Burris, 1994; Wang, 1996). For the current study, participants used the photo exhibits as a way to educate family, friends, and campus stakeholders about their sexual assault experiences, the many psychological effects of sexual assault, including PTSD, and their process of healing and overcoming their trauma. The exhibits occurred at a critical time for the University, as sexual assault policies were already changing to remain in accordance with Title IX expectations and regulations.

Title IX is a nationwide educational policy that is designed to protect university students, staff, and faculty from discrimination based on sex (United States Department of Labor, 1972). The University in this study was in the process of changing how it handled sexual assault cases to remain in compliance with Title IX. The primary change was related to how the University handled its student judicial process. Results of this study informed these policy changes, as university administrators gained a better understanding of the impact sexual assault had on college-aged women. Furthermore,

they had the opportunity to learn more about how campus policy, practice and overall culture played a role in survivor healing at this particular university. In addition, results of the study were used to train Title IX investigators on posttraumatic reactions to sexual assault, specifically in regards to sexual assaults that are perpetrated while the survivor was attending college.

Results from this study were also presented to administrators in the university's Department of Student Life, the entity of campus that houses Greek Life, Residential Life, the university's student government, and social justice programs. This presentation allowed administrators to reevaluate survivor supports, leading to more resources, staff, and campus education or prevention efforts regarding sexual assault.

**Implications for research.** This study highlighted the significance of a mixed-method research design, accompanied with data triangulation, to provide a rich, detailed context for how Photovoice evoked change and what change was produced as a result of the intervention. This study used multiple methods to triangulate the data including focus groups, photos, individual interviews, and standardized measures.

A randomized control trial of PhotoVoice with survivors of sexual assault would make a significant contribution to the trauma-treatment literature. The researcher plans to test PhotoVoice with a larger, randomized sample of sexual assault survivors. In addition, the researcher plans to control for age, sexual assault experience, and other demographics, to allow for more generalizable results.

In addition, the researcher will conduct future studies exploring the use of PhotoVoice as a therapeutic intervention with traumatized populations, it is important to note that this method requires individuals to reflect on memories regarding their

experiences (e.g., sexual assault, suicide, homelessness, etc.). Thus, it is important to ensure appropriate safety and support networks are in place for research participants.

This dissertation advances PhotoVoice research methodology by taking it beyond the fields of health science, public health, sociology, and anthropology, and beyond the basic needs assessment. Findings show the value of using PhotoVoice as a therapeutic tool with survivors of sexual assault; thus, adding to evidence-based practice. This is the first study to explore the use of PhotoVoice as a brief therapeutic intervention with survivors of sexual assault. In this regard, the advances to PhotoVoice research methodology are not only multidisciplinary, but also, multifaceted as the findings from this study suggests it is worthy of future study.

### **Limitations**

The study's sample was small, purposive, and convenient. The researcher was intentional about her sampling techniques in order to explore and learn – in depth – participants' experience with sexual assault and healing. In addition, data triangulation (multiple sources) served to increase the validity and credibility of the overall results. Yet, there were limitations. Quantitatively, this study was underpowered and the sample size limits the generalizability of results. This study also lacked a control group; therefore, the intervention effects could not be compared with a control. Though that is not the goal of this particular study, this limitation does suggest a need for PhotoVoice intervention research to be conducted utilizing randomly controlled trials.

Quantitatively, the design of the research caused threats to the internal validity of the study. First, the demographical differences between each of the groups could have possibly interacted with the independent variable (PhotoVoice intervention), affecting, or

even explaining, the observed outcomes. The primary unequal differences between the groups were race and ethnicity, and survivor experience. Because of this, the argument could be made that these unequal differences had an impact on the dependent variables.

Secondly, even though participants could confidentially submit their completed measures, self-reporting could have also contributed to reporting bias from the participant. Finally, many of the participants had already interacted with the researcher, while utilizing crisis intervention and case management services through the University of Missouri's Relationship and Sexual Violence Prevention (RSVP) Center. This involvement could have inadvertently affected the outcomes of both the qualitative and quantitative data. However, to mitigate this, the researcher practiced reflexivity as a way to control any impacts prior involvement with participants could have had on the study process and outcomes.

### **Conclusion**

In conclusion, sexual assault disproportionately impacts women at epidemic rates in the United States (U.S.), particularly college-aged women (Fisher, Cullen, & Turner, 2000; Tjaden & Thoennes, 2006). The after-effects of sexual assault can lead to Posttraumatic Stress Disorder (PTSD), increased self-blame, and disempowerment (Herman, 1997; Regehr et al., 2013). Psychological interventions designed to reduce symptoms of PTSD typically consist of cognitive and behavioral techniques, often utilizing exposure and cognitive reprocessing as a way to reduce triggers and address maladaptive thoughts that hinder recovery. This study's primary aim was to explore the use of PhotoVoice as a therapeutic intervention with college females, ages 18 to 34, who are survivors of sexual assault/rape and are symptomatic for PTSD. The study's findings

indicate that PhotoVoice is an effective intervention in reducing PTSD while increasing PTG and positive rape attributions in sexual assault survivors.

