Developing a Prototype of an Internet-based Decision Aid to Assist Student Survivors of Sexual Assault at Colleges and Universities with Making Informed Choices about Seeking Care and Pursuing Justice in Real-time

by

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ABSTRACT

Sexual assault at colleges and universities in the United States is a significant health and human rights issue that impacts somewhere between one-in-four and one-in-five students. Despite the alarmingly high burden, overall rates of disclosing to crisis, health, and victim services, and reporting to schools and law enforcement remain low. In order to buffer students from associated short- and long-term harm, and help them reestablish safety and pursue justice, empirically-supported, innovative, and trauma-informed secondary prevention strategies are needed. To address this pressing issue, the current study used a trauma-informed, feminist community research approach to develop and design a prototype of an internet-based decision aid specifically tailored to assist students at Arizona State University who experience sexual assault with making informed choices about reporting and seeking care, advocacy, and support on and off campus. Results from preliminary alpha testing of the tool showed that: 1. It is feasible to adapt decision aids for use with the target population, and 2. While aspects of the tool can be improved during the next phases of redrafting and redesign, members of the target population find it to be acceptable, comprehensible, and usable.

DEDICATION

I dedicate this dissertation to the love of my life, my husband Chito: thank you for making everything in life better and brighter. Also, to my biggest fan: my mom, who passed away eleven years ago this May. This is for us, Roni babe.

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CHAPTER 1

INTRODUCTION

Sexual assault at colleges and universities in the United States is a significant public health and human rights issue, with far-reaching impacts on the overall well-being, safety, and social embeddedness of entire postsecondary learning communities and surrounding areas. According to the Office for Civil Rights with the U.S. Department of Education (2011) the burden of sexual assault at institutions of higher education (IHEs) is "both deeply troubling and a call to action" (p. 2), especially given that a single incident has the capacity to create a hostile learning environment. With somewhere between one-in-four and one-in-five students sexually assaulted during the tenure of their studies, exposure is not only imaginable but probable, particularly for those most at-risk (e.g., first year undergraduate students and students who identify as transgender, genderqueer, questioning, non-gender conforming, and female) (Krebs et al., 2007; Westat, 2015).

Recognized as one of the most severe of all personal traumas (Briere & Jordan, 2004), students who are sexually assaulted while enrolled at colleges and universities are at-risk of developing most forms of nonorganic mental disorder and distress, from temporary impairment in psychological functioning (e.g., acute stress disorder, memory impairment, and dissociation) to intermittent or chronic impairments (e.g., depressive disorders, eating and feeding disorders, posttraumatic stress disorder, self-harm, and substance use disorders) (Basile & Saltzman, 2014; Briere & Jordan, 2004; Carr, 2005; Gidycz, Orchowski, King, & Rich, 2008; Silverman, Raj, Mucci, & Hathaway, 2001; Ullman & Brecklin, 2003; Yeater & O'Donohue, 1999).

Additionally, sexual assault victimization is one of the best overall predictors of health across the lifespan. Described as having a particularly devastating impact on women's health (Campbell, Sefl, & Ahrens, 2003), sexual assault has been tied to a sequelae of acute and chronic physical health outcomes, from the cardiopulmonary and neurological, to gynecological (e.g., sexually transmitted diseases and infections and unintended pregnancy) and gastrointestinal, that may appear within one month and persist for years after an incident occurs (Eby, Campbell, Sullivan, & Davidson, 1995; Fisher, Cullen, & Turner, 2000; Kimmerling & Calhoun, 1994; Koss, Koss, & Woodruff, 1991).

In order to buffer students from the short- and long-term harm associated with campus-related sexual violence, it is imperative that postsecondary learners are connected with critical and appropriate campus and community resources as soon as possible after experiencing an incident of sexual assault. Despite having multiple options available for seeking aid and pursuing justice on and off campus, however, the majority (84-92%) of students never disclose what happened to them to crisis, health, or victim services (Krebs et al., 2007). Further, even fewer (13-26%) report incidences of sexual assault to their schools or police, with reporting rates ranging from 13-26% and 2-13% respectively (Westat, 2015; Krebs et al., 20017).

In fact, according to the Information Seeking of Sexual Assault Survivors (ISSAS) model (Skinner & Gross, 2017), in order for students who have been sexually assaulted while enrolled at IHEs to get the help they need, they must be able to: 1. Assess their needs; 2. Determine whether or not they need help; 3. Feel that the help they need is available, and 4. Navigate a series of enablers and barriers to information seeking. While

in an ideal world, "the process of information seeking that facilitates meaning making and healing would be self-perpetuated and help move the survivor towards a reestablished sense of agency and identity as the individual is increasingly able to integrate what happened into [their] personal narrative" (p. 27), many students struggle to move along this information-seeking pathway (Skinner & Gross, 2017).

First, due to an overall dearth of knowledge within and across student populations regarding how colleges and universities define sexual assault and misconduct, where to get help or file a report, and what happens after they report, many students find it difficult to make sense of their experiences, and very few (<30%) know that the help they need is available (Westat, 2015). Second, because not all survivors share the same values and preferences surrounding care and justice, overall decisional quality and quality of decision making in these circumstances relies more on an individual's capacity to engage in informed decision making (i.e., make decisions that match their personal values and preferences) than access to information (e.g., resource lists and reporting procedures) or knowledge translation (Coulter et al., 2013).

With no 'best choice' or single course of action to take after experiencing a sexual assault, postsecondary learners are faced with making complex, preference sensitive choices, sometimes within the course of a few hours or days. This need for students to engage in higher-level thinking and processing in the aftermath of a sexual assault in order to connect with critical campus and community resources, however, is deeply problematic based on what we know about how the brain responds to acts of sexual assault (Campbell, 2012; Porges, 2001). In fact, because the brain interprets sexual

assault to be one of the most traumatic and horrific of all experiences-akin to that of attempted murder-it has been hard-wired by thousands of years of evolution to trigger the body's flight, flight, or freeze response (Campbell, 2012).

Specifically, during an attempted or completed act of sexual assault, the hypothalamic-pituitary adrenal (HPA) axis floods the brain with hormones to help improve chances of survival. While these hormones serve a protective function by working to keep the organism alive, they also work at cross-purposes by temporarily damaging certain circuits in the brain charged with higher-level thinking and processing, such as rational thought (e.g., "if this…then that" thinking), memory formation, and memory recall (Campbell, 2012). As a result, students who have experienced a recent sexual trauma may be unable to engage in even the beginning stages of the ISSAS model, particularly if they experienced tonic immobility during the assault.

Even in cases where students are able to assess their needs, determine whether or not they need help, and feel that the help they need is available, students must still successfully navigate a series of enablers and barriers to information seeking in order to connect with campus and community resources. This is particularly challenging for postsecondary learners, who cite multiple barriers that prevent and delay disclosure and reporting, including: not thinking the incident was important enough (even in cases of physically forced sexual assault); feeling embarrassed, ashamed, or like it would be too emotionally difficult, and not believing anything would be done about it if they did (Westat, 2015). In fact, 76% of students who experience physically forced sexual assault, and 74% who experience drug- and/or alcohol-facilitated sexual assault state that they

chose not to report because they do not think what happened to them was important enough (Westat, 2015).

While the Internet has the potential to improve information-seeking for survivors of sexual assault at colleges and universities, where the digital divide is small and most (94%) students own smartphones and have access to the Internet (Pew Research Center, 2018), it can also serve as a barrier students must learn to navigate effectively along the information-seeking pathway (Skinner & Gross, 2017). Specifically, while postsecondary learners make up the largest group of internet users in the U.S. (Pew Research Center, 2018), and prefer to look up information on sexual health and violence online (Gray et al., 2002), studies show that postsecondary learners have difficulty retrieving valid and reliable health information online, and connecting with formal resources (e.g., Buhi et al., 2009; Rideout, 2001; Stellefson et al., 2011). In fact, because students tend to use major search engines like Google, click on sponsored links or the first links that populate, and rarely check to see when information was last updated, they often feel confused, frustrated, and overwhelmed by what they find when they search for information on sexual health and violence online (Buhi et al., 2009).

One way to facilitate information-seeking online when survivors are faced with making complex, preference-sensitive choices is through the use of internet-based decision aids. Used within the fields of Medicine and Public Health for decades to help patients make informed, preference-sensitive choices about palliative and aggressive/curative care strategies, they have only fairly recently begun to be adapted for use by other fields. Specifically, decision aids aim to improve the extent to which

individual choices and behaviors match goals and preferences by: 1. Providing individuals with unbiased, empirically-supported, and relevant information and 2. Helping people clarify and communicate their personal values and preferences surrounding all available options and outcomes (International Patient Decision Aid Standards Collaboration, 2012).

Unlike other web-based public health resources tailored to this population that solely focus on preventing new cases from occurring (e.g., Circle of 6 and OnWatchOnCampus®), or provide impersonal information in text-heavy and non-interactive ways (e.g., the ASU sexual violence website), decision aids (i.e., 'patient decision aids' or 'PtDAs') help people evaluate their personal values and preferences surrounding all available options, in order to make informed choices that match what is most important to them (Coulter et al., 2013; Sepucha et al., 2013).

Given the many challenges that students who experience sexual assault face along Skinner & Gross' (2017) information-seeking pathway that delay or prevent contact with formal resources, empirically-supported and trauma-informed secondary prevention (i.e., safety net) programs are needed. Too often, however, IHEs resist embracing new science and technology, and focus primarily on primary prevention strategies (Lopez, 2017). Additionally, due to a lack of guidance from the federal government regarding program format, implementation, and evaluation, there exists a large range of programs offered at within and across IHEs that are not required to use empirically supported methods or undergo any program evaluation (Vladutiu, Martin, & Macy, 2011).

In order to respond to this pressing issue, the current study developed and designed a prototype of an internet-based decision aid specifically tailored to assist survivors of sexual assault at colleges and universities with making informed choices about reporting/pursuing justice, and seeking care, support, and advocacy on campus and in the community. Specifically, using a trauma-informed and feminist community research (FCR) approach, and following guidelines proposed by the International Patient Decision Aid Standards (IPDAS) Collaboration, this study aimed to: 1. Assemble a steering committee of expert clinicians and professionals and student survivors; 2. Elicit views on student information and decisional support needs and map out all potential pathways for seeking care and justice on and off campus; 3. Determine the format and distribution of the decision aid; 4. Review and synthesize the evidence in order to determine the theoretical framework and incorporate current clinical practices and guidelines; 5. Create a prototype of the proposed internet decision aid (including storyboarding, scripting, graphics, web design, etc.), and 6. Alpha test the prototype with 'typical' users to elicit direct feedback from stakeholders on acceptability, comprehensibility, and usability to establish efficacy.

Terminology

Sexual assault. Sexual assault (SA) is a specific type of sexual violence (SV) that can also be a sub-type of gender-based violence (GBD) and intimate partner violence (IPV) that captures all unwanted sexual experiences involving penetration. Penetration is defined here as "physical insertion, however slight, of the penis into the vulva; contact between the mouth and the penis, vulva, or anus; or physical insertion of a hand, finger,

or other object into the anal or genital opening of another person" (Basile, Smith, & Breiding, 2014, p. 11). In the state of Arizona, SA is a felony defined by the Arizona State Legislature (Title 13-1406) as intentionally or knowingly engaging in "sexual intercourse or oral sexual contact with any person without consent of such person".

There are three main types of unwanted sexual contact that involve penetration: 1. Penetration of a victim by force, 2. Penetration of a victim by alcohol/drug-facilitation, and 3. Non-physically pressured unwanted penetration. Penetration by force is defined as, "completed or attempted unwanted vaginal (for women), oral, or anal insertion through the use of physical force or threats of physical harm toward or against the [individual]" (Basile, Smith, & Breiding, 2014, p. 11). Examples include pinning people down and/or using your body weight to keep them from escaping, assault, and use or threats of using a weapon (Basile, Smith, & Breiding, 2014). It is important to note here that threats of physical harm, even in the absence of a weapon or any use of physical harm, are classified as use of force.

Penetration by alcohol/drug-facilitation (also called drug- or alcohol-facilitated rape, drug-facilitated rape, drug-facilitated date rape, and party rape) includes any "completed or attempted unwanted vaginal (for women), oral or anal insertion when the [individual] was unable to consent due to being too intoxicated" (Basile, Smith, & Breiding, 2014, p. 11). Administering date rape drugs (e.g., flunitrazipam (Rohypnol) or gamma hydroxybutyrate acid (GHB)) to individuals without their consent or knowledge is just one coercive tactic used to perpetrate sexual violence through the use of drugs or alcohol (Schwartz, 2000; Weir, 2001).

Lastly, non-physically pressured unwanted penetration is defined as pressuring someone to consent or acquiesce to having sex, verbally or through intimidation or the misuse of authority (Basile, Smith, & Breiding, 2014). Examples of tactics used to coerce individuals into engaging in or being exposed to sexual acts include:

> Being worn down by someone who repeatedly asked for sex or showed they were unhappy; feeling pressured by being lied to, or being told promises that were untrue; having someone threaten to end a relationship or spread rumors; and sexual pressure due to someone using their influence or authority (Basile, Smith, & Breiding, 2014).

Consent. Consent in the context of SA is defined as "words or overt actions by a person who is legally or functionally competent to give informed approval, indicating a freely given agreement to have sexual intercourse or sexual contact" (Basile, Smith, & Breiding, 2014, p. 11). In order to freely consent, individuals must be both functionally competent and have the ability to refuse. Functional competence refers to factors such as age, consciousness, awareness, use of drugs and/or alcohol, illness, and disability (Basile, Smith, & Breiding, 2014). Inability to refuse, on the other hand, refers to situations in which individuals cannot freely consent due to violence, threats of violence, intimidation, pressure, or the misuse of authority.

Victim/Survivor. Within and outside of the scholarly literature, the terms "victim", "survivor", and even the joint term "victim/survivor" are used to refer to individuals who have experienced sexual assault (SA). Although sometimes used interchangeably, Burk (Northwest Network, 2013) argues that the term "victim" should

be reserved for use within the legal system only, to refer to those individuals "against whom a crime has been committed" (p. 3). While Burk's (2013) work refers to interpersonal forms of violence perpetrated by a current or former intimate partner, it can also be applied to individuals who have experienced SA, since rape, like IPV, is also about power and control. Further, SA is a tactic that is often used by current and former intimate partners (along with emotional and psychological, economic, and physical forms of abuse) to exert power and control over individuals. That being said, individuals may be sexually assaulted by: family members who are not intimate partners; persons in positions of power, authority, or trust; friends/acquaintances; persons briefly known; other non-strangers, and strangers (Basile, Smith, & Breiding, 2014).

Additionally, Burk (2013) points out that the term "victim" is a transitory classification, since it belongs only in legal contexts and people enter and exit the legal system in fluid ways. The term "survivor", on the other hand, is less transitory and is not linked to any crime or legal definition. In fact, outside of legal contexts where the term "victim" is used almost exclusively (with the exception of certain trauma-informed law enforcement agencies like the Arizona State University Police Department), the term "survivor" tends to be used more often and even favored by counselors, advocates, and other allies. Specifically, the term "survivor" is often viewed as empowering (i.e., highlighting the strength and resiliency of individuals who experience incidences of sexual violence), while "victim" is believed to evoke feelings of powerlessness. Additionally, the term "survivor" is often used to combat victim-blaming and shaming practices, because it stresses the importance of survival over prevention.

