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Social support in PTSD: an analysis of gender, race, and trauma type.

ABSTRACT

The current study discusses social support systems and the ways in which they impact persons diagnosed with posttraumatic stress disorder (PTSD). This study analyzes three different variables (race/ethnicity, gender, and trauma type) in a group of 200 adults diagnosed with PTSD. Three measures, the Social Support Questionnaire (SSQ), the Inventory of Socially Supportive Behaviors (ISSB), and the Social Reactions Questionnaire (SRQ) will be utilized to compare differences in the three variables: race/ethnicity, gender, and trauma type. These variables will be analyzed using means-descriptive analysis, and basic ANOVAs on SPSS software. Several studies have shown that social support is crucial to the effectiveness of treatment after the development of PTSD. Some support has been found indicating that certain populations (women, minorities, and those who experienced childhood sexual assault) may be more vulnerable to experiencing low or negative social support. The current study will compare social support within these variables to discover which populations may be particularly vulnerable to a lack of social support.

INTRODUCTION

Posttraumatic stress disorder (PTSD) is a mental disorder that millions of people are diagnosed with each year (Kessler, 2005). Prevalence rates indicate that approximately 3.5% (or 7.7 million people) of Americans age 18 and older currently have PTSD (Kessler, 2005). According to figures collected in 2000 by the National Comorbity Survey (NCS), 56% of Americans experience trauma in their lifetime, and 8% go on to develop PTSD from that trauma (Perkonigg et al., 2000). According to the Diagnostic and Statistical Manual of Mental Disorders, (*DSM-IV-TR*) criteria for PTSD includes a "stressor" (or a traumatic event); intrusive recollection of the trauma that can include dreams or flashbacks; persistent avoidance of stimuli (like thoughts or activities) that may be related to the trauma; hyper arousal, which includes difficulty sleeping, hyper-vigilance, or exaggerated startle response; and the duration of the disturbance must be longer than one month (American Psychological Association, 2000).

Risk

Though PTSD is one of the most common difficulties among those who experience trauma, most trauma victims do not develop PTSD (Charney, 2004). Risk factors for PTSD are varied. Several meta-analyses concluded that prior trauma, perceived life-threat during trauma, trauma severity, additional life-stress, and adverse childhood events were all predictors of a person developing PTSD after experiencing trauma. (Brewin, Andrews & Valentine, 2000; Ozer et. al, 2003). The largest risk factor, however, was

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lack of social support (Brewin et al., 2000). Conversely, the presence of social support is seen as one of the best protective factors against developing PTSD (Lazarus & Folkman, 1984) as well as a predictor of better treatment outcomes (Thrasher et al., 2010). Because of the importance of the factor, social support, in the development and treatment of PTSD, many studies have examined its impact.

Social Support

The impact of social support on treatment outcome can be significant. One study (Thrasher et al., 2010) examined the role of social support in treatment utilizing exposure therapy, cognitive restructuring, a combination of both, or a relaxation control. This randomized, controlled trial assessed 87 men and women with chronic PTSD for their level of intensity in diagnostic symptoms on a Clinician Administered PTSD Scale (CAPS). The same sample was also administered the Significant Others Scale (SOS) to assess their level of social support. This study found that social support predicted greater symptom improvement on the CAPS test, after treatment, more than any other variable, including trauma severity, age, trauma duration, and number of life events pre- and post-trauma. They also found that, although all types of treatment were effective, those who reported less social support received less therapeutic benefit than those who reported greater social support. In essence, social support was a contributing factor in treatment outcome.

Another study (Yuan et al., 2011) examined the kinds of protective factors that were exhibited in a cohort of police officers. A sample of 233 police officers were assessed for PTSD symptoms during their training in the police academy and again after 2 years of service. They found that a number of variables acted as protective factors against developing PTSD, including race (Caucasian), less exposure to trauma prior to service, and greater self-worth. They found, however that greater social adjustment (or socialization) was a protective factor both prior to service as well as after 2 years of service.