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## APPENDIX A

## Participant Demographics

**Demographics**

Today's date: \_\_\_\_\_

Code number: \_\_\_\_\_

Demographics

1. What was the month and year of your birth: Month\_\_\_\_\_ Year\_\_\_\_\_
  
2. Which of the following best describes your racial and ethnic identification?
  - Caucasian/White
  - Native American or American Indian
  - African American/Black
  - Asian or Pacific Islander
  - Mexican, Hispanic or Latino
  - Other (Please Specify) \_\_\_\_\_
  
3. Current Marital Status (Check One)
  - Married
  - Not married, but living together with a partner
  - Widowed
  - Separated
  - Divorced
  - Never Married
  
4. Please indicate the highest level of education that you have completed. (Check one)
  - Didn't go to High School
  - Some High School
  - High School Graduate/GED
  - Vocational or Technical School degree
  - Community or Junior College degree (Associate's degree)
  - College or University degree (Bachelor's Degree)
  - Master's degree or beyond
  
5. Current Employment (Check one)
  - Full-time (35 hours or more)
  - Part-time (1-34 hours)
  - Not employed outside the home
  - Other (Please specify) \_\_\_\_\_
  
6. Affiliation with the University of Missouri (Check all that apply)
  - Student
    - Undergraduate
    - Graduate

- Professional (Med/Vet)  
 Law-School  
 Staff  
 Faculty

7. Do you have children?

- Yes       No

Experience with Sexual Assault:

8. How many times have you experienced sexual assault? \_\_\_\_\_

First experience: -How old were you? \_\_\_\_\_

-What was your relationship to that person?

- Intimate Partner  
 Acquaintance  
 Family Member  
 Stranger/unknown  
 Other (Please specify) \_\_\_\_\_

Second experience: Age\_\_\_\_\_ Relationship\_\_\_\_\_

Third experience: Age\_\_\_\_\_ Relationship\_\_\_\_\_

Please list any other experiences, age, and relationship: \_\_\_\_\_

10. How long has it been since your last experience with sexual assault?

- 0-1 year     2-5 years     6-10 years     11-14 years     15-18 years  
 19 or more years

11. Did your sexual assault occur while you were in college (if you did not attend college, skip number eleven and twelve)?

- Yes       No

\*\*If you answered no to number eleven, please skip number twelve\*\*

12. Did your sexual assault occur at the University of Missouri (on/around campus included)?

- Yes       No

Experience with Intimate Partner Violence/Domestic Violence

13. Are you currently experiencing Intimate Partner Violence/Domestic Violence?

Yes       No

\*\*If you answered “no” to number eleven, please continue to number seventeen\*\*

14. If you checked “yes” for number thirteen, is this violence ongoing?

Yes       No

15. Total years you experienced domestic violence? (Please report in years):

0-1 year     2-5 years     6-10 years     11-14 years     15-18 years      
19 or more years

16. Relationship to partner who harmed you/was abusive to you? (e.g., husband, boyfriend):

Intimate Partner  
 Acquaintance  
 Family Member  
 Other (Please specify) \_\_\_\_\_

Experiencing Childhood Abuse (17 years of age or younger):

17. Did you experience abuse as a child?

Yes       No

\*\*If you answered “No” to number fifteen, please continue to number eighteen\*\*

18. If you answered, “yes” which of the following types of abuse? (Check all that apply)

Physical                       Sexual                       Emotional  
 Verbal                       Neglect                       Other: \_\_\_\_\_

19. During childhood did you witness your mother being abused by an intimate partner (her husband, boyfriend)?

Yes       No

Social Service Experience

20. Have you utilized services at the University of Missouri Relationship and Sexual Violence Prevention (RSVP) Center?

Yes       No

If yes, please specify what type (e.g. academic advocacy, legal advocacy, residential advocacy, medical advocacy, etc.): \_\_\_\_\_.

21. Have you received mental health counseling in the past?

Yes  No

22. Are you currently receiving counseling elsewhere?

Yes  No

23. If you checked “yes” for number 22, please answer the following:

Are you currently receiving counseling (or other psychological health services) from the University of Missouri Counseling Center?

Yes  No

Are you currently receiving counseling (or other psychological health services) from the University of Missouri Student Health Center?

Yes  No

Are you currently receiving counseling (or other psychological health services) from another mental health service in Columbia, MO?

Yes (If yes, please specify: \_\_\_\_\_)  No

24. Have you received domestic or sexual assault services from True North Shelter?

Yes  No

If yes, please specify: \_\_\_\_\_

25. Have you received domestic or sexual assault services from another shelter that is not True North Shelter?

Yes  No

If yes, please specify: \_\_\_\_\_

26. If you answered, “yes” to number 24 and/or number 25, please describe the services you received (Check all that apply):

Shelter services  Counseling Services  
 Case Management  Crisis intervention  
 Transitional Living  Other (Please Specify)

## APPENDIX B

## CONSENT FORM

**CONSENT FORM TO PARTICIPATE IN A RESEARCH STUDY****INVESTIGATOR'S NAME:** ABIGAIL ROLBIECKI**PROJECT #:** 1209257**STUDY TITLE:** Photovoice: A Brief Therapeutic Intervention for Survivors of Sexual Assault**INTRODUCTION**

**This consent may contain words that you do not understand. Please ask the investigator or the study staff to explain any words or information that you do not clearly understand.**

This is a research study. Research studies include only people who choose to participate. As a study participant, you have the right to know about the procedures that will be used in this research so that you can make the decision whether or not to participate. The information presented here is simply an effort to make you better informed so that you may give or withhold your consent to take part in this research study.

You are being asked to participate in this study because you meet the following inclusion criteria:

- Participants must be between the ages of 18 and 35.
- Survivors of some sort of sexual assault.
  - Definition: "Sexual assault is any type of sexual contact or behavior that occurs without the explicit consent of the recipient. Falling under the definition of sexual assault are sexual activities as forced sexual intercourse, forcible sodomy, child molestation, incest, fondling, and attempted rape."
    - *Source: Office of Violence Against Women:*  
<http://www.ovw.usdoj.gov/sexassault.htm>
- Affiliated with the University of Missouri as a student, staff, or faculty member.
- Willing to participate in a focus group.
- Willing to sign a consent form.
- Participants must score a 44 or higher on their PTSD Check List (PCL-C) for civilians. This study is sponsored by the University of Missouri's RSVP Center. In order to participate in this study, it will be necessary for you to give your written consent.