Recently, however, there has been a movement to reclaim the term "victim" in an effort to push back against unrealistic pressures to exclusively use positive coping strategies, heal quickly, and move on (i.e., "just get over it"). According to this perspective, therefore, the term "victim" is not only appropriate outside of legal contexts, but may have the potential for some to validate the severity and extent of rape-related trauma. Additionally, while the brain perceives SA to be life threatening, not all individuals who live through a SA feel that they have survived anything, because they may not think their life was ever in danger.

In *Hunger: A Memoir of (My) Body* (2017) Gay describes her struggle with identifying with the terms "victim" and "survivor", noting that while she didn't want to think of her body as a crime scene ("something gone horribly wrong, something that should be cordoned off and investigated"), it was in many ways the scene of a crime in which she herself felt like both a victim and a perpetrator. In fact, Gay states that

> I am marked, in so many ways, by what I went through. I survived it, but that isn't the whole of the story. Over the years, I have learned the importance of survival and claiming the label of "survivor," but I don't mind the label of "victim." I also don't think there's any shame in saying that when I was raped, I became a victim, and to this day, while I am also so many other things, I am still a victim (p. 20).

Gay went on to state that,

> it took me a long time, but I prefer "victim" to "survivor" now. I don't want to diminish the gravity of what happened. I don't want to pretend I'm on some triumphant, uplifting journey. I don't want to pretend that everything is okay. I'm

> living with what happened, moving forward without forgetting, moving forward without pretending I am unscarred (pp. 20-21).

Due to differences in how individuals prefer to be referred to at different points after experiencing an incident of sexual assault, some (e.g., the United Nations) recommend using the joint term "victim/survivor".

The current paper cautions against ascribing any label to individuals who have been sexually assaulted, and instead, recommends inviting each individual to determine what term resonates with them most at any given time. Therefore, the current paper will try to use the phrase "individuals who have experienced sexual assault" in lieu of "survivor", "victim" or "survivor/victim". That being said, at times the paper will use these transitory and highly subjective terms with caution when deemed situationally appropriate, in addition to "reporter" (the term used to describe individuals who report incidents of sexual misconduct to school administrators) in the context of administrative justice.

CHAPTER TWO

REVIEW OF THE LITERATURE

SA at colleges and universities in the United States is a significant public health and human rights issue with far-reaching impacts on the overall well-being, safety, and social embeddedness of entire postsecondary learning communities. Despite political pressure from the Obama administration to increase institutional transparency and ramp up prevention efforts, colleges and universities remain heavily criticized for their failure to adequately address this pervasive issue (Schroeder, 2013). Additionally, with the *Dear Colleague Letter* rescinded by the current administration this past fall, many students feel more vulnerable now than ever.

Current Climate of Sexual Assault at Colleges and Universities

Burden. Campus-based SA is far from a new issue. In fact, campus SA was first documented in the scholarly literature 60 years ago when Kirkpatrick and Kanin published the article "Male Sex Aggression on a University Campus" in the *American Sociological Review* in 1957. It was not until 30 years later, however, when Koss and Gidycz (1985) published findings from the Sexual Experiences Survey that the burden of sexual violence at colleges and universities was first estimated. While the one-in-four statistic is still the most commonly cited figure within and outside of academia, measuring the prevalence and incidence of sexual violence at colleges and universities is complicated by multiple factors.

First, SA is labeled, defined and measured differently within and across multiple studies and fields. In fact, according to the United States Government Accountability

Office (2016), the federal government alone uses 23 different terms to describe acts of sexual violence in data collection efforts, resulting in different and sometimes even conflicting findings. Second, few studies have looked at risk from an intersectional perspective, and therefore little is known about how the interplay of factors such as race and ethnicity, citizenship, indigeneity, gender identity, and sexual orientation collectively impact risk of victimization.

Third, measuring the burden of SA at colleges and universities relies heavily on self-reporting, which is problematic considering that these incidents are believed to be grossly underreported. In fact, postsecondary learners cite multiple barriers that prevent and delay disclosure and reporting, including not thinking the incident was seriousness enough to report (even in cases of penetrative nonconsensual acts involving physical force), feeling embarrassed or ashamed, and not believing that anything would be done, most students (84%-92%) never disclose what happened to crisis, health, or victim services, and very few (2-20%) report incidences of SA to police or campus (Krebs et al., 2007; Sinozich & Langton, 2014; Westat, 2015). Lastly, reporting varies according to type of violence, with incidences of sexual touching involving physical force and incapacitation reported the least, at just 7% and 5% respectively (Westat, 2015).

Distribution and risk. Despite epidemiological challenges, findings from the most recent and comprehensive studies on interpersonal violence at colleges and universities in the United States (The Campus Climate Survey and The Campus Sexual Assault Study) estimate that somewhere between one-in-four (26.1%) and one-in-five (19.8%) students are at-risk of experiencing nonconsensual sexual contact by penetration, or sexual

touching by force or incapacitation (i.e., rape and sexual battery/touching) during the tenure of their studies (Krebs et al., 2007; Westat, 2015). While the one-in-four statistic is a powerful figure used within and outside of the scholarly literature to communicate the overall scope of campus-related SA, it is often taken out of context, and fails to capture the actual burden of all forms of sexual violence, particularly for those most at-risk.

First, sexual violence is not distributed equally within and across all student populations. In fact, incidence and prevalence rates for sexual violence vary according to various factors, such as gender, class year, time of year, and type of IHE (Krebs et al., 2007; Westat, 2015). Specifically: 1. Students who identify as TGQN and female are significantly more at-risk for experiencing all forms of SGBV compared to their cisgender male peers; 2. Freshman (particularly between the months of August-November after initial enrollment) and sophomores are more at-risk than juniors and seniors, with risk of experiencing sexual violence negatively correlated with years spent in college (OR = 1.2); 3. Undergraduate students at small, private schools are more at-risk for sexual harassment than undergraduates enrolled at large, public colleges and universities, and 4. Graduate/professional students at large, public IHEs are more at-risk for sexual harassment than those enrolled at small, private schools.

Second, while several risk factors are consistent across multiple forms of SA (e.g., class year), others (e.g., frequency of attending fraternity parties or number of sexual partners) only apply to certain types (Krebs et al., 2007). For example, women who experience a physically forced SA or have had a partner who has threatened, humiliated, or physically injured them prior to entering college, are seven to eight times more likely

to be physically forced to engage in sex during college. When looking at drug- and/or alcohol-induced SA, however, we see the introduction of an entirely different set of risk factors, such as a history of incapacitated SA, frequency of getting drunk, and attending fraternity parties. These findings are particularly important with regard to their implications for victim-blaming and shaming practices, since class year and lifetime history of victimization are more consistent predictors of campus-related SGBV than other more frequently addressed factors, such as number of sexual partners or alcohol or drug use, which place more blame and agency on survivors.

Third, not all types of sexual violence have the same incidence and prevalence rates (Table 1). Overall, sexual harassment has the highest prevalence rate at 47.7%. When broken down by gender and degree-type, however, we see that over 75% of undergraduate students who identify as TGQN and 61.9% who identify as female are sexually harassed across the tenure of their studies. The most common types of sexual harassment experienced by students are non-contact, and include "comments about their body, appearance, or sexual behavior" and "making sexual remarks or insulting or offensive jokes or stories (29.5%) (Westat, 2015, p. xvi). Nonconsensual sexual contact by coercion, and nonconsensual sexual contact by absence of affirmative consent were experienced the least often, with prevalence rates far lower than overall estimates at 1.6% and 14.8% respectively. For a comprehensive overview of the major findings on SA at colleges and universities see Table 2.

Associated harm. Exposure to sexual violence has been associated with multiple, interlocking negative health outcomes, ranging from the strictly physical, to the

emotional and psychological. Additionally, because trauma is believed to alter the didactic relationship between the mind and body-a process referred to by Wilson (2015) as the "psychic nature of the organic interior" (p. 23)-mental health issues are often expressed physically (e.g., through the process of somatization). Additionally, physical health issues can have devastating impacts on psychological health and well-being. In some cases, the causal mechanisms that drive this health-victimization relationship are palpable (e.g., becoming pregnant or contracting a sexually transmitted infection/disease), however, in others they are less clear (e.g., chronic migraines or pain during intercourse after experiencing an incident of sexual violence that did not cause any physical injury to the head or pelvis). Koss, Koss, and Woodruff (1991) propose that secondary or undetected physical outcomes related to victimization are due to a combination of biobehavioral factors, such as a weakened immune system due to posttraumatic stress and engagement in risky health behaviors (e.g., substance abuse) as victims/survivors attempt to cope with traumatic experiences (Koss, Figueredo, & Prince, 2002).

Mental health outcomes. Victims/survivors of sexual violence are also at-risk for experiencing short- and long-term psychological harm and distress. In fact, recognized as one of the most severe of personal traumas, SA has been linked to multiple nonorganic mental disorders, including: posttraumatic stress disorder; depression; anxiety; low self-esteem; dissociation, and somatization (Briere & Jordan, 2004). Pinning down the exact types of psychological harm associated with incidences of sexual violence, however, can be difficult, given that psychological effects of victimization tend to vary greatly from

person-to-person, and victims/survivors do not always develop the entire range of symptoms belonging to a particular disorder (Briere & Jordan, 2004). Further, variations in symptomology may differ according to situational factors, severity, and number of incidents (Briere & Jordan, 2004; Koss, Figueredo, & Prince, 2001). Therefore, according to Briere & Jordan (2004) the psychological effects of exposure to sexual violence cannot be "defined by preformulated assault syndromes or lists of expected syndromes", but instead, are the result of "a wide variety of trauma-specific, historic, victim, and sociocultural factors" (p. 1267) from anxiety and depressive disorders, to eating and feeding disorders and substance use and abuse disorders.

That being said, the literature clearly demonstrates that exposure to sexual violence is commonly associated with certain mental health issues, including but not exclusive to anxiety, depressive, dissociative, eating, sleep, somatic, substance-related, and trauma- and stressor-related disorders (e.g., Carr, 2005; Gidycz, Orchowski, King, & Rich, 2008; Silverman, Raj, Mucci, & Hathaway, 2001; Ullman & Brecklin, 2003; Yeater, 2000). Further, history of trauma and/or the presence of comorbid mental disorders (i.e., preexisting or co-occurring conditions such as depression, anxiety, and substance use or abuse) can increase the likelihood and severity of sexual violence, and exacerbate levels of postvictimization reactivity (Briere & Jordan, 2004). Postsecondary students who experience sexual violence specifically have been shown to experience a "multiplicity of behavioral problems, including drug use, eating disorders, heavy drinking, physical fights, lowered academic achievement, and dropping out of school" (Vladutiu, Martin & Macy, 2011, p. 67).

Physical health outcomes. Sexual violence is often described as one of the best predictors of health along with age, education, and socioeconomic status (Campbell, 2002). Victims/survivors of sexual violence are at-risk of developing a sequela of acute and chronic negative health problems, from the gynecological and gastrointestinal, to cardiopulmonary and neurological (e.g., Campbell, Sefl, & Ahrens, 2003; Fisher, Cullen, & Turner, 2000; Koss, Koss, & Woodruff, 1991). Additionally, multiple studies (e.g., Eby, Campbell, Sullivan, & Davidson, 1995; Fisher, Cullen, & Turner, 2000; Koss, Koss, & Woodruff, 1991) document the occurrence of chronic headaches, fatigue, sleep disturbances, sexually transmitted infections, and unintended pregnancy in victims/survivors of SA. Not only are victims/survivors of sexual violence at-risk of experiencing these negative health outcomes, according to the National Center for Health Statistics (1999), they experience them in greater number and at higher frequencies than the national average (Campbell, Sefl, & Ahrens, 2003).

Additionally, the literature supports a positive causal relationship between exposure to SA over time and the severity of associated harm (Eby, Campbell, Sullivan, & Davidson, 1995), as well as the additive effect between incidences of physical and sexual violence (Koss, Woodruff, & Koss, 1991). Further, since the negative health impacts associated with SA extend well-beyond the duration of a violent event, this may additionally create long-term or permanent alterations to the physical body (Campbell, 2002).

Policy. According to the Office for Civil Rights (2011) with the U.S. Department of Education the burden of sexual violence at IHEs is “both deeply troubling and a call to

action" (p. 2), especially given that a single incident has the capacity to create a hostile learning environment. Several landmark pieces of legislation have been instituted since Title IX was passed in 1972, including: The "Dear Colleague Letter" (which has since been rescinded by the Trump Administration); The Jean Clery Disclosure of Campus Security Policy Act (i.e., The Clery Act); The Campus Sexual Assault Victims' Bill of Rights; The Campus Crime Statistics Act; The Campus Sexual Violence Elimination Act (i.e., The SaVE Act), and The Campus Accountability and Safety Act. Specifically, these efforts have worked to: increase gender equity in higher education; require IHEs to address campus-related sexual violence and its effects; enhance institutional transparency and accountability, and expand victim rights and resources.

While these efforts have collectively helped colleges and universities begin to heal the current climate of campus-related sexual violence, there are major limitations and loopholes that must be addressed. First, while The Clery Act requires IHEs to publish campus crime statistics, as well as information about policies, procedures, and victim rights in their Annual Security Report (ASR) there exists an overall dearth of knowledge both within and across student populations regarding the scope of the issue, as well as how and when to report and seek care after an incident of sexual violence occurs, suggesting the presence of a knowledge-behavior gap (Westat, 2015).

Second, due to a lack of guidance from the federal government, while two- and four-year colleges and universities that receive federal funding are required to respond to and remedy hostile learning environments under Title IX, how schools interpret these responsibilities varies. As a result, every college and university has different policies and

procedures surrounding everything from mandated reporting to investigating that students must learn to either navigate or circumvent. Additionally, IHEs are not always held responsible when they fail to take immediate action to eliminate hostile learning environments, prevent future incidences, or address the impacts of sexual violence on their campuses (Schroeder, 2013). While some schools (e.g., the University of California system, the University of Kentucky, and the University of Texas at Austin) have become pioneers in seeking to better understand and address incidences of campus-related sexual violence, other schools are more well-known for sweeping them under the rug (e.g., Baylor University and Stanford), and with the rescinding of the Dear Colleague Letter (2011) by the Trump Administration, many students feel more vulnerable now than ever. For a comprehensive overview of campus-sexual violence legislation see Table 3.

Existing Programs. There are a large number of primary, secondary, and tertiary sexual violence prevention programs currently offered at colleges and universities throughout the United States. Unfortunately, few of these programs are based on empirically-supported methods, or have undergone evaluation to assess for effectiveness or efficacy (Lopez, 2017). A review of the programs that have been evaluated for effectiveness and/or efficacy shows that wide variation exists among available programs, specifically with regard to the following characteristics: 1. Duration, 2. Format, 3. Facilitation, 4. Audience, 5. Content, and 6. Outcomes of Interest (Vladutiu, Martin, & Macy, 2011).