Many studies have shown that low levels of social support are met with negative health outcomes (Berkman & Syme, 1979; Cohen & Wills, 1985; House, Landis & Umberson, 1988). In one study, specifically, a sample of over 1000 New Yorkers were evaluated on their levels of social support post-9/11. Those who reported high levels of social support were much less likely to develop PTSD and depression than those with low levels of social support (Galea et al, 2002). Based on the protective factor of social support, as well as the increased efficacy of treatment that occurs when a patient has high levels of social support, we can conclude that social support is a significant variable to discuss in the realm of mental health. Social support, as a whole, has been proven to be significant, but is *all* social support positive?

Facets

The facets, or components, of social support have also been examined in various studies. The differences between the quality and quantity of social support were observed in several studies, noting that quantity did not denote quality when examining social support (Barrera, 1981; Sarason, Levine, Basham & Sarason, 1983). Social support is characterized in one model, the social networks model. This model describes *how many* people one interacts with, and *how often* they interact. Another way of to analyze social support is to look within the context of the *quality* of the relationships a person has. For example, a person may only have one close relationship, but this relationship is mutually understanding, empathetic, and rewarding for both parties. Studies (Kessler, Price & Wortman, 1985; Sarason, Shearin, Pierce, & Sarason, 1987) have compared the effectiveness of both types of support in predicting psychopathology. They found that the quality of social support was much more important in predicting protective effects of social support rather than the quantity of social contacts a client may have. Because some groups may lack sufficient quality of social support, practitioners may need to focus on certain "target" groups that are susceptible to lower levels of quality social support.

Another important factor to discuss when considering social support is whether the support is perceived as negative or positive by the patient or client. Positive support is similar to quality support in that both kinds of support have beneficial effects and are perceived by a person as "supportive." Both positive support and quality support can include empathetic or understanding reactions, as well as offering continuing support and reassurance. However, a person may have a support system in place (quantity) but is receiving negative or hurtful feedback after a traumatic event. Despite a perceived system of support, such as a family, spouse, or Church group, negative social support or reactions can play a role in impeding recovery. (Zoellner, Foa & Bartholomew, 1999).

One study (Ullman & Fillipas, 2005) examined how social reactions to trauma differed in a sample of men and women, and also looked at how social reactions could affect PTSD symptom severity. A sample of 733 college students took a survey on sexual abuse experience, history and details of disclosure. Of this sample, 22% reported having experienced childhood sexual abuse (CSA),

and 66.5% of those who experienced CSA disclosed their abuse to someone else. The study found that in both men and women, positive social reactions to disclosure were more common and related to less PTSD symptom severity, while negative social reactions were related to greater PTSD symptom severity. Women were more likely to experience greater PTSD symptom severity, and the mean number of negative reactions were nearly twice that of the men in the study. This is perhaps supportive of the idea that women may be more vulnerable, after trauma, especially CSA, to develop PTSD because of their risk of experiencing negative reactions to their trauma.

A different study by the same researchers (Ullman & Fillipas, 2001) examined how the effect of social reactions may or may not predict PTSD symptom severity, and also compared demographic variables. A sample of 323 sexual assault victims were assessed for PTSD and demographic factors like socioeconomic states, race, and gender. Social support was assessed using various methods, including the Inventory of Socially Supportive Behaviors (ISSB), Social Reactions Questionnaire (SRQ), and asking about frequency of social contact. They found that having an ethnic minority race was significantly related to receiving more negative social reactions; however, they found that there were no racial differences in PTSD symptom severity.

Disclosure of a traumatic event plays a major role in the receipt of social support. If a person does not disclose his or her traumatic event, the likelihood of him or her receiving any sort of support regarding that event is, consequently, very low. Childhood sexual assault is one type of trauma that is consistently underreported and seldom disclosed (Herman, 1981; Russell, 1983; Summit, 1983). Even when children do disclose the sexual abuse, they reported facing greater physical abuse and use of violence during abuse than those who disclosed childhood sexual assault during adulthood (Jonzon & Lindblad, 2004). More severe abuse was also related to negative reactions from a child's social network (Jonzon & Lindblad, 2004). This may indicate that victims of childhood sexual abuse may be particularly vulnerable to the development of PTSD, as social support may not have been available at the time of the abuse.