**WHY IS THIS STUDY BEING DONE?**

The proposed research is designed to test the efficacy of photovoice (PV)—a participatory action research (PAR) method—as a brief therapeutic intervention for survivors of sexual assault. The purpose of the research is to examine how PV facilitates empowerment and resiliency, as well as reduce post-traumatic stress disorder (PTSD) symptoms.

The follow scales will be used as pre- and post-tests:

- 1) **PTSD Checklist-Civilian Version (PCL-C)**. This is a 17-item measure that looks at PTSD symptoms.
- 2) **Coping Strategies Inventory**. This is a 32-item measure designed to assess coping thoughts and behaviors in response to a specific stressor.
- 3) **Post-traumatic Growth Inventory—PTGI**. This is a 21-item measure designed to assess positive outcomes reported by people who have experiences traumatic events.
- 4) **Rape Attribution Questionnaire—RAQ**. This is a 25-item measure designed to look perceptions of present control of recovery process.

### **How Many People Will Take Part In The Study?**

About fourteen (14) to twenty (20) participants will take part in this study, at the University of Missouri RSVP Center.

### **WHAT IS INVOLVED IN THE STUDY?**

If you take part in this study, you will do the following things (underlined below):

- (1) Attend five group meetings (initial camera training, two focus group meetings, an exhibit design meeting, and one exhibit). Each meeting will last about 1-2 hours. In meeting one, you will learn about the project and how to use the camera. Then you will take pictures. You do not have to take pictures that reveal who you are (e.g., you can take pictures of things or objects that are important to you), and you do not have to use your real name as an author of the photos. During meeting number two and three you will discuss the photos that you took, and their meaning, with other members of the group. The group sessions will be recorded using a digital audio recorder. The audio recordings are important for the *analysis of the data only*. We will not release any audio records of you speaking for any public presentation. You will sign an extra permission form, in addition to this consent, to release the use of your photos; and to get permission from other people that you photograph.
- (2) Attend a photo exhibit (i.e., show) or presentation that displays the work of the group. Together we will choose pictures for an exhibit, and an exhibit location in the community. You do not have to display any pictures that you do not want to show to others. Pictures of minors (children under 18) will not be allowed in the exhibit. If you are uncomfortable attending a photo exhibit, you will not be able to participate in the study. Participants can choose whether or not they will display their photos at the exhibit.
- (3) Attend a follow-up interview, to talk about how this project affected you. This interview will last about 1.5 hours.

### **HOW LONG WILL I BE IN THE STUDY?**

Six meetings for approximately 2 months. The group meetings will take place over the course of the study. The timing of the exhibit will depend on our planning process, but will most likely take place within the month of our final group meeting. The follow-up interview will follow the exhibit. **You can stop participating at any time. Your decision to withdraw from the study will not affect in any way your participation in MU services, and/or any other benefits.**

#### **WHAT ARE THE RISKS OF THE STUDY?**

Potential participants will be asked to talk about their experience with sexual assault, and whether they have received mental health services after the assault. You may feel uncomfortable talking in a group setting, or talking about personal issues, such as your experiences with being a survivor of sexual assault. You do not have to talk about anything that you do not want to discuss. Additionally, a potential risk of the exhibit is that you may feel uncomfortable with other viewing your photos. Further, a breach of confidentiality is a risk to this study. To learn more about how the investigator plans to protect participant confidentiality please refer to the 'What About Confidentiality' section of this consent form.

Although it is not likely, there is a risk that members of the group may disclose information about what is discussed within the group to other people not involved. The investigator will discuss the importance of respecting the privacy of others as well as state that the group is a safe space; anything brought up in the group discussion must stay in that space.

The Investigator's e-mail address is [ajrzqd@mail.missouri.edu](mailto:ajrzqd@mail.missouri.edu). For more information inquire with the investigator.

#### **ARE THERE BENEFITS TO TAKING PART IN THE STUDY?**

You will expect to benefit from taking part in this research to the extent that you are contributing to knowledge about sexual assault and the Mizzou campus community. Further, we hope the study will help participants increase empowerment and resiliency while reducing PTSD, stress, anxiety, and depression. Additionally, information learned from the exhibit will benefit other survivors in the future. Other benefits may include: You may expect to benefit from learning to use a digital camera, and from sharing your photos with others. You may enjoy meeting and talking with other students about these issues.

#### **WHAT OTHER OPTIONS ARE THERE?**

Whether you choose to participate in the study or not, you can utilize crisis intervention and case management services provided by the RSVP Center and any other resources at MU. Please discuss these and other options with your investigator.

#### **WHAT ABOUT CONFIDENTIALITY?**

Information produced by this study will be stored in the investigator's locked file cabinet and on the RSVP Center's secure H-Drive found on the investigator's password protected computer. Audio transcripts will be stripped of all identifying information (name, locations,

etc.). Information contained in your records may not be given to anyone unaffiliated with the study in a form that could identify you without your written consent, except as required by law. Audio-recordings, pictures and study transcripts will be maintained for 7 years and then destroyed.

The results of this study may be published in a book or journal or used for teaching purposes. However, your name or other identifying information will not be used in any publication or teaching materials without your specific permission.

In addition, if photographs or audiotapes were taken during the study that could identify you, then you must give special written permission for their use. In that case, you will be given the opportunity to view as applicable, to the photographs, before you give your permission for their use if you so request.

#### **WHAT ARE THE COSTS?**

You will not be charged for the activities that are part of this research study. We can only provide one study camera. If you lose that camera and want to continue to participate in the study, you must purchase your own additional camera. All lost cameras will need to be replaced.

#### **WILL I BE PAID FOR PARTICIPATING IN THE STUDY?**

There will be no monetary benefits to participate in this study.