First, available prevention programs vary in duration with regard to length of sessions and number of sessions offered. The literature yields mixed findings regarding

the relationship between program duration and efficacy, however, most studies support the use of programs that have longer sessions with regard to length, and offer a larger number of sessions (particularly when attempting to change rape-related attitudes and beliefs) (Anderson & Whiston, 2005; Bachar &Koss, 2001; Lonsway, 1996; Yeater & O'Donohue, 1999). Second, there are a number of formats offered for delivering content on sexual violence to postsecondary learners, from online trainings and videos to in vivo lectures and workshops. Overall, the literature does not point to any one gold standard for formatting sexual violence prevention programs, but instead, suggests that efficacy of delivery may vary by content and the gender of the target audience (Vladutiu, Martin, & Macy, 2011). For example, lectures have been shown to be effective at reducing acceptance of rape myths, but not at changing overall rape-related attitudes and beliefs. Further, Bachar & Koss (2001) found that presentations by rape victims/survivors are not effective at changing rape-supportive behaviors among male students.

With regard to facilitation, most sexual violence prevention programs are either led by peers or professionals. According to Vladutiu, Martin, & Macy (2011), effectiveness of facilitation varies according to program characteristic, with certain topics more effectively led by professionals, and others by peers. Specifically, while both peer- and professional-facilitated programs are successful at improving rape attitudes, findings support that professional facilitators are more effective at improving rape-related attitudes and behavioral intentions, while peers are the most effective facilitators of workshops aimed at reducing rape myth acceptance.

Another important program characteristic to consider when looking at efficacy is the type of audience targeted for prevention efforts surrounding sexual violence at colleges and universities. Specifically, sexual violence prevention programs differ in target audience according to gender (single-gender v. mixed-gender), Greek life membership, and risk. It should be noted, however, that the most frequently targeted high-risk populations are students with a history of sexual victimization, mental health issues, and alcohol use (Vladutiu, Martin, & Macy, 2011), and not transgender, genderqueer, non-gender conforming, and questioning students who are at the highest risk of sexual violence victimization of all postsecondary groups. Further, most studies target audiences based on gender binaries, further excluding and erasing these groups.

Although overall, studies (e.g., Anderson & Whiston, 2005; Bachar & Koss, 2001; Brecklin & Forde, 2001; Breitenbecher, 2000; Lonsway, 1996; Schewe & O'Donhohue, 1993a; Yeater & O'Donohue, 1999) demonstrate that college- and university-based sexual violence programs that target single-gender audiences are most effective, this varied according to program outcomes (Vladiutiu, Martin, & Macy, 2011). Specifically, while mixed gender studies have been shown to effectively change rape attitudes, behavioral intent, and rape myth acceptance, studies (e.g., Anderson & Whiston, 2005; Bachar & Koss, 2001; Lonsway, 1996; Yeater & O'Donohue, 1999) show that programs targeting females only are most successful at improving rape awareness and knowledge. Further, studies (e.g., Anderson & Whiston, 2005; Bachar & Koss, 2001; Brecklin & Forde, 2001; Lonsway, 1996; Yeater & O'Donohue, 1999) show

that programs targeting only males are most effective at improving rape-related empathy and rape-supportive behaviors.

In addition to having disparate formats, facilitators, sizes, and target audiences, not all programs instituted by colleges and universities cover the same content. In fact, Vladutiu, Martin, & Macy (2011) found that college and university programs covered a range of topics, including the following: risk-reduction strategies; gender-role socialization; sexual assault education; human sexuality; rape myths; rape deterrence; rape awareness, and self-defense. All of the aforementioned topics have been shown to be effective at improving at least one of the following outcomes of interest: rape attitudes, behavioral intentions, sexual assault knowledge, rape myth acceptance, rape tolerance, sexual victimization, and intent to engage in risky behaviors.

Lastly, programs vary according to outcomes of interest. One commonly studied outcome of interest is rape attitudes, which include: rape-related attitudes (those that promote the "occurrence of sexual assault, including: sex-role stereotyping, attitudes toward women, and adversarial sexual beliefs"), rape-supportive attitudes, and rape myth acceptance (Vladutiu, Martin, & Macy, 2011, p. 73). Other outcomes of interest include: the incidence of SA perpetration and/or victimization; dating behaviors and rape awareness behavior; behavioral intent (defined as "intent to rape or engage in certain dating behaviors"); rape empathy (defined as the "degree to which participants identified with rape victims or perpetrators), and rape/sexual assault knowledge (Vladutiu, Martin, & Macy, 2011, p. 73).

Sexual violence prevention programs at ASU. Arizona State University (ASU) has two main types of prevention programs: those offered to new students, staff, and faculty, and those that are part of ASU's ongoing campaign to prevent sexual violence. While ASU lists a total of 40 university policies, education and training programs, and advocacy and awareness efforts in the 2016 Annual Safety Report (ASR), not all of these focus specifically on sexual violence (e.g., Marijuana E-checkup to Go is a brief online self-assessment of marijuana use). Additionally, included in this list are the broader categories (e.g., "Bystander Intervention") as well as the sometimes multiple programs they subsume (e.g., "Step Up! ASU" and "Consent 101"). Further, this list also includes all meetings, workshops, and trainings for peer and professional staff facilitators for programs listed.

Additionally, ASU has a sexual violence website, called Sexual Violence Awareness and Response (https://sexualviolenceprevention.asu.edu/). The website, which includes information on resources, reporting, policies and procedures, as well as education materials, also publishes information on upcoming ASU events surrounding campus-related sexual violence (e.g., Denim Day and Take Back the Night). Specifically, the Sexual Violence Awareness and Response website provides the following types of resources: 1. Medical, 2. Counseling, 3. Reporting, 4. Safety, 5. Dating and Domestic Violence, and 6. LGBTQIA (in addition to other resources and supports of interest that do not fit within these categories).

Under the umbrella of medical resources, ASU Health Services and Sexual Assault Response Team (SART) Centers (places where students can obtain services such

as advocacy and forensic nurse examinations) are listed. The website also offers information on counseling resources both on and off campus, such as ASU Counseling Services and EMPACT-SPC. Under reporting resources, the website lists contacts for ASU Police, and City Police Departments surrounding all ASU campuses. Additionally, ASU publishes information on how to request an ASU Safety Escort at all campuses. Under dating and domestic violence, ASU lists information such as national hotlines (e.g., the Domestic Violence Helpline), the Phoenix shelter hotline (e.g., 2-1-1), legal advocacy (e.g., the Arizona Coalition Against Domestic Violence Legal Advocacy Hotline), and local and national domestic violence coalitions (e.g., the Arizona Coalition Against Domestic Violence and the Sun Devil Movement for Violence Prevention). Lastly, under LGBTQIA resources, the website provides information on Gay Lesbian Straight Education Network (GLSEN), the QLine, and the Gay Lesbian Bisexual and Transgender (GLBT) National Help Center.

The website also includes information on how to report incidences of campus-related SGBV (Figure 1). In addition to providing links for students to learn how and where they can file a report, the website also provides information on how students can seek help reporting incidences from the ASU Hotline, the Title IX Coordinator, ASU Counseling, ASU Health Services, and ASU Police Department Victim Advocates. Students also have the option of clicking on links to get immediate assistance, confidential support, or remain anonymous. Students who are unsure of what to do are prompted to contact the Sun Devil Student Support Network or Student Advocacy and Assistance on their campus.

Overall, ASU is certainly doing its due diligence to comply with Title IX standards. Not only does ASU provide new and returning students and staff with numerous education and training programs, but over the 2015-2016 AY there were multiple advocacy and awareness efforts on the topic of sexual violence. Further, the newly developed ASU Sexual Violence Awareness and Response website provides students with critical information about reporting and campus and community resources. None of the aforementioned resources, however, help students decide which resources to connect to and when online in real-time.

Decision Aids

In an effort to move away from patriarchal and authoritative methods of decision making in health care settings, there has been a push towards more collaborative and equitable methods that increase patient and consumer knowledge, and empower individuals to make informed decisions. Informed decision making (IDM) is defined as any Public Health intervention that promotes informed decisions can occur before and/or during clinical settings, in person, over the phone, via mail, or online. When IDM occurs in clinical settings where patients and providers participate in decision making together, however, this process is referred to as shared decision making (SDM) (Briss et al., 2004; Stacey et al., 2011).

IDM is particularly helpful in situations where individuals are faced with making complex decisions about their health care, such as when there is no clear choice or gold standard of care, or when potential benefits and harms of available options depend more on individual values and preferences than access to the most recent scientific literature

(Stacey et al., 2011). In cases where choices depend more on understanding the scholarly literature surrounding a particular option, knowledge translation (KT) (the process by which physicians communicate recent and relevant scientific knowledge to patients) is more appropriate (see, BMJ, 2005).

One way of increasing active and informed decision making is through the use of decision aids (i.e., Patient Decision Aids or PtDAs). Decision aids have been used for nearly two decades within the field of medicine to improve quality of decisions when individuals are faced with making complex, preference sensitive decisions about health care (Coulter et al., 2013). Decisions are considered 'preference sensitive' in situations with no single recommended course of action, when there are multiple courses of action with features that individuals tend to value differently, or when there are insufficient outcomes or tradeoffs between known benefits and harms. In these unique cases, quality of individual choices depends on personal values and preferences about benefits, potential harm, and uncertainties (Coulter et al., 2013).

Decision aids aim to increase quality of decision making (i.e., the extent to which choices and behaviors match goals and preferences) in these circumstances by: 1. Providing individuals with unbiased, empirically-supported, and relevant information, and 2. Helping people clarify and communicate their personal values and preferences surrounding available options (International Patient Decision Aid Standards Collaboration, 2012). It is important to note that decision aids do not advise individuals to take any single course of action, nor are they intended to replace consultation with professionals (e.g., physicians, counselors, etc.). Instead, decision aids provide

individuals with critical information on options (including associated risks and benefits) and help them evaluate personal values to make informed decisions that match with what is important to them (Coulter et al., 2013).

In an effort to establish an evidence-based framework for developing, implementing, and evaluating decision aids, the International Patient Decision Aids Standards (IPDAS) Collaboration was established in 2003. In 2006 a steering group developed the initial IPDAS Checklist that stressed the importance of empirically supported criteria and highlighted gaps in the literature (Elwyn et al., 2006). The checklist was refined in 2009 (the IPDASi), and in 2013 a set of minimal standards (qualifying, certification, and quality criteria) were agreed upon for decision aids to be certified. One year later, a revised set of minimum standards for certification were proposed by Joseph-Williams (2014).

Minimal standards. The IDPAS Collaboration has developed a set of minimal standards for decision aids, including qualifying, certification, and quality criteria, assessed for using the IPDASi instrument. There are six qualifying criteria (Table 4) that are required in order for a particular intervention to be considered a decision aid. Qualifying criteria are scored on a binary (yes/no) (Joseph-Williams et al., 2014). Next, to ensure that decision aids avoid risk of harmful bias and qualify for certification, each decision aid must score a three or above on all ten certain certification criteria, scored on a 4-point Likert scale (where 1 = strongly disagree and 4 = strongly agree) (for a full list of certification criteria see Table 5). Lastly, the IPDAS has come to a consensus on 28 quality criteria (for all quality criteria see Table 6), which include desirable, but not

necessary features. Like certification criteria, Quality criteria are also scored on a 4-point Likert scale (where 1 = strongly disagree and 4 = strongly agree), however, there is no score cut-off since these features are optional (Joseph-Williams et al., 2014).

Development. According to the IPDAS Collaboration, decision aids should be "carefully developed, user-tested, and open to scrutiny with a well-documented and systematically applied development process" (Coulter et al., 2013, p. 1). Complying with recommended development guidelines is not only critical for creating an empirically supported tool, but also to ensure the safety of users, since poorly developed decision aids may cause harm. Specifically, there are seven recommended phases of development necessary to establish that a tool is both efficacious and effective: 1. Scoping, 2. Steering 1, 3. Design 1-4, 4. Prototype, 5. Alpha Testing 1 & 2/Steering 2, 6. Beta Testing 1 & 2, and 7. Steering 3 (see Figure 2).

First, during the scoping phase, developers must conduct an extensive review of the relevant scholarly literature to define the scope and purpose of the decision aid, and identify the target audience. Next, during the steering phase, a group of clinical experts, professionals, and patients are recruited to help with designing, developing, and alpha testing the tool. After the steering group has been formed, members work together during the design phase to: 1. Assess views on decisional and victim/survivor needs (through focus groups, stakeholder interviews, surveys, systematic reviews of the literature, and/or direct observation), 2. Determine format and distribution plan (described in detail below), and 3. Review and synthesize the evidence (comprehensive literature reviews, clinical

practice guidelines, etc.). After the first two phases are complete, a draft of the decision aid is developed during the prototype phase (Coulter et al., 2013).

Once developed, the draft of the decision aid goes through alpha testing, where it elicits direct feedback from and is reviewed by members of the original steering committee (as well as anyone else involved in the development process). During alpha testing, feedback is sought in stages through an iterative process. Lastly, decision aids are beta (field) tested for feasibility in 'real-world' settings with patients (users) and providers through small-scale observation studies and randomized control trials with members of the target population (e.g., expert clinicians, professionals, and patients/users) who did not participate in the development of the tool (Joseph-Williams et al., 2014).

In order for any decisional support technology (regardless of how basic or advanced) to qualify as a decision aid, the IPDAS Collaboration requires that interventions to meet all six qualifying criteria (Table 4). Additionally, due to a recent push for certification of decision aids in an effort to improve overall quality and reduce risk of harmful bias, the IPDAS also recommends that decision aids meet all ten certification criteria (Table 5). Lastly, in order to strengthen decision aids, all applicable quality criteria (Table 6) should be met, however, omission of these criteria does not increase risk of harmful bias (Joseph-Williams et al., 2014).

Design. While all decision aids share certain core characteristics (e.g., qualifying criteria), they may be formatted in various ways with regard to bioinformatics and graphic design. Specifically, decision aids may be: text-heavy (e.g., text, worksheets, or

text-based presentations) or graphics-heavy (e.g., videos, graphs, animations, photos, etc.); mixed media, multimedia (i.e., include audio), rich media (i.e., interactive), and/or hypermedia (e.g., hyperlinks that allow users to move around between pages or content); delivered in a linear (i.e., content is presented in the same order every time, with progression requiring completion of previous sections) or open (i.e., users are free to navigate the website and choose which information to view and in what order) format; static (i.e., all users view the same design and content) or dynamic (i.e., different information is provided depending on what a user chooses/clicks on), and tailored (i.e., content is specific to users' characteristics, needs, and preferences with regard to risk/benefit, decisional support, or design) or non-tailored (Volk & Llewellyn-Thomas, 2012).

Further, decision aids differ with regard to user characteristics, accessibility, and interaction, and may: be designed for anonymous (i.e., no identifying information is collected on users), de-identified (i.e., data is obscured so user identification is protected), or identifiable use (i.e., data is directly linked to a user's identity)[1]; accommodate diverse groups of users and persons with disabilities (e.g., through the use of voice commands, braille, larger font sizes, and options for different literacy levels, etc.); range from non-interactive (i.e., users are only asked to read content) to fully-interactive (users can navigate content and/or respond to interactive questions); and provide passive (i.e., provide content about the process of informed decision making) or deliberate (i.e., guide

[1] If identifiable information is collected (e.g., email addresses, etc.) researchers and tool developers must consider how has access to this information, what third party hosts and Internet providers are secure, and if it is necessary to use password protected accounts.

users through the process of informed decision making) support in the decision making process (Volk & Llewellyn-Thomas, 2012).