Social support and its relation to PTSD is undeniable through the vast amount of research that has been conducted over the past few decades. However, there is a significant lack of research that discusses the demographic variables that exist within social support for those diagnosed with PTSD. Though it is clear that lack of social support plays a role in the risk of developing PTSD, we know little about how facets of social support vary among those diagnosed with PTSD. The current study seeks to evaluate a sample of chronic PTSD sufferers and to examine the demographics of those who receive social support. The study will compare men and women, minorities and non-minorities, and trauma type (specifically CSA vs. non-CSA), and examine any significant differences that exist in social support within these variables. Based on the literature reviewed, the current study hypothesizes that in a sample of people diagnosed with PTSD, minorities, women and survivors of childhood sexual assault will have less social support (or more negative social support) than that of Caucasians, men, and those who did not experience childhood sexual assault.

METHODS

Participants

Participants for this study included 200 men (24.5%, n=49) and women (75.5%, n=151) that were recruited from a PTSD treatment-outcome study at two sites. Participants were recruited via referrals and advertising around the community. Exclusion criteria for this study included: (a) current psychosis, unstable bipolar disorder, substance dependence, or high suicide risk and, (b) in assault cases, an ongoing relationship with the perpetrator. Thirty-five percent of participants who were evaluated for this study did not have a primary diagnosis of PTSD, and therefore were excluded. The average age of participants in this study was 37.1 years (SD=11.3); average time since trauma was 11.9 years (SD=11.0). Trauma varied within this sample, including adult sexual assault (30.9%), childhood sexual assault (17.8%), adult non-sexual assault (22.0%), accident (motor vehicle, or natural disaster; 14.1%), childhood non-sexual assault (6.8%), death of or violence towards a loved one (5.8%), and military combat (2.6%). The sample also included 21.5% African Americans, 65% Caucasians, and 13.5% other.

Measures

The Inventory of Socially Supportive Behaviors (ISSB; Barrera, Sandler & Ramsey, 1981) is a 40-measure assessment used to measure the participants' objective levels of social support. Questions include, how often someone in their life gave them money, assisted them in setting goals, expressed respect, or looked after a family member while they were away, etc., within 2 weeks prior to the time of the survey. Higher scores on this scale indicate higher levels of social support. This measure has been established as showing good reliability and validity (Barrera et al., 1981).

The Social Reactions Questionnaire (SRQ; Ullman, 2000) is a 48-item measure that assesses objective trauma-related support on a Likert Scale from 1-4. Questions are intended to determine the frequency of positive social support (i.e., how often someone comforted the participant or told him or her that “it would be all right”) as well as negative social support (or how often someone focused on his/her own needs and neglected the participant). Two scores are identified on the SRQ, higher scores indicating either higher levels of positive or negative social support. The SRQ has been established as having demonstrated adequate reliability (Ullman, 2000).

The Social Support Questionnaire (SSQ; Sarason, Levine, Basham & Sarason, 1983) is a 27-item measure that evaluates the number of perceived social supports in a person’s life. The scale consists of questions that ask the participant to list the people involved in a certain socially supportive task (i.e., “Whom can you really count on to listen when you need to talk?” or “Who do you feel really appreciates you as a person?”). The participant is then required to report how satisfied they are with the level of support they received, within a certain category, on a scale of 1 to 6, with 1 being “very dissatisfied” and 6 being “very satisfied.” The SSQ was established as being a stable measure and also had high internal consistency among items.

The PTSD Symptom Scale- Interview (PSS-I; Foa, Riggs, Dancu, & Rothbaum, 1993) was used to establish a primary diagnosis of PTSD in all participants. The PSS-I is a 17-item semi-structured interview that requires the participant to focus on one specific traumatic event, and the scale then evaluates the symptom severity and presence of PTSD symptoms according to the DSM-IV-TR. Symptoms are measured on a four-point scale where 0 indicates “not at all” and 3 indicates “5 or more times per week/very much.” Only symptoms occurring within the two weeks prior to the interview are assessed. The PSS-I has been established as a reliable and valid measure used to assess diagnostic criteria for PTSD.

Procedure

Participants were required to sign forms that indicated that they consented to the policies and procedures of the study. Once informed consent was obtained, participants were required to answer a series of assessments (including the ISSB, SSQ, and SRQ). Participants were also administered the PSS-I in order to determine their eligibility for the study (a primary diagnosis of PTSD). Once results were obtained, we analyzed the data using SPSS, utilizing standard ANOVA tests, a descriptive analysis, and a means comparison of all variables.