#### **WHAT ARE MY RIGHTS AS A PARTICIPANT?**

**Participation in this study is voluntary. You do not have to participate in this study. Your present or future involvement in MU resources and services will not be affected should you choose not to participate.** If you decide to participate, you can change your mind and drop out of the study at any time without affecting your ability to obtain crisis intervention and case management services from the RSVP Center. Leaving the study will not result in any penalty or loss of benefits to which you are entitled. In addition, the investigator of this study may decide to end your participation in this study at any time after she has explained the reasons for doing so, if needed. You will be informed of any significant new findings discovered during the course of this study that might influence your safety, welfare, or willingness to continue participation in this study.

#### **WHOM DO I CALL IF I HAVE QUESTIONS OR PROBLEMS?**

If you have any questions regarding your rights as a participant in this research and/or concerns about the study, or if you feel any pressure to enroll or to continue to participate in this study, you may contact the University of Missouri Institutional Review Board (which is a group of people who review the research studies to protect participants' rights) at (573) 882-9585. You may ask more questions about the study at any time. For questions about the study or a research-related injury, contact Abigail Rolbiecki at [ajrzqd@mail.missouri.edu](mailto:ajrzqd@mail.missouri.edu). You may also contact the

advisor of the research study, Kim M. Anderson, Ph.D., at [andersonki@missouri.edu](mailto:andersonki@missouri.edu) or (573) 884-8077. A copy of this consent form will be given to you to keep.

**SIGNATURE**

I confirm that the purpose of the research, the study procedures, the possible risks and discomforts as well as potential benefits that I may experience have been explained to me. Alternatives to my participation in the study also have been discussed. I have read this consent form and my questions have been answered. My signature below indicates my willingness to participate in this study.

---

Participant

Date

**SIGNATURE OF STUDY REPRESENTATIVE**

I have explained the purpose of the research, the study procedures, the possible risks and discomforts as well as potential benefits and have answered questions regarding the study to the best of my ability.

---

*Study Representative*

*Date*

## APPENDIX C

## Phone Interview

**Script Phone Consent**

**Instructions:** The principal investigator will read this script to all people who inquire to participate in the study. For fidelity, it is important that the exact script is read to each person. There will be a time for questions at the end.

*Note:* The double \*\* indicates items that do not need to be read aloud to the person inquiring.

**Principal Investigator:** “The purpose of this study is to test the feasibility of Photovoice, a documentary photography method, as a way to reduce avoidance, hyperarousal, and emotional numbing while increasing resiliency and posttraumatic growth in survivors of sexual assault. In a moment, I will read through the consent with waiver of documentation, which will allow you to verbally consent to participate in a pre-screening session, to check eligibility for participation in the study. If you verbally consent, we will schedule a time for you to come in and fill out the following forms: a posttraumatic stress disorder checklist for civilians (a measure designed to look at how you’ve been affected by the sexual assault), and a demographics form (to capture basic information, such as age, year in school, major, etc.).

\*\*Read consent with waiver of documentation form. Sign and date this form.\*\*

\*\*If the person inquiring gives verbal consent, sign and date the consent with waiver of documentation form, and continue with the script below.\*\*

\*\*If the person inquiring does not give verbal consent, provide packet of additional resources.\*\*

**Principal Investigator:** “The next step would be to schedule a pre-screening to see if you meet criteria to participate in the study. Do you need time to grab a calendar or schedule? (\*\*Allow for time if necessary\*\*). Another study personnel, named Jennifer, will conduct your pre-screening. This pre-screening will take place at the MU Women’s Center’s counseling room. The MU Women’s Center is located in the lower level of the Student Center, in between the Multicultural Center and the Office of New Student Programs. Here are some times Jennifer has available, which would work best for you?

Friday, December 6<sup>th</sup>, from 1:00-1:30pm, 1:30pm-2:00pm, 2:00pm-2:30pm, 2:30pm-3:00pm, 3:00pm-3:30pm.

-or-

Friday, December 13<sup>th</sup>, from: 1:00-1:30pm, 1:30pm-2:00pm, 2:00pm-2:30pm, 2:30pm-3:00pm, 3:00pm-3:30pm.

\*\*Do not overbook. Write down what time they choose.\*\*

Principal Investigator: "Do you have any questions?" \*\*Allow for questions\*\*

Principal Investigator: "Thank you for your interest, I look forward to working with you."

## APPENDIX D

## Consent With Waiver of Documentation

**CONSENT WITH WAIVER OF DOCUMENTATION TO PARTICIPATE IN A RESEARCH STUDY**

**INVESTIGATOR'S NAME:** ABIGAIL ROLBIECKI  
**PROJECT #:** 1209257

**STUDY TITLE:** Photovoice: A Brief Therapeutic Intervention for Survivors of Sexual Assault

**INTRODUCTION**

**This consent may contain words that you do not understand. Please ask the investigator or the study staff to explain any words or information that you do not clearly understand.**

This is a research study. Research studies include only people who choose to participate. As a study participant, you have the right to know about the procedures that will be used in this research so that you can make the decision whether or not to participate. The information presented here is simply an effort to make you better informed so that you may give or withhold your consent to take part in this research study.

You are being asked to participate in this pre-screening to see if you meet the following inclusion criteria:

- Participants must be between the ages of 18 and 35.
- Survivors of some sort of sexual assault.
  - Definition: "Sexual assault is any type of sexual contact or behavior that occurs without the explicit consent of the recipient. Falling under the definition of sexual assault are sexual activities as forced sexual intercourse, forcible sodomy, child molestation, incest, fondling, and attempted rape."
- Affiliated with the University of Missouri as either a student, staff, or faculty member.
- Willing to participate in a focus group.
- Willing to sign a consent form.
- Participants must score a 40 or higher on their PTSD Check List (PCL-C) for civilians.