Delivery. Decision aids may be delivered in-person or online. Decision aids that are delivered online fall under one of three categories: 1. Internet-available decision aids, 2. Internet-adapted decision aids, and 3. Internet-based decision aids. Unlike Internet-based decision aids which are developed specifically for online use, Internet-available and Internet-adapted decision aids were originally developed, tested, and evaluated in paper, audio, or video format, and were later uploaded online or adapted for online use. As such, not all Internet-available or Internet-adapted decision aids have been tested or evaluated with online users, and therefore, may not be effective (Volk & Llewellyn-Thomas, 2012).

Measures of evaluation. The IPDASi (v4.0) is the measurement instrument used to evaluate whether or not decision aids meet qualifying, certification, and quality criteria across ten dimensions. There is currently no consensus, however, for establishing the effectiveness of decision aids (Coulter et al., 2013). Instead, the literature documents the use of seventeen different scales and sub-scales to measure primary outcomes of interest (Coulter et al., 2013; Sepucha et al., 2013; Stacey et al., 2017) (Table 7). Further, none of these measurement instruments currently evaluate all attributes of the core constructs, and therefore, evaluation requires the use of multiple scales and sub-scales (Coulter et al., 2013; Sepucha et al., 2013). That being said, the most comprehensive scale used to evaluate decision aids is the Preparation for Decision Making Scale (PDMS), although

the Decisional Conflict Scale (DCS) is used most frequently, followed by the Control Preference Scale (PCS) (Coulter et al., 2013).

Effectiveness. In order to the establish efficacy/effectiveness of a decision aid, developers must provide evidence that the tool improves two primary outcomes of interest: quality of the decision-making process and decisional quality (Sepucha, Thomson et al., 2012). First, tools that improve the quality of the decision- making process must help users: 1. Recognize that a decision needs to be made (i.e., there is more than one reasonable approach), 2. Feel informed about options and their associated risks, benefits, and consequences, 3. Be clear about what matters most to them with regard to the decision being made, 4. Discuss goals, concerns, and preferences with health care providers, and 5. Be involved in the decision making process.

Next, decisional quality (i.e., the extent to which users are informed and make decisions about care seeking and reporting that reflect their goals and preferences) assesses how informed users are (e.g., objective knowledge of options and outcomes, including known risks and benefits) and how well their decisions match their goals and preferences (Sepucha et al., 2013). Additional primary outcomes that are measured (but not required) include:

> decision self-efficacy, percentage of patients who were able to state a clear preference (as opposed to being unsure), decision regret, and patient satisfaction with decision making and choice of option (Sepucha, Thomson et al., 2012, p. 3).

Secondary outcomes of interest include behavioral factors (e.g., choice and adherence to the chosen option), health outcomes (e.g., health status, quality of life, and symptoms of

mental disorder or distress), as well as impacts on the healthcare system (e.g., cost-effectiveness, consultation length, litigation rates, etc.) (Stacey et al., 2017).

According to the most recent review of the literature on the effectiveness of decision aids conducted by Stacey et al. (2017) (Table 8): 1. 27 studies (N=5,707) have shown decision aids to decrease decisional conflict related to feeling uninformed (MD=-9.28/100; 95% CI); 2. 23 studies (N=5,068) have shown decision aids to decrease indecision about personal values (MD=-8.81/100; 95% CI); 3. Sixteen studies (N=3,180) have been shown to decrease the proportion of people who were passive in decision making (RR=0.68; 95% CI); 4. 52 studies (N=13,316) have shown decision aids to effectively increase participant knowledge (MD=13.27/100; 95% CI); 5. Seventeen studies (N=5,096) demonstrate the effectiveness of decision aids for increasing accuracy of risk perceptions (RR=2.10; 95% CI), and 6. Ten studies (N = 5,626) show the effectiveness of decision aids at increasing congruency between informed values and care choices (values-choice agreement) (RR = 2.06; 95% CI).

The internet as a design space. The internet provides a promising design space for the delivery of decision aids at colleges and universities in the United States, where the digital divide is small and studies show students prefer to use the internet to look up health information. In fact, students enrolled at two- and four-year colleges and universities make up the largest group of internet users in the U.S., with at least 94% of all college students using the internet and owning smartphones (Pew Research Center, 2018). Additionally, in the U.S. looking up health information is the third most common

reason for using the Internet, and half of all smartphones users state that they use their phones to look up health information (Fox & Duggan, 2013).

Studies (e.g., Buhi et al., 2009; Rideout, 2001; Stellefson et al., 2011) show that postsecondary students specifically prefer to use the internet to internet to access information on sexual health and interpersonal violence. In fact, 75% of all 15-24 year-olds, and 67-74% of students enrolled in IHEs in the U.S. use the internet to look up health information, with sexual health specifically being one of the most common health topics college-age students search for (Rideout, 2001; Stellefson et al., 2011). Further, Gray et al. (2002) found that young adults prefer to use web-based technologies to access health information on sexuality, physical and sexual violence, and sexually transmitted infections/diseases in particular, because they are embarrassed and feel uncomfortable discussing these topics with parents, educators, and health care providers.

That being said, having access to basic health information, such as through Web-based technologies, is not enough; in order to demonstrate health literacy, consumers must also have the capacity to understand, process, and apply what they have learned in order to make strength-based health decisions (Stellefson et al., 2011). While Ickes and Cottrell (2010) estimate that the average college student in the United States tends to have adequate functional health literacy and therefore can navigate the health care system, studies (e.g., Buhi et al., 2009; Stellefson et al., 2011) show that postsecondary learners have difficulty retrieving valid and reliable health information online and connecting with community resources. In fact, according to the American Institute of Research (AIR), only 20% of students with four-year college degrees and 30% of

students with two-year degrees in the U.S. possess basic quantitative literary skills, with a high percentage unable to make informed health care choices.

First, students tend to use major search engines like Google, click on sponsored links or the first links that come up, and rarely check to see when information was last updated. In fact, while 63% of students feel confident in their ability to make appropriate health care decisions, 44% of students who retrieve information on health online report feeling confused by what they find, 26% feel frustrated by a lack of available information while another 19% feel overwhelmed by the amount of information, and 15% feel frightened by what they find. When looking at how students access information on sexual health and violence specifically, the literature shows that while students are often able to find accurate answers to sexual health concerns, they have difficulty finding where to locate community resources. Further, students tend to have the most difficult and time locating community resources for receiving care and support after experiencing a SA (Buhi et al., 2009), which may explain low overall care-seeking behaviors among this population.

CHAPTER 3

CONCEPTUAL FRAMEWORK

In order to create a prototype of an internet-based decision aid that is specifically tailored for postsecondary learners who experience SA at Arizona State University, the current study used a trauma-informed and feminist community research (FCR) approach and followed guidelines proposed by the International Decision Aids Standards (IPDAS) Collaboration.

Theoretical Rationale for Internet-based Decision Aids

The use of internet as a design space to disseminate health information tailored to individual goals and preferences is supported by several major theories belonging to the fields of Cognitive Psychology, Decision Psychology, and Communication (Hoffman et al., 2012). First, Becker's (1979) Health Belief Model (HBM) "emphasizes the importance of providing tailored information to motivate active engagement in health care" (Hoffman et al., 2012, p. 2). According to the HBM, individuals will engage in positive health behaviors if they: 1. Believe a negative health condition can be avoided (based on perceptions about susceptibility), 2. Have positive expectations that taking recommended actions will prevent a negative health condition from occurring (based on perceptions about severity and benefits), and 3. Believe they can comfortably, confidently, and successfully engage in recommended health behaviors (based on perceptions about barriers, cues to action, and self-efficacy) (Rosenstock, Strecher, & Becker, 1988).

Second, Bandura's Social Cognitive Theory demonstrates how "interactive, deliberate tasks foster self-efficacy and lead to increased engagement" (Hoffman et al., 2012, p. 2). Specifically, unlike linear (i.e., unidirectional) models of causation, Bandura's (1977;1986) model of reciprocal determinism demonstrates the continuous interaction between the environment, personal factors (e.g., cognition), and behavior. According to this model, personal factors such as self-efficacy (i.e., the belief in one's ability to perform desired behaviors) play an important role in motivating health behavior (Kruglanski & Higgins, 2007).

Third, Petty and Cacioppo's (1986) Elaboration Likelihood Model (ELM) "proposes that people attend to and actively process information more if it is perceived as personally relevant" (Hoffman et al., 2012, p. 2). According to the ELM, when individuals are not motivated or able to carefully and thoughtfully consider information (e.g., because it is not personally relevant or because they are distracted), emotions tend to impact attitudes under the peripheral (i.e., low effort or low thinking) route. Conversely, under the central (i.e., high thinking) route, individuals are able to carefully and thoughtfully consider all information, and examine whether or not personal emotions or affective states justify their judgements (whether good or bad) about something. Essentially, meaningful and enduring attitude change is best achieved in high thinking states in which individuals are both motivated and able (Petty & Briñol, 2014).

Fourth, Locke and Latham's (1990) Theory of Goal Setting and Performance "supports the role of interactivity in producing tailored and actionable personal health goals" (Hoffman et al., 2012, p. 2). The premise behind goal setting theory is that

conscious human behavior is regulated by goals surrounding purposeful action. There are two attributes of goals that underpin this theory: 1. Content (described on a spectrum ranging from vague to specific), and 2. Intensity (level of difficulty-i.e., easy, moderate, impossible, etc.). According to Locke and Latham (1990), there is a positive correlation between goal difficulty and performance, with performance increasing as goal difficulty increases. Further, specific and challenging goals have a greater impact on performance compared to vague and challenging or vague and unchallenging goals (e.g., "do your best" goals).

Fifth, Prochaska and DiClemente's (1983) Stages of Change Theory "supports the value of having up-to-date information and accessibility over time" (Hoffman et al., 2012, p. 2). The Stages of Change Theory is a part of Prochaska and DiClemente's (1983) Transtheoretical Model of Behavior Change, which states that when modifying health behaviors, people move through a series of stages (precontemplation (not ready), contemplation (getting ready), preparation (ready), action, and maintenance). According to this theory, action-oriented guidance is only effective when given to people during the contemplation and preparation stages (i.e., when they intend to make changes within the next six months, or when they are ready to take action in the immediate future, such as within the next month). It is important to note that during the contemplation stage, individuals are more aware of the pros and cons, which can lead to ambivalence or stagnation (as characterized by chronic contemplation or procrastination) (Prochaska, 2013).

Lastly, Active, discovery, and social learning theories inform the optimal design of internet-based decision aids (Hoffman et al., 2012). Specifically, Behavioral Psychology emphasizes the importance of measurable behaviors to check for learning (e.g., optional activities or quizzes) that both reinforce awareness and facilitate realistic expectations of outcomes. Additionally, Cognitive Psychology looks at how interactive activities (e.g., values clarification) integrate new information into preexisting schemas via the internal processes that underpin memory, motivation, thinking, and reflection.

Building on theories belonging to Cognitive and Behavioral Psychology, Constructivism emphasizes how three critical constructs (observation, processing, and interpretation) influence personal notions of reality. Lastly, Ally (2004, as cited by Hoffman, 2012) expands on all of these theories to make a case for use of internet-based technologies to assist individuals with learning about available options with regard to "what" (Behaviorist), "how" (Cognitive), and "why" (Constructivist) (p. 2). For a full discussion on the theoretical rationale of internet-based decision aids, see Hoffman et al. (2012).

Cultural targeting and tailoring of decision aids for use with diverse populations. Alden, Friend, Schapira, and Stiggelbout (2014) expand upon the notion of providing personally relevant and tailored information, and recommend that when creating and testing decision aids, researchers measure differences in cultural mindsets up front, and tailor decision aids accordingly. This two-step theoretical framework is based on multiple cognitive and social psychology theories (e.g., Cognitive-Affective Processing System Theory, Theory of Situated Cognition, Cultural Task Theory, and

Regulatory Fit Theory) about the role of cultural congruency (and in particular, the role of individualism-collectivism) in the effectiveness of decision aids.

Collectively, these theories suggest that culturally appropriate and relevant information: 1. Tends to feel more right and comfortable than information that is culturally incompatible; 2. Is more personally relevant to users and therefore has a greater chance of reducing health disparities; 3. Is more likely to be perceived as kind or aggressive rather than dishonest and assertive, and 4. Is often given equal importance by members of the same cultural group, however, they might not engage in the same behaviors to achieve related health goals (Alden, Schapira, and Stiggelbout, 2014).

In order to deliver culturally targeted and tailored decision aids to diverse groups of users, the authors suggest first having users self-identify in phase one. Users would then receive a culturally tailored or targeted decision aid (with culturally-targeted colors, language, and use of narrative), based on which group users self-identified with. Then, users would take a validated measure in order to determine whether they ascribe to more independent (congruent with individualistic cultures) or interdependent (belonging to more collectivistic cultures) thinking.

Application of Interdisciplinary and Trauma-informed Approaches

Information seeking of sexual assault survivors (ISSAS) model. According to the Information Seeking of Sexual Assault Survivors (ISSAS) model (Figure 3) (Skinner & Gross, 2017), survivors of SA must navigate a series of enablers and barriers to information seeking as they move through Harney, Lebowitz, and Harvey's (1993) three stages of healing (restoring safety, remembrance and mourning, and reconnecting with

others). Essentially, as survivors attempt to heal and make sense of (or find meaning in) what happened to them, they encounter multiple interrelated decision points, beginning with the simple recognition that more information is needed to move forward (Skinner & Gross, 2017).

Next, survivors must determine what it is that they need, and assess whether or not they feel like help they need is available. If a survivor feels that the help they need is available, they then move through a series of enablers (e.g., Internet access) and barriers (e.g., cost of treatment, stigma, previous experiences, etc.) to connect with critical resources to get help. If, however, a survivor feels that the help they need is not available (or accessible), they will either: 1. Move backwards along the path to reassess their needs, or 2. Decide that their need cannot be met at that time, in which case, information-seeking ends (although it may be picked back up again at any point) (Skinner & Gross, 2017).

How survivors navigate this information-seeking pathway, as well as what enablers and barriers they encounter, is impacted by two major factors: 1. Their stage in the healing process, and 2. What type of information they are seeking. First, the ISSAS model (Skinner & Gross, 2017) presumes that all survivors of SA seek out information within the context of Harney, Lebowitz, and Harvey's (1993) three stages of healing. As such, how survivors appraise their needs is mediated by what stage they are in within this process of healing. Specifically, during stage one, survivors will seek out information to meet their initial needs and restore safety (e.g., medical care and reestablishing trust); during stage two, survivors seek out resources that can help them cope with trauma and

associated loss, in order to begin the process of emotional recovery; lastly, during stage three, survivors seek information on reconnecting with others, but only once they feel that their sense of safety and trust has been restored.

Second, the ISSAS model (Skinner & Gross, 2017) states that how individuals move along this "information-seeking path" is also impacted by the type of information being sought. Specifically, individuals may seek out: 1. Formal resources, 2. Informal resources, or 3. Recorded information. While formal resources include experts, institutions, and recorded information (e.g., campus police, crisis workers, victim advocates, student counseling centers, and informational websites), informal resources include trusted individuals without specific training or skills, such as family and friends. Lastly, students may also turn to digital or printed forms of recorded information (e.g., websites or books) to retrieve information directly (e.g., a website on the side effects of Rohypnol). How available or accessible these resources are perceived to be depends on various factors, such as resource knowledge, stigma surrounding SA, and beliefs about how responsive (or unresponsive) certain resources will be.