RESULTS

After performing standard ANOVAs and means comparisons for all three dependent variables (gender, minority status, and trauma type) against the independent variables (the ISSB, SRQ, and SSQ scores), it was found that there were several significant relationships between the variables.

Gender

ISSB scores were significantly lower ($p= .017$) for women ($\bar{x}=86.46$) than for men ($\bar{x}=89.87$), indicating that women had lower levels of objective social support. Women also had significantly less positive support (SRQ; $p=.001$; men $\bar{x}=39.14$; women $\bar{x}=36.97$); had significantly less available social support (SSQ; $p=.015$; men $\bar{x}=13.49$; women $\bar{x}=12.42$), and were less satisfied with the support they did have than men (SSQ; $p=.079$; men $\bar{x}=22.33$; women $\bar{x}=21.54$). (See Table 1).

CSA vs. non-CSA

Interestingly enough, those who experienced trauma, who did not have a history of childhood sexual assault, had significantly higher levels of negative social support than that of trauma survivors who did experience childhood sexual assault (SRQ; $p=.015$; Non-CSA $\bar{x}=35.23$; CSA $\bar{x}=30.99$). No data was found to support the hypothesis that survivors of childhood sexual assault had significantly different levels of social support than that of survivors of other trauma. (See Table 2).

Minority Status

Finally, there was no evidence that supported the hypothesis that minorities had significantly less social support than Caucasians. In fact, minorities scored slightly higher (though not statistically significant) in both social availability (SSQ; minority $\bar{x}=13.15$; Caucasian $\bar{x}=12.42$) and satisfaction (SSQ; minority $\bar{x}=21.65$; Caucasian $\bar{x}=21.54$), and also slightly higher in positive support (SRQ; minority $\mu=$; Caucasian $\mu=36.97$). Implications for this finding will be evaluated in the discussion. (See Table 3).

DISCUSSION

The current study revealed three main findings after analyzing data from a sample of 200 men and women diagnosed with PTSD. 1) Women reported significantly lower levels of social support than men; 2) the differences between non-CSA and CSA trauma were negligible; in fact, those reporting a trauma that did not involve childhood sexual assault had higher levels of negative social

Table 1. Means comparisons of social support inventories and Gender

		ISSB	SRQ		SSQ	
		Total Score	Negative Total Score	Positive Total Score	Availability Subscale	Satisfaction Subscale
Total	**Mean**	77.71	30.1	30.36	9.12	19.12
	SD	30.63	18.29	15.72	10.93	11.1
	N	48	48	48	49	49
Male	**Mean**	89.88	31.26	39.15	13.5	22.33
	SD	32.33	15.25	16.05	10.95	11.39
	N	146	147	146	151	151
Female	**Mean**	86.86	30.97	36.97	12.43	21.55
	SD	29.55	19.22	15.04	10.75	10.93
	N	194	195	194	200	200

support and 3) Minority status was a non-significant factor in social support; actually, there was some evidence that minority status slightly correlated (though not significantly) with higher levels of social support.

We found that womens' low levels of social support were congruent with our hypothesis and previous research that alludes to the idea that women have a harder time finding positive social support than men. This study further supports the idea that women may be more vulnerable after trauma, due to their lack of positive social support (and increased levels of negative social support), than men, are after trauma. This could also allude to the different kinds of trauma men and women generally face; with women more likely to face sexual assault (17.6% of women vs. 3% of men), and men more likely to face trauma from combat exposure (57.1% of men developed PTSD; 27.8% of women developed PTSD) (U.S. Dept. Justice, 2005; Pereira, 2002). Victims of combat may be more likely to receive positive support (family, friends, and the VA) after having experienced trauma than victims of sexual assault. Therefore, it is possible that, because men are more likely to experience combat trauma and women experience sexual trauma, the levels of social support for men and women may be markedly different. Because two of the assessment instruments used only measured perceived social support, this may have altered the data outcomes. It is possible that women perceive social support more negatively than men, but we did not find research to support this hypothesis.