This study is sponsored by the University of Missouri's RSVP Center. In order to participate in this study, it will be necessary for you to give your written consent.

**Why Is This Study Being Done?**

The proposed research is designed to test the efficacy of photovoice (PV)—a participatory action research (PAR) method—as a brief therapeutic intervention for survivors of sexual assault. The purpose of the research is to examine how PV facilitates empowerment as well as reduce post-traumatic stress disorder (PTSD), depression, stress, and anxiety.

**WHAT IS INVOLVED IN THE STUDY?**

If you take part in this study, you will do the following things (underlined below):

- (4) Attend five group meetings (*initial camera training, two focus group meetings, an exhibit design meeting, and one exhibit*). Each meeting will last about 1-2 hours.
- (5) Attend an additional photo exhibit (i.e., show) or presentation that displays the work of the group.
- (6) Attend a follow-up interview, to talk about how this project affected you. This interview will last about 1.5 hours.

#### **HOW LONG WILL I BE IN THE STUDY?**

Seven meetings for approximately 2 months. **You can stop participating at any time. Your decision to withdraw from the study will not affect in any way your participation in MU services, and/or any other benefits.**

#### **WHAT ARE THE RISKS OF THE STUDY?**

Potential participants will be asked to talk about their experience with sexual assault, and whether they have received mental health services after the assault. You may feel uncomfortable talking in a group setting, or talking about personal issues, such as your experiences with being a survivor of sexual assault. You do not have to talk about anything that you do not want to discuss. Further, a breach of confidentiality is a risk to this study. To learn more about how the investigator plans to protect participant confidentiality please refer to the 'What About Confidentiality' section of this consent form.

Although it is not likely, there is a risk that members of the group may disclose information about what is discussed within the group to other people not involved. The investigator will discuss the importance of respecting the privacy of others as well as state that the group is a safe space; anything brought up in the group discussion must stay in that space.

The Investigator's e-mail address is [ajrzqd@mail.missouri.edu](mailto:ajrzqd@mail.missouri.edu). For more information inquire with the investigator.

#### **ARE THERE BENEFITS TO TAKING PART IN THE STUDY?**

We hope the study will help participants increase empowerment and resiliency while reducing symptoms of PTSD.

#### **WHAT ABOUT CONFIDENTIALITY?**

Information produced by this study will be stored in the investigator's locked file cabinet and on the RSVP Center's secure H-Drive found on the investigator's password protected computer. Audio transcripts will be stripped of all identifying information (name, locations, etc).

You will not be charged for the activities that are part of this research study. We can only provide one study camera. If you lose that camera and want to continue to participate in the study, you must purchase your own additional camera.

#### **WHAT ARE MY RIGHTS AS A PARTICIPANT?**

**Participation in this study is voluntary. You do not have to participate in this study. Your present or future involvement in MU resources and services will not be affected should you choose not to participate.** If you decide to participate, you can change your mind and drop out of the study at any time without affecting your ability to obtain crisis intervention and case management services from the RSVP Center.

**WHOM DO I CALL IF I HAVE QUESTIONS OR PROBLEMS?**

If you have any questions regarding your rights as a participant in this research and/or concerns about the study, or if you feel any pressure to enroll or to continue to participate in this study, you may contact the University of Missouri Institutional Review Board (which is a group of people who review the research studies to protect participants' rights) at (573) 882-9585. You may ask more questions about the study at any time. For questions about the study or a research-related injury, contact Abigail Rolbiecki at [ajrzqd@mail.missouri.edu](mailto:ajrzqd@mail.missouri.edu). A copy of this consent form will be given to you to keep.

**VERBAL CONSENT (OVER THE PHONE)**

Ask: Do you confirm that the purpose of the research, the study procedures, the possible risks and discomforts as well as potential benefits that I may experience have been explained to me? Do you confirm that alternatives to my participation in the study also have been discussed? Do you verbally agree to participate in this pre-screen?

Signature of Personnel Conducting pre-screen: \_\_\_\_\_

Date: \_\_\_\_\_ Time: \_\_\_\_\_

## APPENDIX E

## Photo Consent Form

For valuable consideration received, I hereby give The Curators of the University of Missouri, a public corporation, (“University”) the absolute and irrevocable right and permission, with respect to the photographs/images/audio that the University have taken in regard to the research project entitled, “Photovoice: A Brief Therapeutic Intervention for Survivors of Sexual Assault”.

- a) To copyright the same in its name, The Curators of the University of Missouri;
- b) To use, re-use, publish and re-publish the same in whole or in part, individually or in conjunction with other photographs, audio or images, in any printed or electronic medium for the University purposes;
- c) To use the same in whole or in part, individually or in conjunction with other photographs, audio or images on the University’s World-Wide Web sites, for University purposes only.
- d) To use my name in connection therewith if the University so chooses.

Signed \_\_\_\_\_

\_\_\_\_\_

Print name \_\_\_\_\_

Date \_\_\_\_\_

Witnessed by \_\_\_\_\_

## APPENDIX F

## Recruitment

*Therapeutic Photovoice Study*

Participants desired for an innovative research study called, "Photovoice: A Brief Therapeutic Intervention for Survivors of Sexual Assault." To participate, you must meet inclusion criteria, ages 18-35, and be affiliated with MU. Once inclusion criteria are met, participants will be given cameras to document their life or experience with being a survivor of sexual assault. Participants will meet with 6 to 9 individuals in a focus group to discuss their photos and their experience with Photovoice. The group will design a photo exhibit to share with friends, family, and other members of the MU community to examine the impact of empowerment and resiliency. If interested, contact Abby at [RSVP@missouri.edu](mailto:RSVP@missouri.edu) for details.