The neurobiology of sexual assault. While the ISSAS model captures many aspects of information-seeking that survivors encounter along the "information-seeking path" (including important implications for potential enablers and barriers to connecting with campus and community resources), it fails to consider implications from the literature on the neurobiology of SA. Specifically, according to Campbell (2012) the brain interprets SA to be one of the most traumatic and horrific of all experiences-akin to that of attempted murder. As such, it has been hard-wired by thousands of years of

evolution to trigger the hypothalamic-pituitary-adrenal (HPA) axis, which floods the brain with hormones that work together to: 1. Improve chances of survival by activating the body's fight, flight, or freeze response and 2. Manage any physical and/or emotional pain that might be experienced during a traumatic event.

First, because information related to attempted or completed SA is emotionally charged and fearful, the amygdala picks it up (Campbell, 2012). Once the amygdala detects that there is a threat, it activates the hypothalamus, which in turn triggers the hypothalamic-pituitary-adrenal (HPA) axis, sending a signal to the body that there is a traumatic event happening. Specifically, during a SA, the brain releases four hormones: 1. Catecholomies to trigger the body's fight, flight, or freeze response; 2. Cortisol to provide the body with the energy necessary to run away or fight; 3. Opioids to prevent any potential pain associated with physical trauma, and 4. Oxytocin to promote good feelings and buffer individuals from the emotional pain often associated with traumatic events.

Most people are aware of the body's fight and flight responses, however, many are unaware that in somewhere between 12-50% of SAs, individuals experience something called tonic immobility (TI) (i.e., rape-induced paralysis). TI is an autonomic response that causes temporary muscle paralysis. TI most often occurs in situations where it is unsafe to fight back (e.g., when the perpetrator has a weapon or is perceived to overpower the survivor) or, when individuals are unable to flee (e.g., when the perpetrator is blocking the only exit). Additionally, individuals who experience TI during a SA are more likely to experience muscle paralysis if re-victimized across their lifespan.

Therefore, students who were sexually assaulted prior to enrolling in college (e.g., during childhood or adolescence) and froze, are more likely to enter into a freeze state if they perceive they are going to be sexually assaulted again while in college.

While the hormones released during an attempted or completed act of SAs play a critical role in keeping survivors alive, they also work at cross-purposes, temporarily damaging certain circuits in the brain, impairing memory formation and recall, as well as higher-level thinking and processing (e.g., if "this…then that" thinking) (Campbell, 2012). Specifically, survivors often have difficulty encoding, consolidating, and recalling memories related to SA. Despite the fact that memories formed during a SA are slow, difficult to retrieve, and fragmented, according to Campbell (2012), the information recorded is almost always accurate, unless they were under the influence of drugs/and or alcohol.

Understanding how the brain responds to attempted and completed acts of SA is critical, particularly when developing first response and secondary prevention strategies for survivors that aim to increase initial engagement and prevent disengagement over-time. In fact, according to Campbell (2012), poor understanding of how survivors' brains respond to SA may lead to victim-blaming and disengagement on the part of the first responders and the survivors. Therefore, in order to help survivors seek out information and connect to critical resources during all stages of the healing process, it is imperative that first responders and safety net programs are trauma-informed.

Post-colonial feminist critiques and ethics in feminist community research. Post-colonial feminists (PCF) raise valid critiques about traditional approaches to

community-based research used within fields like Public Health, such as community-based participatory research (CBPR), participatory action research (PAR), and community-based participatory action research (CBPAR). Specifically, PCF critiques of community research draw attention to issues such as the: 1. Social embeddedness of how knowledge is produced; 2. Reliance on positivist strategies and silencing of lived experiences; 3. Lack of intersectional analyses, and 4. Ignoring voices that disrupt the dominant framework.

Instead, feminist approaches to community research stress the importance of decolonizing research methodologies (including challenging the dominant frameworks and disciplinary silos) that have historically exploited, silenced, and ignored certain communities and minority members of communities. Specifically, by taking essentialist and reductionist views of "community", traditional forms of community research have neglected to examine and understand the complexity and intersectionality of how different and overlapping axes of power and oppression impact people's lives and expdriences. Additionally, feminist approaches reject claims of ownership over communities or the research produced, and encourage researchers to be visible-even political-as long as they are also self-reflexive.

Feminist community research (FCR) is defined by Creese and Frisby (2011) as an approach that uses "innovative methodological approaches to tackle complex social problems faced by those who are rarely included in knowledge production and policy making" (p. 1). Essentially, feminist community research attempts to do things differently, by promoting respectful and ethical approaches to community research that

are both mutually beneficial and productive, but not exploitative. First, FCR challenges the "social embeddedness of the process of knowledge production" and calls for "increased collaboration between universities and communities to generate knowledge that is widely distributed and that contributes to improved social policies" (Creese & Frisby, 2011, p. 1). By adopting an FCR approach, therefore, researchers take into consideration how the sometimes tense relationships between key players (e.g., community members, community-based organizations, institutions of higher education, funders, etc.) shape research, including what projects get funded and who benefits from research-as well as who does not (Creese & Frisby, 2011, pp. 1-2).

Next, FCR approaches depart from traditional community research (e.g., community-based participatory research and participatory action research) by rejecting and challenging positivistic strategies, reliance on objectivity, unequal power relations, and contested notions of truth and knowledge. Instead, FCR approaches promote knowledge production based on lived experiences or "real world" accounts (Creese & Frisby, 2011, 3), based on the notion that "gender is inextricably tied to other axes of power, including race, social class, colonial histories, sexuality, age, and other forms of oppression that have a profound influence on the knowledge claims made" (Creese & Frisby, 2011, p. 2).

In fact, according to Creese and Frisby (2011), "the starting point for [FCR] is acknowledging that our own knowledge claims are historically situated, socially embodied, and mediated through multiple and shifting relations of power and privilege" (p. 3). By disrupting "dominant frameworks, disciplinary silos, and taken-for-granted

assumptions that maintain the status quo", FCR attempts to "bring to the surface voices that are often excluded from knowledge production and policy making" by questioning whose voices get heard, as well as whose voices have been silenced (Creese & Frisby, 2011, p. 3). This is particularly important, considering that the goal of FCR is to create social change (i.e., inform policy and reform), considering that too often, the voices that are most impacted are not considered or consulted when informing policy, resulting in a disconnect between community-based work, and the communities they are intended to serve.

If the goal of feminist research is to create social change, the work often naturally assumes a political and activist tone. In order to make FCR a political project, PCF approaches reject the idea that the researcher should be objective and invisible, and instead, makes a case for visibility and transparency on the part of researchers-particularly with regard to how they simultaneously occupy spaces of privilege and oppression. In fact, FCR creates a space for researchers to not only be political, but conduct research that is subjective-and even at times emotional by encouraging them to engage in self-reflexivity and controlled self-disclosure. Specifically, according to Frisby and Creese (2011), engaging in reflexivity is a feminist scholar's "epistemic responsibility" (Skeggs, 1997 as cited by Creese & Frisby, 2011), because it helps researchers see that research is never innocent, and as such, "learning to share in processes of knowledge creation is a precondition to decolonizing research methodologies" (p. 3).

Lastly, FCR challenges the very notion of 'community' by calling into question what a community is or how it is often conceptualized and portrayed through research questions and methods. Specifically, FCR approaches caution against problematizing "essentialist constructions of community" and consider the "historically grounded relations of power that can be inferred by *community*" (*Feminist Community Research*, p. 26). Essentially, FCR asks researchers to depart from the tendency to fetishize, romanticize, and problematize minority and indigenous communities, and consider how factors such as the theory that informs their research, the questions they are asking, and what members of these communities they are talking to (or not talking to for that matter) impact the trajectory and findings of research projects. Further, how do the findings that we publish portray and potentially harm these communities, and are we doing justice to them?

In fact, according to feminist research, and PCF critiques of social research (and in particular, qualitative research), while the conversation surrounding ethics in community and qualitative research has typically focused on protection, confidentiality, and anonymity (Birch, Miller, Mauthner & Jessop, 2002), feminist approaches argue that we should be thinking about ethics on a much larger scale. Specifically, it is imperative to also consider the many empirical and theoretical implications for ethics in feminist research, because "the complexities of researching private lives and placing accounts in the public arena raise multiple ethical issues for the researcher that cannot be solved solely by the application of abstract rules, principles, or guidelines (Birch, Miller, Mauthner, & Jessop, 2002, pp. 1-2).

Specifically, unlike quantitative forms of research or research that is done in a lab, community-based research and other forms of social research that utilize qualitative methods, revolve around establishing relationships with others in unpredictable and diverse settings. In fact, FCR is centered on "developing meaningful and ethical relationships" and doing research *with* and *for* communities, rather than *to* or *on* them (*Feminist Community Research*, p. 187). Despite the fact that FCR and qualitative research both hinge upon these trusted and meaningful relationships, Martin, Murphy, and Buchanan (2011) point out that "ethical agreements often remain dictated and controlled by centralized research ethics boards (REBs) based on the academy or funding bodies" (p. 189).

In fact, while ethical review boards are in place to protect community members and participants from incurring any harm, they have to balance the best interests of the academic institution with those of the community, which "limits the ability of those of us conducting research in communities to respond to the unique, ever-changing and context-specific needs of our projects" (*Feminist Community Research*, p. 187). Again, this raises the following critiques about traditional forms of community and qualitative social research: 1. Whose questions we are asking, and 2. Whose research we are doing? Further, how do we balance the interests of the ethical review boards (and key players and stakeholders, including academic institutions and funders) with those of the community and the community members themselves? Specifically, if we are truly doing feminist research, it is imperative to critique the "exploitative power hierarchies between researcher and researched, and the espousal of intimate research relationships, especially

woman-woman, as distinctly feminist mode of inquiry" (Birch, Miller, Mauthner, & Jessop, 2002, p. 15).

Collectively, feminist approaches to community research and qualitative social research projects provide researchers with a methodology for conducting more respectful, equitable, and ethical research with community members and communities as a whole. By examining power relations that exist not only between institutions and key stakeholders and players and the communities, but also the researcher and the community members, feminist approaches consider the many historical and intersectional notions of power and privilege that shape research from conception to publication. Additionally, if we acknowledge that feminist research takes many shapes, but shares the underlying goal of making the world a more equitable place for everyone (and in particular, those communities that have been silenced and ignored by traditional and positivist approaches), it must be ethical, political, reflexive, and transparent.

CHAPTER FOUR

METHODS

Research Questions

Considering the alarmingly high burden of SA at institutions of higher education in the United States, coupled with the short- and long-term associated harm, innovative, empirically-supported, and trauma-informed secondary prevention strategies are needed to help students move along the information-seeking pathway and connect to critical and appropriate campus and community resources. While there have been known attempts to adapt decision aids for use with postsecondary learners who experience attempted and/or completed acts of SA, the literature shows promise for potential efficacy among the target population, particularly if delivered online.

As the most innovative university in the nation with one of the largest student bodies of undergraduate, graduate, professional, and non-degree seeking students, Arizona State University serves as a promising field site to answer the following questions:

> *Q1. What are the different pathways available to student survivors of sexual assault at Arizona State University for reporting/pursuing justice, and seeking care, support and advocacy on and off campus?*
>
> *Q2. What are the decisional needs of the target population?*
>
> *Q3. To what degree does direct feedback from the steering group members during alpha testing demonstrate that the prototype is acceptable, comprehensible, and usable?*
>
> - H(1): it is hypothesized that direct feedback from the steering committee during alpha testing will show that the intervention is well-received by the steering committee and meets the needs of the target population.

- H(2): it is hypothesized that direct feedback from the steering committee during alpha testing will show that information included in the intervention is easy to understand.
- H(3): it is hypothesized that direct feedback from the steering committee during alpha testing will show that members of the steering committee would use the proposed tool in "real-life" settings.

Additionally, the current project originally intended to answer, a fourth research question to establish whether or not the prototype could be classified as a certifiable decision aid:

> *Q3. Can decision aids be adapted for use with the target population by following development standards recommended by the International Patient Decision Aids Standards (IPDAS) Collaboration?*
>
> - H(1): it is hypothesized that the prototype will qualify as a decision aid as measured by the IPDASi (v4).
> - H(2): it is hypothesized that the prototype will meet all six qualifying criteria on the iPDASi (v4) (measured on a binary yes or no scale) and therefore qualify as a decision aid.
> - H(3): it is hypothesized that the proposed intervention will receive a score of at least three (measured on a 4-point scale where 1=strongly disagree and 3=strongly agree) on all ten certification items on the IPDASi (v4), and therefore be certifiable.

Unfortunately, however, the current study was limited by: 1. Size restrictions imposed by prototyping software that limited the researcher's ability to create one comprehensive prototype that demonstrates all possible combinations of outcomes and pages, and 2. A lack of funds (estimated to be a minimum of $10,000) to create a fully functioning mobile-friendly website that would not be restricted by limitations on the total number of pages and/or hotspots (i.e., links) between pages. As a result, the PI was unable to assess for IDPAS qualification, quality, and certification criteria.

Aims

Due to the fact that there have been no previous attempts to adapt decision aids for use with the target population, the current study aimed to first determine feasibility. Specifically, the current study aimed to: 1. Assemble a steering committee of expert clinicians and professionals and student survivors; 2. Elicit views on student information and decisional support needs and map out all potential pathways for seeking care and justice on and off campus; 3. Determine the format and distribution of the decision aid; 4. Review and synthesize the evidence in order to determine the theoretical framework and incorporate current clinical practices and guidelines; 5. Create a prototype of the proposed internet decision aid (including storyboarding, scripting, graphics, web design, etc.), and 6. Alpha test the prototype with "typical" users to elicit direct feedback from stakeholders on acceptability, comprehensibility, and usability to establish efficacy.

Current Study

The current study used a trauma-informed and feminist community research (FCR) approach to develop and design a prototype of an internet-based decision aid tailored to assist student survivors of SA at Arizona State University (ASU) with making informed choices about care and justice in real-time. Over the 2017-2018 Academic Year, the PI completed five (1. Scoping; 2. Steering 1; 3. Design 1-4; 4. Prototype; 5. Alpha testing 1 and 2, and 6. Steering 2) of the seven recommended phases for developing decision aids proposed by the International Patient Decision Aids Standards (IPDAS) (figure 1).

Scoping. During the scoping phase, an extensive review of the scholarly literature was conducted in order to define the scope and purpose of the decision aid, and identify the target audience. Based on findings from the scholarly literature, it was determined that the purpose of the decision aid would be to: 1. Increase participation in the decision making process, and 2. Improve overall decisional quality among undergraduate, graduate, professional, and non-degree seeking students who have been sexually assaulted while enrolled at any ASU campus in Maricopa County. If effective, the tool has the potential to not only increase initial engagement with appropriate crisis, health, and victim services on and off campus, but also reduce disengagement over time among students who choose to disclose and/or report, by educating and empowering them to engage in informed decision making. Lastly, the tool will screen for immediate harm (including environmental safety, bodily injury, psychological distress, and IPV) in order to connect at-risk students with appropriate crisis and emergency services in real-time.