Trauma-type did not appear to be a significant factor in the levels of social support. We did find that those

Table 2. Means comparison of social support inventories and Trauma History

		ISSB	SRQ		SSQ	
		Total Score	Negative Total Score	Positive Total Score	Availability Subscale	Satisfaction Subscale
Total	**Mean**	87.29	28.56	35.97	12.49	21.63
	SD	30.7	18.27	15.69	10.99	11.13
	N	121	122	121	125	125
No	**Mean**	85.42	35.23	37.98	12.12	21.09
	SD	31.61	16.56	16.5	11.25	11.3
	N	70	70	70	72	72
Yes	**Mean**	86.61	30.99	36.71	12.36	21.43
	SD	29.26	20.34	14.21	10.58	10.89
	N	191	192	191	197	197

Table 3. Means comparisons of social support inventories and minority status

		ISSB	SRQ		SSQ	
		Total Score	Negative Total Score	Positive Total Score	Availability Subscale	Satisfaction Subscale
Total	**Mean**	89.39	31.62	36.17	11.07	21.34
	SD	30.63	18.29	15.72	10.93	11.1
	N	67	68	68	70	70
Minority Status	**Mean**	85.53	30.63	37.41	13.15	21.65
	SD	29.52	20.84	15.88	10.64	12.59
	N	127	127	126	130	130
Caucasian	**Mean**	86.86	30.97	36.97	12.43	21.55
	SD	31.24	16.84	15.67	11.06	10.26
	N	194	195	194	200	200

who experienced trauma, that was *not* childhood sexual assault, experienced significantly higher levels of negative social support than those who did experience childhood sexual assault. The data found in this study challenges the conventional notion that survivors of childhood sexual assault receive less social support. Research shows that childhood sexual assault is consistently underreported and seldom disclosed (Herman, 1981; Russell, 1983; Summit, 1983). Because children may not disclose or report their trauma to others, they may not receive the negative social support that may come with other kinds of trauma that people disclose more readily. Additionally, this study only examined whether or not the participant reported childhood sexual assault; we did not examine if childhood sexual assault was the primary trauma that caused their PTSD diagnosis. We also compared childhood sexual assault to all other traumas. Consequently, this pitted CSA against adult sexual assault survivors, perhaps concealing data patterns that showed that sexual assault survivors, in general (whether it occurred in childhood or adulthood), may experience lower levels of social support or higher levels of negative social support.

Although we found no statistical significance in the relationship between social support and minority status, we did find that minorities scored slightly higher in social availability and satisfaction (SSQ), and also slightly higher in positive support (SRQ). However, they did score slightly lower on the ISSB. Several factors may be contributing to these results. Minority families have higher feelings of collectivism than do white families, thus stressing the importance of social support rather than dealing with a stressor or trauma on an individual level (Plant, 2004). Additionally, minorities are more likely to face hardship than whites, leading them to then seeking out social support from others (who are also facing hardship) and developing close social bonds (Gump, 1997). Minorities also tend to have larger families than whites, therefore increasing the trauma survivor's "natural" source of social support (Taylor et al., 1996). The strength of racial and ethnic identity was not measured in this data; however, studies have shown that ethnic minorities gain a sense of their racial or ethnic identity earlier and stronger than Caucasians. This is due to the realization that they do not fit into the cultural "White paradigm," which results in the identification of their status as non-whites (Chaves & Guido-DiBrito, 1999). A stronger sense of identity could perhaps have been a factor in developing positive social support.

The data from this study suggests that women, in treatment for PTSD, may need more attention paid to them in order to improve their social support and their perceptions of social support, as well. This "specialized" treatment may involve routinely assessing female trauma survivors' social support and analyzing whether or not they feel they are receiving adequate support, both in the therapeutic relationship and in their personal lives. The results of the current study failed to support the idea that minorities and survivors of childhood sexual assault require extra care. However, future studies may be interested in expanding these results by examining the relationship between sexual vs. non-sexual trauma to determine if sexualized trauma, in general, may be more indicative of lower levels of social support. Additionally, future studies may consider examin-

ing the levels of social support in minority families, on a more specific level, in order to find out what kinds of support exist in different races or ethnicities. It is quite likely that there is fluctuation between levels of social support between minority races or ethnicities rather than the assumption that all minorities receive the same levels of social support.