*Sponsored by: The Relationship and Sexual Violence Prevention (RSVP) Center, an auxiliary of MSA/GPC*

**FB Status:**

Interested in participating in an expressive intervention that uses documentary photography and focus groups as a way to increase empowerment and resiliency? If you are a survivor of sexual assault and affiliated with MU would like to know more about getting involved with this research study, please contact Abigail Rolbiecki at [RSVP@missouri.edu](mailto:RSVP@missouri.edu) for more information.

**Twitter (must be 140 characters or less):**

Documentary photography MU research study designed to increase empowerment and resiliency for survivors of sexual assault. Contact Abby @ [RSVP@missouri.edu](mailto:RSVP@missouri.edu) for info.

**E-mail:**

Greetings!

You are receiving this e-mail because you have either utilized RSVP Center Services, or you know someone who has. I am working with the RSVP center to provide innovative intervention studies to help enhance service

delivery for survivors utilizing the RSVP Center for sexual assault crisis intervention and case management. We are looking for participants to join an MU research study called, "Photovoice: A Brief Therapeutic Intervention for Survivors of Sexual Assault." After consenting to the study, participants will complete a pre-test questionnaire that determines eligibility. If eligible, potential participants will be randomly assigned to two groups, a pilot study group (that will begin in October) or a comparison group receiving the same intervention (that will begin in January or February). Those who start the intervention in October, they will participate in an orientation where they will learn more about the study and how/what to photograph. They will then have approximately one week to photograph images they feel pertain to their lives as survivors of sexual assault. Once this process is complete, participants will meet for a focus group, where they will discuss their photos in a group setting with other survivors of sexual assault. They will meet together as a group two more times; once to design an exhibit and again to display the exhibit. After this is complete, participants will meet with the investigator for an individual interview where they will discuss additional pictures and their experience with Photovoice as an intervention. They will then be asked to complete a posttest survey (identical to the pre-test survey). Interested participants who do not meet the eligibility criteria will be provided crisis intervention services offered through the RSVP Center.

If you are interested in participating in this study, please contact Abigail Rolbiecki at [ajrzqd@mail.missouri.edu](mailto:ajrzqd@mail.missouri.edu).

Thank you for your continued support in advancing our service delivery options at the RSVP Center.

Sincerely,

Abigail Rolbiecki  
RSVP Center Staff

## APPENDIX G

## Individual Interview

**Photovoice: A Brief Therapeutic Intervention for Survivors of Sexual Assault**  
***Semi-structured Individual Interview Guide***

1. How has experiencing sexual assault impacted your life?
  - a. Priorities? Relationships?
  - b. How are your priorities different?
2. How did the photos you took relate to your life as a survivor of sexual assault?
  - a. Are there any additional photos you would like to share with me?
3. Who, if anyone, did you share your photos with?
  - a. What were your expectations in showing your photos to others?
4. What problems or major challenges did you identify through your photos?
5. What strengths did you identify through the photos?
6. What did you learn (or capture) about yourself during this project?
7. How did participating in the focus group impact your sense of empowerment, resiliency, and/or other trauma related symptoms?
8. How did participating in the exhibit impact your sense of empowerment, resiliency, and/or other trauma related symptoms?
9. What did you learn about other survivors of sexual assault in general?
10. In what ways did the pictures impact how you see yourself?
  - a. Others?
11. How would you describe the therapeutic photovoice project to someone else if they asked you what it was?
12. Who did you invite to see the exhibit?
13. How did you decide whom to invite?
14. How do you think this exhibit can impact society (locally, state-level, etc.)?
15. What was the most meaningful part of the project for you?
  - a. What made it meaningful?
  - b. What was the most challenging part of the project?
16. What part(s) of the project would you change to benefit other sexual assault survivors?

## APPENDIX H

## Posttraumatic Stress Disorder Checklist for Civilians (PCL-C)

**PTSD Checklist - Civilian Version (PCL-C)**

Below is a list of problems that adults sometimes have in response to the stressful experience of sexual assault (you being harmed by an intimate partner). Please read each one carefully, put an "X" in the box to indicate how much you have been bothered by that problem *in the last two weeks*.

No.	Response	Not at all (1)	A little bit (2)	Moderately (3)	Quite a bit (4)	Extremely (5)
1.	Having upsetting thoughts or images about the event that came into your head when you didn't want them to.					
2.	Having bad dreams for nightmares.					
3.	Acting or feeling as if the event was happening again.					
4.	Feeling upset when you think about or hear about the event.					
5.	Having					

	feelings in your body when you think about or hear about the event (heart beating fast upset stomach, breaking out in a sweat)					
6.	Trying to not think about, talk about or have feelings about the event.					
7.	Try to avoid activities or people, or places that remind you of the event.					
8.	Not being able to remember an important part of the upsetting event.					
9.	Having much less interest or not doing the things you used to do.					

10.	Not feeling too close to the people around you.					
11.	Not being able to have strong feelings (being able to cry or feel really happy)					
12.	Feeling as if your future hopes or plans will not come true.					
13.	Having trouble falling or staying asleep.					
14.	Feeling irritable or having fits of anger.					
15.	Having trouble concentrating.					
16.	Being very careful (checking to see who is around you)					

17.	Being jumpy or easily startled.					
-----	--	--	--	--	--	--

PCL-M for DSM-IV (11/1/94) Weathers, Litz, Huska & Keane National Center for PTSD – Behavioral Science Division

## APPENDIX I

## Posttraumatic Growth Inventory (PGTI)

**TAKING STOCK:  
Growth Through Resilience**
**The Posttraumatic Growth Inventory**

It is strongly recommended that you allow some time to pass from the hardship or tragedy you experienced before you use this inventory. Also keep in mind that it may take time to experience change in the areas addressed by this exercise: relating to others, appreciation of life, new possibilities, spiritual change and personal strength. People often show growth in some areas but not in others, and rarely show growth in all areas at a given time.