Steering (Phase 1). During the first steering phase, a total of fifteen expert clinicians (Table 9) and professionals who work firsthand with students who experience SA on and off campus, and four students who have experienced an incident of SA while enrolled at ASU were recruited to help with designing, developing, and alpha testing the prototype. In order to join the steering committee, individuals had to meet the following inclusion criteria: 1. Be at least eighteen years of age, 2. Be proficient in written and spoken English, and 3. Either work directly or indirectly with victims/survivors of SA either on campus or in the surrounding Phoenix Metropolitan area, or be a student enrolled at ASU (or have graduated within the past Academic Year) who is a firsthand or

secondhand survivor of SA at ASU, with at least one incident occurring since enrollment at ASU.

Individuals under the age of eighteen and/or who are not proficient in written and spoken English were excluded from the study, due to mandated reporting issues (since the PI is a master's level counselor seeking licensure) and a lack of validated measures for IPDAS available in languages other than English. Additionally, expert clinicians or professionals who do not work directly or indirectly with students who experience SA at ASU (e.g., who work with victims of other crimes that do not involve unwanted sexual experiences or who work primarily with student survivors at other IHEs) were excluded from joining the steering committee. Further, students who have not experienced a SA themselves, or who don't know someone who has experienced a SA while enrolled at ASU (e.g., had only experienced SA during childhood or high school, or had experienced SA while enrolled at another IHE before transferring to ASU) were excluded from the study. Lastly, students who met all inclusion criteria but attended ASU outside of the Phoenix Metropolitan area (including students at the Havasu campus or online students who do not attend any classes on campus in Maricopa County) were also excluded.

The PI obtained IRB approval to recruit steering committee members via email through direct contact or by referral from other members. Specifically, members of the expert professional and clinician steering group were recruited via email (Appendix A) through direct contact, or referral by other steering committee members (i.e., snowballing). The PI had already established professional relationships with four of the steering committee members, through networking and other professional experiences at

ASU, and within the surrounding Phoenix Metropolitan area (e.g., by attending ASU's sexual violence symposium and as a former crisis counselor/trauma therapist with Trauma Healing Services at La Frontera/EMPACT-SPC). The remaining members were recruited by the existing four members, who either introduced the PI via email, or provided the PI with professional or personal email addresses.

Members of the student steering committee were also recruited via email (Appendix A). Specifically, students were recruited by ASU faculty and staff who had preexisting, trusted relationships with firsthand and secondhand survivors of SA, or who were teaching classes in either Global Health or Women and Gender Studies. The majority of students (three of the four) who participated were recruited via email by the Program Manager of Outreach and Education at ASU and a sexual violence peer educator and advisor with the Sun Devil Support Network with the Office of Sexual Violence Prevention/Education Outreach and Student Services.

All members of the student steering committee were given a $25 Visa Gift Card for their participation (with the exception of one participant who stopped participating in the study after the initial interview in the Fall and was unable to be reached thereafter). While members of the steering committee were also offered $25 Visa gift cards, they all declined, stating that they wanted to volunteer their time and contribute to the project. Funds to purchase the gift cards were secured during the 2016-2017 Academic Year through the SHESC Student Research Award, and were transferred into the investigator's bursar account in the Fall of 2017.

Additionally, in an effort to make the experience more mutually beneficial than exploitative, the PI offered student survivor committee members opportunities for future professional development and involvement, and community agencies and organizations free, unrestricted usage of the tool once it is released to the public. Specifically, student survivors were provided with opportunities for authorship in any articles accepted for publication in peer-reviewed journals that result from this dissertation, and continuing professional development and research experience should the project move onto beta testing as planned in the 2018-2019 AY.

Design (Phases 1-4). After the steering groups were formed, the PI conducted individual, semi-structured qualitative interviews with twelve of the fifteen expert clinicians/professionals and all four student survivors (Appendix B) on the steering committees, and met with one stakeholder to discuss ASU support for the project. The purpose of individual interviews was to: 1. Elicit views on student information and decisional support needs, 2. Map out all potential pathways for seeking care and justice both on and off campus, and 3. Determine the format and distribution of the tool. Students who requested to receive a copy of the semi-structured interview script prior the interview were sent a digital copy of the interview script via email. After all interviews were conducted, electronic notes from the interviews taken and stored on the PI's personal, password-protected computer were then synthesized and reviewed.

Prototype. From January to February of 2018, a prototype of the internet-based decision aid was developed using an iterative process. First, the PI mapped out all potential pathways for reporting/pursuing justice, and seeking care, advocacy, and

support available to ASU students who are sexually assaulted in the Phoenix Metropolitan area. After mapping out all potential options and action plans (as well as possible outcomes), the PI began working with a web developer/graphic designer to storyboard, script, and design a prototype of the tool using InVision © software.

About halfway through, the PI held a focus group with three of the four student survivors on the steering committee (two were present in-person, one was conferenced in, and another was unable to attend due to a scheduling conflict) to receive preliminary feedback on the design and format of the tool. Specifically, students were asked to talk about how they felt about features such as vocabulary/vernacular and color schemes, and were asked to reflect on how easy or difficult it was to navigate the tool and provide suggestions for improvement. Feedback from the student survivor focus group was then used to revise and redraft the existing pages, as well as to shape further development.

While the initial goal was to create a single, working prototype demonstrating all possible outcomes (i.e., all combinations of options and action plans tailored to each user based on their responses), the PI was unaware that prototyping usually involves only the creation of about 50-75 pages. As such, most prototyping programs are not intended to support hundreds (or in this case, thousands) of pages, particularly when each page includes multiple "hot spots" or links to other pages. After uploading over 3,000 pages, each with at least two hot spots per page, the program crashed, and the prototype was too slow to function.

After consulting with the program support staff and the web developer/graphic designer, it was determined that the tool would need to be limited to 75-100 pages to run

smoothly. While it should be noted that these size restrictions are restricted to the prototype software and would not be an issue when developing the fully-functioning website (and therefore does not impact feasibility of tailoring decision aids for this population), the PI decided 75-100 pages would not be sufficient in order to demonstrate feasibility or efficacy in the current study. Therefore, in order to provide steering group members with different user experiences from start-finish without crashing or overloading the software with thousands of duplicate pages, the PI decided to create three separate prototypes (see Appendices C-E).

The first prototype (Appendix C) takes users through the decision aid from the standpoint of a student at ASU who: was sexually assaulted by another student who is also a current or former intimate partner on ASU property within the past 120 hours, and is interested in getting a forensic nurse exam and learning more about red flags of abuse; is currently in a safe environment, and does not have any emergent physical or mental health issues, does not have a mental health provider, and would prefer to address their primary mental and physical health concerns on campus, and would like to report the incident to ASU and ASU police.

The second prototype (Appendix D) takes users through the decision aid from the standpoint of a student at ASU who: was sexually assaulted by someone who works for ASU or with ASU students who is not a current or former intimate partner, on ASU property but within the past 120 hours; is currently in a safe environment, and does not have any emergent physical or mental health issues, does not have a mental health

provider, and would prefer to address their primary mental and physical health concerns off campus, and would like to report the incident to ASU and ASU police.

The third and final prototype (Appendix E) takes users through the decision aid from the standpoint of an ASU student who: was sexually assaulted by someone who is not affiliated with ASU off campus, who is not a current or former intimate partner, not within the past 120 hours; is currently in a safe environment, and does not have any emergent physical or mental health issues, does have a mental health provider and PCP/OB/GYN and would prefer to make an appointment with their offices directly to care for primary physical and mental health issues, and would like to report the incident to local PD.

While each prototype allows users to select options for students in crisis, and looks and feels fully functional to a certain degree, most pages contain inactive buttons in order to prevent users from answering in ways that lead to every possible outcome and combination of outcomes. The inactive buttons, therefore, essentially guide users to click on certain answers in order to progress through the decision aid as a specific type of survivor (e.g., a student assaulted by another student or faculty member at ASU, or a student assaulted by someone not affiliated with ASU off campus). These three prototypes were chosen because collectively, they demonstrate every possible option and action plan, and allow users to see and engage with every page in the decision aid. Additionally, in order to show users every possible option and action plan, an action plan menu page was created and positioned at the end so users can explore all potential pathways available to student survivors.

Alpha testing (Phases 1-2) and steering (Phase 2). After the prototypes of the decision aid were developed, four separate focus groups were held with members of the steering committees: 1. One with members of the student survivor steering committee; 2. One with expert professionals and clinicians who not affiliated with ASU in the Mesa/Tempe area; 3. One with expert clinicians and professionals not affiliated with ASU in the downtown Phoenix area, and 4. One with expert clinicians and professionals affiliated with ASU on campus.

While originally the PI had hoped to assess for acceptability, comprehensibility, and usability in-person during the focus groups, each focus group had to be limited to one hour in order to accommodate the conflicting schedules and limited availability of steering group members. Instead, the PI used the focus groups to help members of the steering committee understand and learn how to navigate the different prototypes, and to review all supplementary materials distributed electronically at the time of the meetings, including: 1. A handout (i.e. cheat sheet) highlighting the key features of the prototypes, with helpful hints and tips for navigating the prototypes, and answers to anticipated questions (Appendix F); 2. The pros and cons lists (Tables 14-20), 3. The breathing exercise (which was too large to include in the prototype), and 4. Links to all prototypes and the electronic survey (Appendix G). Lastly, the PI sent steering committee members SMS messages with links to each prototype, so they could pull one up on their smartphones and go through a few pages together.

Steering group members were then given one full week to review the prototypes, email the PI any edits to the pros and cons lists in their area of expertise using Track

Changes in Word, and complete the brief electronic survey in Qualtrics. All steering group members stated that one week was a reasonable amount of time to finish reviewing the prototypes and supplementary materials, and complete the brief electronic survey. Further, each steering group member was encouraged to contact the PI (via text, phone, or email) at any point if they were confused or had any questions. The prototype then went through two additional rounds of revision, to account for some (but not all) of the edits and improvements suggested by the committees, with further edits to be made over the summer of 2018.

CHAPTER FIVE

RESULTS

Available Pathways

Information from individual semi-structured interviews with members of the student survivor and expert clinician/professional steering groups showed that students who are sexually assaulted while enrolled at Arizona State University have multiple options for seeking care, reporting/pursuing justice, and obtaining support and advocacy both on and off campus. Specifically, steering group members identified a total of eleven options and 40 action plans (see Tables 10-13) for receiving physical and mental health care, reporting/pursuing justice, and receiving support and advocacy on campus and within the community.

Results were organized into options and action plans, with options defined as broad categories for actions that describe help-seeking behaviors (e.g., Option 3: Get a physical exam and receive screening and treatment for non-emergent health concerns on or off campus), while action plans (APs) represent the specific and different ways that students can carry out these options on and off campus (e.g., AP 3A: Walk into ASU Health Services in Tempe, or schedule an appointment by calling 480-965-3349 or logging onto your MyASU Student Health Portal, or AP 3B: Call Planned Parenthood at 1-800-230-PLAN or schedule an appointment online).

Pathways for seeking physical health care on and off campus. Three options (Options 1-3) and eight action (APs 1A; 2A.1; 2A.2; 2B.1; 2B.2; 2C; 3A; 3B, and 3C) plans identified were campus and community resources available to students in need of

physical health care (Table 10). Specifically, students at ASU who have been sexually assaulted have two options for tertiary care/prevention (Options 1 and 2) (both of which are located off campus), and one option (Option 3) for primary care/tertiary prevention, with action plans that allow students to choose if they would prefer to see someone on or off campus. All three options identified allow students to obtain screening and treatment for a variety of health concerns, from sexually transmitted diseases and infections to pregnancy, however, not all resources are the same with regard to cost and services provided/covered. Additionally, not all medical professionals are trained in SA and IPV (i.e., are trauma-informed).

First, students who have urgent, and/or life-threatening physical injuries or health issues (e.g., fractured or broken bones, stab wounds, hemorrhaging, etc.) can go to the nearest hospital and check into the emergency department. Due to the fact that ASU does not have a medical school or partnership with any particular hospital in the community, students can either call 9-1-1 and be transported by ambulance, or find the nearest hospital. Cost of going to the hospital varies by student according to health insurance coverage and type, level of care required, and services (e.g., screening, tests, procedures, etc.) provided.

Next, students who have been sexually assaulted within the last 120 hours may be eligible to get a forensic nurse examination (FNE) (i.e., rape kit). FNEs are essentially a free head-to-toe physical examination completed by a sexual assault nurse examiner (SANE) who is trained to: 1. Collect any potential DNA and trace evidence; 2. Document, describe, and photograph any bodily injuries; 3. Take a comprehensive

medical history; 4. Note the survivor's physical state at the time of the exam; 4. Conduct pregnancy testing (for preexisting pregnancies) and administer medicine to prevent unwanted pregnancies that could result from the SA; 5. Administer antibiotics to treat common sexually transmitted infections/diseases; 6. Use CDC guidelines to determine risk of contracting HIV/AIDS, and 7. Provide survivors with important resources for free follow-up care in the community (e.g., obtaining antiretroviral therapies (ARTs) or follow-up testing for HIV/AIDs). From start to finish the exam (which is a lot like a well-woman's exam or gynecological exam) takes about one hour. During an FNE, the SANEs explain everything before they do it, and nothing is done without the survivor's consent. In fact, survivors can pick and choose which services they do or do not want performed, including the collection of swabs for potential DNA and/or trace evidence.

In addition to being an RN for at least two years, in the state of Arizona sexual assault nurse examiners must also undergo a 40-hour training on how to conduct FNEs (including how to identify and document injuries, and understand causation of injuries), pass 6-8 didactic exams under the supervision of an experienced SANE, and complete trainings on SA and legal statutes surrounding SA. Due to their extensive training, SANEs can serve as compelling expert witnesses if a case goes to trial, and can also educate jurors about common rape myths/misconceptions.

All FNEs in Maricopa County take place through Honor Health at either the nearest family advocacy center (with locations in downtown Phoenix, Glendale, Mesa, and Scottsdale), or at a special exam room at Scottsdale Osborn Hospital if the assault is reported after hours. Survivors can either obtain an FNE through the police (e.g., by

calling 9-1-1) or victim advocate, or by contacting Honor Health directly. If survivors decide to contact Honor Health directly, their kit will be transported in a way that preserves the chain of evidence to the precinct in the jurisdiction where the crime occurred, where it will be held for a certain amount of time (how long varies by precinct but they have to hold them for a minimum of 30 days). During this time, survivors can decide whether or not they want to file a police report and/or press charges. It should be noted that precincts are not required by law to store kits indefinitely, and may dispose of kits after the designated periods have lapsed if a criminal report has not been filed.

Kits that are not attached to a criminal report in the state of Arizona will not be tested. Filing a criminal report, however, does not guarantee that a kit will be tested either. In fact, whether or not a kit is tested depends on several factors, such as whether or not the person/people accused of committing the crime admits that a sex act took place. Specifically, because rape kits cannot prove rape, but only that a sex act took place (not whether or not that sex act was consensual), they are not always useful in circumstances where the accused perpetrator admits that they had sexual contact with the survivor. Additionally, even if a kit is tested, the results from the rape kit may not be entered into the Combined DNA Index System (CODIS), the FBI's database for making DNA matches (e.g., if the DNA from the rape kit matches the DNA sample obtained from a known suspect).