REFERENCES

Barrera, M. (1986). Distinctions between social support concepts, measures, and models. *American Journal of Community Psychology,14(4), 413-445.*

Berkman, L.F., & Syme, S.L. (1979). Social Relationships and Health. Advances in Mind- *Body Health, 17, 5-7.*

Brewin, C.R., Andrews, B., & Valentine, J.D. (2000). Meta-analysis of risk factors for posttraumatic stress disorder in trauma-exposed adults. *Journal of Consulting and Clinical Psychology. 68, 748-66.*

Charney DS. Psychobiological mechanisms of resilience and vulnerability: implications for successful adaptation to extreme stress. *American Journal of Psychiatry.61, 195-21*

Chavez, A.F., & Guido DiBrito, F. (1999). "Racial and Ethnic Identity and Development." In New Directions for Adult and Continuing Education. Vol 84. New York NY: Jossey-Bass Publishers.

Cohen, S., & Wills, T.A., (1985). Stress, social support, and the buffering hypothesis. *Psychological Bulletin, 98, 310-357.*

Foa, E., Riggs, D., Dancu, C., & Rothbaum, B.(1993). Reliability and validity of a brief instrument for assessing post-traumatic stress disorder. *Journal of Traumatic Stress, 6, 459-474.*

Galea, S., Vlahov, D., Resnick, H., Ahern, J., Susser, E., Gold, J., Bucuvalas, M., & Kilpatrick, D. (2002) Trends of Probable Post-Traumatic Stress Disorder in New York City after the September 11 Terrorist Attacks. *American. Journal of Epidemiology,158, 514-524*

Gump, B. B., & Kulik, J. A. (1997). Stress, affiliation, and emotional contagion. *Journal of Personality and Social Psychology, 72, 305-319.*

Herman, J. L. (1981). Father-daughter incest. Cambridge, MA: Harvard
University Press.

House, J.S, Landis, K.R., & Umberson, D. (1988). Social Relationships and Health. *Science,* 241, 540-545

Jonzon, E., Lindblad, F. (2004). Disclosure, Reactions, and Social Support: Findings from a Sample of Adult Victims of Child Sexual Abuse. Child Maltreatment. 9(2): 190-200.

Kessler, R. C., Price, R. H., & Wortman, C. B. (1985). Social and cultural influences on psychopathology. *Annual Review of Psychology, 36, 531-572*

Ozer EJ, Best SR, Lipsey TL, Weiss DS. 2003. Predictors of posttraumatic stress disorder and symptoms in adults: A meta-analysis. *Psychological Bulletin 129(1):52-73.*

Pereira, A. (2002). Combat trauma and the diagnosis of post-traumatic stress disorder in female and male veterans. *Military Medicine, 167(1), 23-7.*

Plant, E. A., & Sachs-Ericsson, N. (2004). Racial and Ethnic Differences in Depression: The Roles of Social Support and Meeting Basic Needs. *Journal of Consulting and Clinical Psychology, 72(1), 41-52*

Russell, D. E. H. (1983). The incidence and prevalence of intrafamilial and extrafamilial sexual abuse of female children. Child Abuse & Neglect, 7, 133-146.

Sarason, I.G. , Levine, H.M., Basham, R.B. & Sarason, B.R. (1983) `Assessing Social Support: The Social Support Questionnaire', *Journal of Personality and Social Psychology, 44: 127-139.*

Summit, R. C. (1983). The child sexual abuse accommodation syndrome. Child Abuse & Neglect, 7, 177-193

Ullman, S.E.. & Filipas, H. H. (2005). Gender differences in social reactions to abuse disclosures, post-abuse coping, and PTSD of child sexual abuse survivors. Child Abuse & Neglect, 29, 767-782

Taylor, R. J., Hardison, C. B., & Chatters, L. M. (1996). Kin and nonkin as sources of informal assistance. In H. W. Neighbors & J. S. Jackson. (Eds.), Mental health in Black America (pp. 130-145). Thousand Oaks, CA: Sage.

Ullman, S. E., & Filipas, H. H. (2001). Predictors of PTSD Symptom Severity and Social Reactions in Sexual Assault Victims. *Journal of Traumatic Stress, 14(2), 369.*

U.S. Department of Justice. 2005 National Crime Victimization Survey. 2005.