**THE POSTTRAUMATIC GROWTH INVENTORY**
**STEP 1: Identify a Life-Altering Event**

Focus on one traumatic or life-altering event that has occurred in your life.

**A. Check the general experience you are thinking of:**

- |   |  |
|---|--|
| <input type="checkbox"/> Loss of a loved one      | <input type="checkbox"/> Financial hardship              |
| <input type="checkbox"/> Chronic or acute illness | <input type="checkbox"/> Career or location change/move  |
| <input type="checkbox"/> Violent or abusive crime | <input type="checkbox"/> Change in family responsibility |
| <input type="checkbox"/> Accident or injury       | <input type="checkbox"/> Divorce                         |
| <input type="checkbox"/> Disaster                 | <input type="checkbox"/> Retirement                      |
| <input type="checkbox"/> Disability               | <input type="checkbox"/> Combat                          |
| <input type="checkbox"/> Job loss                 | <input type="checkbox"/> Other _____                     |

**B. Indicate time lapsed since event occurred:**

- |  |  |
|--|--|
| <input type="checkbox"/> 6 months – 1 year | <input type="checkbox"/> 2 – 5 years       |
| <input type="checkbox"/> 1 – 2 years       | <input type="checkbox"/> More than 5 years |

Information contained in this exercise should not be used as a substitute for professional health and mental health care or consultation.

A licensed mental health professional such as a psychologist can assist people in developing an appropriate strategy for moving forward. It is important to get professional help if you feel like you are unable to function or perform basic activities of daily living as a result of a traumatic or other stressful life experience.

**Learn more information about posttraumatic growth:**

A complete report about the development of the PTGI can be found in the article, "The Posttraumatic Growth Inventory: Measuring the Positive Legacy of Trauma" by Richard G. Tedeschi, Ph.D. and Lawrence G. Calhoun, Ph.D. in the *Journal of Traumatic Stress*, July 1996, Volume 9, pages 455-471.

Tedeschi, R.G., Park, C.L., & Calhoun, L.G. (Eds.) (1998). *Posttraumatic growth: Positive changes in the aftermath of crisis*. Mahwah, New Jersey: Lawrence Erlbaum Associates.

An on-line version of the inventory can be found on: [www.helping.apa.org](http://www.helping.apa.org).

**TAKING STOCK:**  
**Growth Through Resilience**  
 The Posttraumatic Growth Inventory

**STEP 2: Answer the Following Questions**

Indicate for each of the following statements the degree to which the change reflected in the question is true in your life as a result of your crisis, using the following scale:

- 0= I did not experience this change as a result of my crisis.
- 1= I experienced this change to a very small degree as a result of my crisis.
- 2= I experienced this change to a small degree as a result of my crisis.
- 3= I experienced this change to a moderate degree as a result of my crisis.
- 4= I experienced this change to a great degree as a result of my crisis.
- 5= I experienced this change to a very great degree as a result of my crisis.

1. I changed my priorities about what is important in life. \_\_\_\_\_
2. I have a greater appreciation for the value of my own life. \_\_\_\_\_
3. I developed new interests. \_\_\_\_\_
4. I have a greater feeling of self-reliance. \_\_\_\_\_
5. I have a better understanding of spiritual matters. \_\_\_\_\_
6. I more clearly see that I can count on people in times of trouble. \_\_\_\_\_
7. I established a new path for my life. \_\_\_\_\_
8. I have a greater sense of closeness with others. \_\_\_\_\_
9. I am more willing to express my emotions. \_\_\_\_\_
10. I know better that I can handle difficulties. \_\_\_\_\_
11. I am able to do better things with my life. \_\_\_\_\_
12. I am better able to accept the way things work out. \_\_\_\_\_
13. I can better appreciate each day. \_\_\_\_\_
14. New opportunities are available which wouldn't have been otherwise. \_\_\_\_\_
15. I have more compassion for others. \_\_\_\_\_
16. I put more effort into my relationships. \_\_\_\_\_
17. I am more likely to try to change things which need changing. \_\_\_\_\_
18. I have a stronger religious faith. \_\_\_\_\_
19. I discovered that I'm stronger than I thought I was. \_\_\_\_\_
20. I learned a great deal about how wonderful people are. \_\_\_\_\_
21. I better accept needing others. \_\_\_\_\_

**STEP 3: Total Your Responses**

Score each factor by adding your answers from the following questions:

- |                    |                                       |                    |
|--------------------|---------------------------------------|--------------------|
| <b>Factor I:</b>   | Questions 6, 8, 9, 15, 16, 20, and 21 | <b>Total</b> _____ |
| <b>Factor II:</b>  | Questions 3, 7, 11, 14, and 17        | <b>Total</b> _____ |
| <b>Factor III:</b> | Questions 4, 10, 12, and 19           | <b>Total</b> _____ |
| <b>Factor IV:</b>  | Questions 5 and 18                    | <b>Total</b> _____ |
| <b>Factor V:</b>   | Questions 1, 2, and 13                | <b>Total</b> _____ |

**TAKING STOCK:**  
**Growth Through Resilience**  
 The Posttraumatic Growth Inventory

**STEP 4: Reflect on Your Growth**

If you answered 0 or 1 for many of the questions in any section of the exercise, keep in mind that it may take time to experience change in the areas addressed by this question. Also remember, posttraumatic growth is an ongoing process. Your answers to these same questions may change over time as you change – as you develop and build upon your strengths and adjust to new circumstances. You may want to re-do this exercise, six months or even a year down the road to see how your responses change.