In addition to the aforementioned options for receiving tertiary care/prevention in the community, students who are sexually assaulted while enrolled at Arizona State University also have the option to see a primary care provider on or off campus.

Specifically, students can: 1. Visit ASU Health Services, 2. Go to a community clinic (e.g., Planned Parenthood), or 3. See their primary care physician or OB/GYN. While each of these resources should be able to provide the same basic services, they may vary according to access and cost among other factors.

First, students enrolled at ASU who attend classes in the Phoenix Metropolitan area have the option of seeing a medical professional on campus at any of the four ASU Health Services locations (downtown Phoenix, Polytechnic, Tempe, and West). Students can see someone confidentially at ASU Health Services by walking into the Tempe location, or by making an appointment online (through their student health portal), over the phone (by calling ASU Health Services), or in-person (by visiting one of the locations in person). While the cost of health care services varies for students (depending on insurance, and type of services requested/provided etc.), if a student discloses that they were sexually assaulted, ASU Health Services will waive all fees for exams, screening, and related treatments. While students must disclose in order to receive free health care, ASU Health Services employees are not mandated reporters, meaning they will keep what students disclose confidential, and will not report the incident to the school unless a student asks them to.

Next, students have multiple options for addressing primary health concerns off campus. Specifically, students who do not have a primary care physician (PCP) or OB/GYN (or who do not trust or want to disclose to their PCP or OB/GYN, and/or have their exam billed to their insurance company) may go to a community health clinic (e.g., Planned Parenthood). Students identified Planned Parenthood as somewhere that they

would refer other students to in the community, because they felt it has "a pretty good reputation" and "has built a reputation for really valuing inclusivity". Students who wish to see someone at Planned Parenthood can make an appointment over the phone or online regardless of whether or not they have insurance. In fact, while Planned Parenthood takes insurance, they also see individuals without insurance on a sliding scale based on annual income. Lastly, students who have a trusted primary care physician or OB/GYN, and feel safe putting their visit on their insurance can schedule an appointment with their office directly.

Pathways for seeking mental health care on and off campus. Three options (Options 4-6) and eight action plans (APs 4A; 4B; 4C; 4D; 5A; 6A; 6B, and 6C) identified by steering group members during individual interviews were campus and community resources available to students in need of mental health care (Table 11). Specifically, students at ASU who have been sexually assaulted have two options (Options 4 and 5) for tertiary care/prevention (located on and off campus), and one option (Option 6) for primary care/tertiary prevention (on campus and in the community), with action plans that allow students to choose if they would prefer to talk to someone online, over the phone, or in-person. All options for students to talk to someone are confidential, with most of these free or low cost to students regardless of insurance coverage, however, action plans varied greatly with regard to types of services provided (e.g., crisis response, counseling, group therapy, etc.).

First, students in crisis can talk to someone over the phone, online, or in-person by calling one of the following four local or national trauma-informed crisis lines: 1. The

National Suicide Prevention Lifeline; 2. Empact's ASU-specific Hotline; 3. The TrevorLine, and 4. The Rape Incest Abuse National Network (RAINN). Two of the national resources (The National Suicide Prevention Lifeline and the TrevorLine) are specifically for individuals who have thoughts or plans to kill or harm themselves, while RAINN is specifically for individuals who have experienced SA. The ASU-specific Hotline is the only 24/7 crisis line that transfers students who call ASU Counseling Services after hours to crisis workers at La Frontera/EMPACT-SPC, a community agency that specializes in suicide prevention (students in crisis during ASU business hours can call ASU Counseling Services directly); additionally, if the student discloses SA or IPV, they will be transferred to crisis workers with Trauma Healing Services (THS) who specialize in interpersonal forms of violence such as SA and IPV.

While all of these hotlines connect students with crisis specialists immediately, only the ASU-specific hotline and the THS hotline allow students to request a mobile crisis team that specialize in SA, IPV, and suicide-prevention to meet them wherever they are at 24/7. Crisis teams can help students safety plan, coordinate with supervisors at ASU Counseling Services to arrange follow-up care, and can even transport individuals to a hospital if they feel they cannot keep themselves safe.

All of these resources allow students to connect with a crisis specialist in English and Spanish, and the mobile crisis teams can use a language line to translate any additional languages students may speak. Additionally, the TrevorLine is the only suicide-prevention center that is specifically for individuals who identify as LGBTQAI+. Students who have thoughts and/or plans to harm or kill themselves who do not feel like

they can keep themselves safe can call 9-1-1 or visit the nearest hospital and check themselves into the Emergency Department for a 72-hour hold. The cost of going to the hospital varies depending on insurance coverage, type, and length of stay.

Lastly, students can talk to a mental health professional on campus or in the community by: 1. Visiting ASU Counseling Services or the Counselor Training Center (CTC), 2. Scheduling an intake at Trauma Healing Services with La Frontera/EMPACT-SPC, or 3. Making an appointment to see their mental health provider in the community. First, students at ASU can speak with a mental health provider at ASU Counseling Services and ASU Counseling Services. Due to the fact that the CTC is a training center for master's and doctoral-level students obtaining degrees in Counseling and Counseling Psychology at ASU, the Associate Director of ASU Counseling and the PI decided not to refer students to the CTC. While counselors-in-training at the CTC are heavily supervised (via two-way mirrors and videotaped sessions) by licensed mental health professionals, they are generally novice students in their first two years of schooling who lack extensive training in working with survivors of trauma and/or SA, and are therefore unable to provide many forms of trauma-informed counseling and care. Additionally, the CTC cannot provide the same level of advocacy and support (e.g., peer support and processing groups and administrative advocacy) that ASU Counseling Services can.

In order to speak with a counselor at ASU Counseling Services, students enrolled at ASU who take classes on campus in the Phoenix Metropolitan area can either visit any of the ASU Counseling Services locations (downtown Phoenix, Polytechnic, Tempe, and West), or call to make an appointment or talk with a counselor over the phone during

business hours. In addition to being able to seek out services at ASU Counseling, any student who reports an incident of SA to ASU or ASU PD will be contacted by someone at ASU Counseling Services who will check-in and let them know that they are entitled to free counseling services, which students may or may not utilize.

While the fee to see a counselor at ASU Counseling Services is $15/session for students, individuals who have experienced a SA that meets criteria to be a Title IX case (assaulted by someone affiliated with ASU while enrolled at ASU) at ASU qualify to have these fees waived via an automatic Title IX waiver. In addition to individual counseling, students may also be able to attend a cognitive processing therapy (CPT) (i.e., support) group. There is no official limit to the number of sessions students may be eligible to receive through ASU Counseling Services, with length of services varying on a case-by-case basis. While ASU Counseling Services has counselors that specialize in SA, not all students may be appropriate for all services; in order to determine whether students are appropriate for individual and/or group counseling at ASU Counseling Services, students are screened by a mental health provider during an initial intake appointment. If it is determined that a student is not appropriate (e.g., because it is determined that they need a higher level of care than ASU Counseling Services can provide), they will be provided with references to receive the level of care they need in the community.

Next, students who do not want to see someone on campus may be eligible to receive free counseling off campus through Trauma Healing Services with La Frontera/EMPACT-SPC. As a small, grant-funded branch of La Frontera/EMPACT-SPC,

Trauma Healing Services (THS) provides free, trauma-informed individual and group counseling and skills groups for survivors of SA in the Phoenix Metropolitan Area. Unlike other counseling centers in the area, THS does not take insurance or charge for any services. Additionally, THS provides services to individuals in English and Spanish, and never asks about immigration status or documentation. With offices in downtown Phoenix (through the Phoenix Family Advocacy Center), Glendale, and Tempe, most students can access one of the THS locations via public transportation (e.g., the light rail) even if they do not own or have access to a car.

Students are eligible to receive up to 6 months of trauma-intensive counseling at THS, including but not excluded to: eye movement desensitization and reprocessing (EMDR); trauma-focused cognitive behavioral therapy (TFCBT); somatic experiencing (SE); cognitive processing therapy (CPT); dialectical behavioral therapy (DBT); trauma-incident reduction therapy (TIR); acceptance and commitment therapy (ACT); exposure therapy; cognitive behavioral therapy (CBT), and mindfulness. Additionally, THS offers processing and skills groups (DBT and crisis survival skills) in Tempe and Glendale in English and Spanish.

In order to receive trauma-informed individual and/or group therapy from THS, students can call the THS hotline and schedule an intake to determine whether or not they are appropriate for services. Students are ineligible to receive trauma-informed counseling from THS if they: 1. Have a substance use or abuse disorder and are actively using; 2. Are not currently living in a safe or stable environment, and/or 3. Do not have sufficient coping skills or a support system among other factors. If students are not

determined to be appropriate for trauma-intensive counseling services they will be provided with references for care elsewhere in the community.

Lastly, if students have a mental health provider (e.g., a counselor, psychologist, psychiatrist, etc.) who they see on a regular basis, and they feel safe disclosing to them, they can call their office directly to schedule an appointment. Cost of services with providers varies according to type of practice (private v. public) as well as session fees, whether or not providers offer a sliding scale, and whether or not they take insurance (and what types of insurance they accept). It should be noted that not all mental health providers specialize in SA and/or trauma, however, it is the job of each mental health provider to know the limits of their training, and refer clients who require a level of care they cannot provide to a mental health professional who can.

Pathways for pursuing justice on and off campus. Students who are sexually assaulted while enrolled at Arizona State University have two options (Options 7 and 8) and six action plans (APs 7A; 7B; 7C; 7D; 8A, and 8B) for pursuing justice on and off campus (Table 12). Specifically, students have the same options for pursuing justice through the criminal justice system as their unenrolled peers, however, some students also have the option to report what happened to ASU and pursue administrative channels under Title IX (Table 3). First, students who are sexually assaulted while enrolled at ASU by someone affiliated with ASU (e.g., another student, a faculty or staff member, a coach, or someone who is contracted to work with students) have the option of reporting what happened to the school. Where and who students report incidences of sexual misconduct

to, depends on how the person or people/people who assaulted them are affiliated with ASU.

Students who are assaulted by another student can report the incident to the Office of Student Rights and Responsibilities (OSRR) with the Dean of Student's Office. In addition to disclosing to the OSRR directly, students can also: tell anyone at ASU who is a mandated reporter (e.g., a community assistant, teacher, teaching assistant, advisor, coach, etc.), go to ASU Counseling and ask to have a counselor help them file a report, or make an anonymous report over the phone. Additionally, students who disclose to ASU PD (described in detail later on in this section) will be contacted by the OSRR; while the OSRR will offer students resources and will start an investigation if they have the respondent's name, students do not have to respond to or participate in the investigation.

Once an incident is reported to the OSRR, participating students will meet with the investigator who will handle their case. Title IX investigators are OSRR staff undergo specialized training on Title IX policies and procedures, who must remain completely neutral during the course of the investigation (i.e., they are neither on the side of the reporter or respondent). Once the Title IX investigator interviews the reporter (formerly referred to as the "complainant"; i.e., the student survivor who discloses the incident), they will then interview the respondents (the student or students who are being accused of the student conduct violation), and any potential witnesses. Once the investigator has collected all available evidence to support or refute a claim, they put together a formal report (which the reporter has the right to receive a copy of/read) for the director of the OSRR, the Dean of Students, and a senior associate dean to hear the case.

If a student files an anonymous report, and does not disclose their name, the OSRR will try to investigate, but cannot suspend or expel anyone if they do not have the name of the reporter. As a result, while the OSRR tries to investigate anonymous complaints, they often do not have enough information to pursue the case further and are forced to drop it. While students may request that their names are not included in reports put out by the OSRR, ASU cannot guarantee total anonymity of any reporter. Students who are concerned about disclosing their name, or who fear retribution while an investigation is taking place can, however, request a no contact order, which prohibits the respondent from contacting them during the course of the investigation. If the reporter is granted a no contact order and the respondent contacts them, they will be found guilty of violating the student code of conduct. Conversely, if during this time the reporter violates the no contact order, they too can be found guilty of violating school conduct codes.

Unlike criminal justice courts that require that the evidence demonstrates beyond a reasonable doubt that a crime occurred, in order to rule on the side of the reporter, the Dean of Students must determine whether or not there is more than a 50% chance that a student conduct violation occurred (known as the preponderance of guilt or "feather rule"). If the respondent is found guilty, they may receive administrative sanctions such as probation, suspension, or even expulsion. If a student is found guilty and is expelled from ASU, they will also be prohibited from reapplying to ASU, or attending Northern Arizona University or the University of Arizona for the rest of their life. If the school decides to expel the respondent, however, the reporter will be asked to testify in front of the committee. While the reporter does not have to testify, it can only help their case if

they do, and if they do not, it could help the respondent's case. Students who feel unsafe testifying can ask to testify behind a screen, have their testimony videotaped, or have someone (e.g., an advocate) read their testimony on their behalf.

From start to finish this process takes on average 30 days at ASU. While students do not need to obtain legal representation during this time, every reporter and respondent is entitled to have a lawyer represent them if they want one. As a result, many respondents hire lawyers in administrative cases, even though they are not being charged with a criminal act, due to the gravity of potential outcomes. Additionally, once an outcome is delivered, the respondent has the right to file an appeal (i.e., a Title IX complaint) or lawsuit against the school, if they feel that their case was handled unfairly. When reporters file Title IX lawsuits against the school, they often lose, because they have to prove that the school had knowledge that a student conduct violation occurred, and did nothing about it. Conversely, when respondents sue the school, schools often settle and award monetary compensation to avoid going to court. Again, given the gravity of the possible sanctions handed down by the school in these cases, many respondents who are found guilty file an appeal or sue the school.

While the OSRR is the appropriate place to report an incident of sexual misconduct committed by another student, students who are assaulted by employees of ASU (e.g., advisors, teachers, coaches, etc.) report to the Office of Equity and Inclusion (OEI) instead. Specifically, the OEI handles cases of sexual misconduct when the person accused is a staff or faculty member, or a third party (e.g., a contract employee or vendor). The OEI is responsible for looking into potential violations that expressly

prohibit or address relationships between ASU employees and students. Specifically, relationships between students and faculty are prohibited when the faculty member is in a position of authority over the student (e.g., is a mentor, supervisor, teacher, etc.), and preexisting relationships have to be disclosed beforehand. Additionally, relationships between employees or volunteers (e.g., athletics volunteer coaches or staff who are not employees of the university but work with students) and students are prohibited, when the member has some kind of authority or influence over the student, or if the student is employed by that party as a student worker. Lastly, ASU athletics has its own policy that prohibits relationships between students and anyone who works within athletics.

Students who are sexually assaulted by someone who works at ASU, or who works with students at ASU can report the incident to the OEI directly by phone or email. Additionally, students can: 1. Disclose what happened to them to anyone at ASU who is a mandated reporter, 2. Ask a counselor at ASU Counseling Services to help file a report or report the incident for them, or 3. File an anonymous report over the phone. Once the OEI finds out about an allegation of sexual misconduct, one of their four investigators will reach out to the person who reported the incident (if they have a name) to try to get more information. During this time the investigator will also communicate with the Title IX Coordinator, the general council, the provost office, and the appropriate Deans and Vice Presidents to "keep everyone in the loop".