**Factor I: Relating to Others**

**Your Score** \_\_\_\_\_

People who experience trauma typically score approximately 23 within the category of relating to others. If you answered with 4 or 5 to many of the questions in this section, you may be developing even stronger bonds with loved ones, reestablishing relationships with estranged family members and friends, or gaining more compassion for others, especially those who have suffered in similar situations.

**Factor II: New Possibilities**

**Your Score** \_\_\_\_\_

People who experience trauma typically score approximately 18 within the category of new possibilities. If you answered with 4 or 5 to many of the questions in this section you may be noticing that you are beginning to make choices in a more conscious manner according to a plan. You also may be more likely to try to change things that need changing.

**Factor III: Personal Strength**

**Your Score** \_\_\_\_\_

People who experience trauma typically score approximately 15 within the category of personal strength. If you answered with 4 or 5 to many of the questions in this section, you may be expressing greater self-reliance and feeling more able to accept how things turn out and developing personal strength that may help you through such hardships you encounter in the future.

**Factor IV: Spiritual Change**

**Your Score** \_\_\_\_\_

People who experience trauma typically score approximately 5 within the category of spiritual change. If you answered with 4 or 5 to the questions in this section, you may be reevaluating spiritual beliefs, associating with a community of similar believers, or connecting with your spiritual roots.

**Factor V: Appreciation of Life**

**Your Score** \_\_\_\_\_

People who experience trauma typically score approximately 11 within the category of appreciation of life. If you answered with 4 or 5 to many of the questions in this section, you may be developing a greater appreciation of life as a result of your crisis. Some explain this as trying to live each day more fully. Some may rethink their values and priorities about what is important in their life and act differently if they change their priorities – for example, by spending more time with their family.

3

**The Road to Resilience**



## APPENDIX J

## Rape Attribution Questionnaire (RAQ)

**Rape Attribution Questionnaire**

**DIRECTIONS:** Below are statements describing thoughts women often have about why an assault occurred. Please indicate how often you have had each of the following thoughts in the past week.

1	2	3	4	5
Never	Rarely	Sometimes	Often	Very Often

How Often have you thought: I was assaulted because...

*Behavior Self-Blame*

1. I used poor judgment.
2. I should have resisted more.
3. I just put myself in a vulnerable situation.
4. I should have been more cautious.
5. I didn't do enough to protect myself.

*Rapist Blame*

1. The rapist thought he could get away with it.
2. The rapist wanted to feel power over someone.
3. The rapist was sick.
4. The rapist was angry at women.
5. The rapist wanted to hurt someone.

1	2	3	4	5
Strongly Disagree	Disagree Somewhat	Neither Agree nor Disagree	Agree Somewhat	Strongly Agree

*Control Over the Recovery Process*

1. The assault is going to affect me for a long time but there are things I can do to lessen its effects.
2. I don't feel there is much I can do to help myself feel better. (reversed)
3. I know what I must do to help myself recover from the assault.
4. I am confident that I can get over this if I work at it.
5. I feel like the recovery process is in my control.

*Future Likelihood*

1. I am afraid that I will be assaulted again. (reversed)
2. It is not very likely that I will be assaulted again.
3. Now that I have been assaulted, the odds are it won't happen again.
4. I feel pretty sure that I won't be assaulted again.
5. No matter what steps I take, I could be assaulted again. (reversed)

*Future Control*

1. I have changed certain behaviors to try to avoid being assaulted again.
2. Since the assault, I try not to put myself in potentially dangerous situations.
3. I do not take any special precautions since the assault occurred. (reversed)

4. I have taken steps to protect myself since the assault.
5. I have made the change in my living situation since the assault.

## APPENDIX K

## Reduced Codes

**Reduced codes**

- Photo representation
  - Triggers
  - Social withdraw
  - Strength
  - Exposure
  - Coping (Maladaptive)
    - Emotional numbing
    - Fear
  - Shattered assumptions
  - Self-blame
- Self-blame
  - Behavioral self-blame
  - Shattered assumptions (condensed under self-blame)
- Coping
  - Avoidance/dissociation
  - Emotional numbing
  - Cognitive restructuring
- Rape Attributions
  - Control over recovery process
  - Forgiveness
  - Perceived likelihood of future assaults
  - Taking precautions to avoid future attacks
- Posttraumatic Growth
  - Perceived change in self
  - Changes in relationships with others
  - Increased connectedness
    - Connection with other group members
    - Connection with others
  - Changed philosophy of life
    - Meaning-making
- PTSD/Trauma symptoms
  - Hypervigilance
  - Triggers
  - Fragmented memory
- Reason for doing PV:
  - Creative expression
  - Empowerment

- Connection with other survivors
- Consciousness raising/policy change

## VITA

Abigail Rolbiecki was born in Honolulu, Hawaii, before moving to Texas, where she was raised in a small town north of Dallas. She began her undergraduate studies at Texas A&M University, in College Station, and came to the University of Missouri her sophomore year, to pursue an undergraduate degree in Nutritional Sciences. Upon graduation, Abigail became a civilian contractor for the Missouri National Guard, providing reintegration services and programming to service members and their families. This experience opened her eyes to the many issues impacting our nation's service men and women, primarily the issue of sexual assault. Abigail pursued both a Master of Public Health degree and a Master of Social Work degree, where she researched the topic of military sexual trauma (MST). As a clinical social work student, Abigail provided individual and group therapeutic social work services to survivors of sexual assault at the University of Missouri. This experience provided her the opportunity to collect a small sample of women to participate in this dissertation research project.

Abigail's research interests include: posttraumatic stress disorder (PTSD), posttraumatic growth (PTG), and the use of narrative and photographic techniques (like PhotoVoice) as a way to facilitate healing among survivors of trauma.