When the investigator meets with the reporter, they inform them of their role in the process, including what policies they are responsible for upholding and what their practices are. Additionally, the investigator makes it clear to the reporter that they are not

a confidential source, and will refer students who want to speak with someone confidentially to ASU Counseling Services. During this time, students are also given a list of resources for receiving administrative support and advocacy, as well as information on the policy that pertains to their specific case. If interim measures are necessary, either after the investigator talks to the reporter or after they gather any evidence, the OEI investigator will speak with the Title IX Coordinator, the Provost Office (if it involves a faculty member) and the VP or Dean over the particular division to determine what measures should be taken.

For issues involving faculty, the OEI cannot always guarantee immediate removal of faculty from teaching responsibilities while an investigation is pending. That being said, there might be other things the OEI can do for students to help them feel safe in the interim. For example, if the person who assaulted the student is their teacher or advisor, advocates at ASU can help students switch classes or advisors. Additionally, if the student is currently enrolled in a class taught by the person who assaulted them, students can ask the OEI to delay the investigation until after their grades are posted.

During an OEI investigation, both parties (the reporter and the respondent) are asked to not discuss the case with anyone affiliated with ASU. While no two cases are alike, there is usually a period where the investigator goes back and forth, speaking with witnesses and the reporter. After the investigation is complete, detailed reports are drafted and sent to the director of the OEI, as well as any other involved parties (e.g., the provost/CFO, athletic director, VP/Dean, etc.). In cases where there is not enough evidence, rulings are often based on credibility (i.e., who is more credible-the reporter or

the respondent?). If the respondent denies that sexual misconduct took place, but there is evidence to contradict what they deny, this will impact their credibility. Often, however, it comes down to the word of a student against that of sometimes a tenured and well-respected faculty member. If conduct is egregious enough to warrant termination, the person could be fired from ASU. It is, however, more difficult to fire faculty that have tenure, so they could be asked to retire or leave the university instead.

In addition to pursuing administrative pathways for justice, students can also file criminal charges with the police in the jurisdiction where the crime occurred. In fact, students have the right to file with the school in lieu of filing criminal charges, or file criminal charges concurrently or consecutively to filing a Title IX report. Due to the fact that ASU has a police force, students who are assaulted on ASU property (e.g., in a dorm room or teacher's office) can file a criminal report with ASU PD. That being said, students who file a criminal report with ASU PD will be referred to either the OSRR or the OEI depending on who the alleged perpetrator is, which will follow-up with students about whether or not they want to pursue administrative channels as well. If, however, a student reports to the OSRR or OEI, they will not report what happened to ASU PD.

If a student is sexually assaulted on ASU property, they can either call ASU PD directly or dial 9-1-1 to file a criminal report, either of which will connect them to a dispatcher with ASU PD who will ask some broad questions to determine whether or not what happened might be a SA. Due to the fact that ASU PD is a trauma-informed agency, every employee from dispatchers to sergeants are trained in SA. As such, dispatchers are

trained to help advise victims about what to do (e.g., preserve the crime scene) and not to do (e.g., shower, eat or drink) while they wait for the officer to arrive on the scene.

Patrol officers who are dispatched to respond to 261 calls (i.e., calls pertaining to SA) will meet victims at the scene of the crime (or wherever they are at) in order to obtain a very basic understanding of what happened (Who? When? How?), in order to determine whether or not a crime has occurred. From there, the patrol officer will contact their sergeant to determine next steps. If evidence needs to be collected, a detective from the special victim's unit (SVU) or a criminal investigator will be called out to collect any potential evidence. If the crime did not occur on ASU property, the patrol officer will contact the appropriate police department who will come out and meet them there, and the county will take over.

If the crime occurred on ASU property, the victim will be given the opportunity to speak with the ASU victim advocate, who may or may not be able to come out to the scene. If the crime occurred within the past 120 hours, the victim will be given the option to be transported to either a family advocacy center or Scottsdale Osborn Hospital to have a forensic nurse exam (i.e., rape kit) conducted by a certified sexual assault nurse examiner (SANE) to collect any potential DNA and trace evidence. If a rape kit is performed, a police officer with ASU PD will be pick up the kit from the site where the exam is performed within 72 hours.

Next, victims are transported to the police station where they will be asked if they want to go over some "macro-level stuff" to gather basic information about what happened by revisiting things they talked about with the officer, and trying to establish a

little more detail (e.g., is there a suspect? Do they have any identifying information on them? Etc.). Additionally, if there is any evidence on the victim's phone, the detectives can either take their phone and download what they need, or take photos of evidence on their screens using a body cam to prove timeframe. If there was evidence on the victim's phone that has been deleted (e.g., on Snapchat), detectives have software that can access public and private information from social media that has been deleted.

If the victim knows who assaulted them, the officers may try to find the suspect and ask them questions right away. Sometimes, however, the detectives may want to wait to do a confrontation call later. Confrontation calls are monitored/recorded phone conversations that take place between victims and alleged perpetrators, with the aim of getting a taped confession. Whether or not detectives ask victims to do a confrontation call depends on several factors, such as the relationship with the alleged perpetrator and prior communication patterns that have been established with them. For example, if the perpetrator is someone the victim met through an online dating app (e.g., Tinder or Bumble), they would most likely only have spoken to them through the App, and therefore the person might find it suspicious if they asked to speak to them over the phone. If, however, the perpetrator is someone the victim knows and has spoken with frequently, it would not seem as abnormal for them to reach out and initiate a conversation to talk about what happened.

At the end of initial contact (within 120 hours of reporting), the victims are then given phone numbers for the detectives, and resources for legal advocacy and counseling, and are asked to schedule a forensic interview three-four sleep cycles later. While waiting

three-four sleep cycles before conducting forensic interviews is not standard practice, it is a trauma-informed approach based on the literature on how the brain responds to SA, and in particular, how memories related to SAs are often fragmented, disorganized, and difficult to recall (Porges, 2001; Campbell, 2012).

Forensic interviews with ASU PD are conducted by detectives with the SVU and take place in a special room that has been decorated to make victims feel more comfortable than a traditional interrogation room, complete with cozy couches and blankets, soft lighting, and walls painted with warm colors. Depending on the detective who is conducting the interview, victim advocates may or may not be allowed in forensic interviews. Forensic interviews may last anywhere from 30 minutes to three hours, with or without breaks, depending on what each victim prefers. During the forensic interview, victims are asked more detailed questions, as detectives have them walk through what happened from start to finish, and ask them specific questions (did you drink? If so, how many drinks did you have? Did you do drugs? If you did, what drugs did you do?). While the questions asked during a forensic interview can feel like the detectives are blaming the victim for what happened to them, they are intended instead to establish exactly what happened, with the goal of getting as much detail as possible.

After the forensic interview, the detectives determine the best next steps, to establish that what happened meets every aspect of the Arizona statute for proving beyond a reasonable doubt that a SA took place (i.e., that the alleged perpetrator knew that what they were doing was wrong and did it anyways). This includes contacting and interviewing the suspect(s), and possibly arresting the suspect(s) if it has been determined

that a crime occurred. Once everything has been established, all the evidence has been collected, and the results are in (which can take three months to a year if there is DNA evidence involved for example from a rape kit), the detectives put together their case to establish probable cause. If there is enough evidence to proceed, if the suspect is not already incarcerated, they will be mirandized and arrested, photographed, fingerprinted, and taken into custody.

At any point during this process, victims have the right to stop the investigation. Once the case is turned over to the county attorney's office, however, the county attorney will decide whether they will: 1. Take the case to trial, 2. Ask the detectives to collect more evidence and resubmit the case once they have, or 3. Drop the charges. If the county attorney decides to prosecute the case, the victim no longer has the right to stop the process, and can even be subpoenaed to appear in court if the case goes to trial and they do not want to testify. It can take a year for a case to get to the county attorney, and another one-three years to obtain a ruling if the case goes to court.

Lastly, students who are sexually assaulted off campus can file a criminal report with the police department in the jurisdiction where the crime occurred. Students who are interested in filing a criminal report can call 9-1-1, and a dispatcher will help them determine which precinct has jurisdiction over their case, and then will send an officer out to the scene to meet them and gather basic information. If a student calls ASU PD and once on-site, officers determine the crime did not take place on ASU property, they will contact the appropriate precinct and stay on the scene until they arrive.

While reporting to non-ASU PD is a similar process to reporting to ASU PD, every police department handles things slightly differently. Specifically, police departments vary in terms of what percentage of cases get forwarded to the county attorney's office, whether or not they have a special victim's or sex crimes unit, and how trauma-informed their methods are (e.g., do they use a victim/survivor-centered process?). For example, while ASU PD forwards 100% of cases to the county attorney's office, in other precincts, this percentage is much lower. It is important to note, however, that just because your case gets forwarded to the county attorney does not mean they will choose to take it to court.

Pathways for receiving support and advocacy on and off campus. Students who want to receive support and/or advocacy have three options (Options 9-11) and twelve action plans (APs 9A; 9B; 10A; 10B; 10C; 10D; 10E; 10F; 10G; 11A; 11B, and 11C) available on and off campus (Table 13). Of these, one option (Option 9) and two action plans (APs 9A-9B) are for administrative support; one option (Option 10) and seven action plans (APs 10A-G) are for obtaining legal advocacy, and one option (Option 11) and three action plans (APs 11A-C) for receiving support on campus or in the community. First, students who have an open Title IX case can speak with someone at ASU about changing dorms, switching classes or advisors, and receiving medical withdrawals. Specifically, students who feel comfortable reporting what happened to them to ASU and disclosing their names, and who are okay with ASU investigating their case can speak to an advocate with the Office of Student Rights and Responsibilities (OSRR) by calling or visiting the Dean's office on their campus during office hours. If,

however, students do not feel safe disclosing their name, or if they do not want the school to investigate their case, they can speak with a counselor at ASU Counseling Services who can help students bypass the OSRR to receive administrative advocacy (see AP 6A).

Additionally, students can speak with a confidential legal advocate on or off campus to receive advocacy and support with obtaining orders of protection and injunctions against harassment; getting help writing victim impact statements, and/or applying for victim's compensation. First, students at ASU who file a criminal report with ASU PD can call or email the ASU PD victim advocate to receive confidential support and advocacy. While the ASU PD victim advocate is not a legal advocate per se, she can provide all of the aforementioned support services for students. Second, students with or without a police report in Maricopa County can contact a victim advocate off campus with the Family Advocacy Center, which has several offices including downtown Phoenix, Glendale, Mesa, and Scottsdale. Additionally, students can walk into the Phoenix Family Advocacy Center during business hours to speak with an advocate confidentially, regardless of what city the crime occurred in.

Third, students speak with a legal advocate with Trauma Healing Services (THS), La Frontera/EPACT-SPC off campus by calling either the ASU-specific hotline or the THS hotline. THS advocates are trained specifically in providing legal advocacy for individuals and families in Maricopa County who have experienced SA and IPV. Fourth, students can contact the Arizona Coalition to End Sexual and Domestic Violence (ACESDV) during business hours to speak with a legal advocate trained specifically in sexual and IPV, or get free legal representation and/or social services through the Crime

Victim's Rights Project. Fifth, students can receive plain-language legal information by state and types of abuse, get safety tips, prepare for court, and find social services in Arizona (including domestic violence shelters) by visiting RAINN.org or Women'sLaw.org. Lastly, students can find out how to preserve evidence of Cyber Exploitation, have images removed from the internet, register to copyright their images, get restraining orders, and learn about statutes and resources pertaining to cyber exploitation/revenge porn in AZ by visiting Without My Consent.

Finally, students have one option (Option 11) and three action plans (APs 11A-C) for receiving support on campus or in the community, two of which are confidential. First, students who would like to receive support on campus can visit or call ASU Counseling Services during business hours to speak to a counselor confidentially, or receive non-confidential peer support by contacting a member of the Sun Devil Support Network (SDSN) at ASU (all members of the SDSN are mandated reporters). Additionally, students who are interested in receiving free, confidential support off campus can contact one of several local or national hotlines, including but not excluded to: 1. EMPACT's ASU-specific hotline; 2. The Trauma Healing Services hotline, and 3. The national SA hotline-the Rape Abuse Incest National Network (RAINN) (which also has a 24/7 chat line).

Decisional Needs

Decisional conflict (uncertainty). Individual, semi-structured interviews with members of the student survivor and expert clinician/professional steering groups unveiled multiple points of decisional conflict or uncertainty survivors of SA at ASU

may face as they move along Skinner and Gross' (2017) information-seeking pathway. First, steering committee members pointed out that many students are not sure whether or not what happened to them was a crime or student conduct issue. Even in cases where students feel like what happened to them was wrong, however, they often second guess themselves. Part of this seemed to stem from misconceptions surrounding campus-related SA perpetration and victimization and common rape myths perpetuated by the mainstream media. For example, one student stated that movies often portray SA in a way that makes survivors doubt if they are a victim if they "didn't scream", do not "have bruises", or if it "wasn't in a back alley". The participant continued this thought, stating:

> We think that if we weren't screaming bloody murder and having visible bruises, and what have you, then it was just a bad night, and it's not worth bringing the legal system in.

Additionally, participants pointed out that not all students want to be seen as a victim, with one student stating, "I didn't want to be a statistic…that's not me".

Along with not wanting to be labeled a victim of SA, participants also reported that most students who are sexually assaulted do not want to tell anyone what happened, because they do not want anyone to know. Interestingly, this was not true for all crimes (or even all violent crimes), but specifically for SA victimization. For example, one participant stated that while they would feel embarrassed and uncomfortable reporting a SA, they would tell someone right away if they were "in the street and someone started beating [them] up". Further, they said:

> If someone were to come in and rob my apartment, I would not hesitate to talk about that, I would not hesitate to tell everyone around me that there is someone in our neighborhood who is robbing apartments, and immediately go to the police, and I would be very loud about it.

The student then elaborated on this, stating however, that "in many ways, sexual assault is also stealing. It is stealing choice. It is just an emotional type of stealing".

Participants stated that students particularly do not want anyone to find out about what happened to them in cases where they were assaulted by someone in their peer group, and/or if the person is a well-liked member of the ASU community. Specifically, several participants stated that many students do not want to disclose or report because they do not want to risk loosing their friends. In fact, one student stated that:

> Unfortunately, when things like this happen, we are a community, so they might feel like, fearful about reporting because they might feel like they then have to call out a person who they are friends with or live with.

The same participant then continued, reiterating what another participant had stated about campus-based rape myths, saying:

> It's terrible, but people don't always realize-they have this view that it happens like strangers jumping out of bushes wearing trench coats, and that does happen, but on college campuses it might be a person you are friends with, or in your social circle, same frat or sorority, same classes; you don't have to tell every person, but if you decide to report and they face any sort of punishment, it might be something you can't control who they tell.

Another important point of decisional conflict that the steering group members raised, was survivors not wanting the person/people who assaulted them to get into trouble, or not wanting to ruin their lives. Again, this was particularly true if they knew the person who assaulted them, or if they were friends with them. While most participants stated that they would want the person who attacked them to "have some kind of consequences", they were not exactly sure what those should be, nor did they think that it should be the same for every person and every circumstance, and they definitely were not sure that the person should be incarcerated. In fact, students expressed worry about "potentially ruining their lives" and many made excuses for, and even admitted trying to protect their rapists for a variety of reasons (e.g., "I had to interact with him for weeks"; "I don't even know if he realized what happened"; he's "a nice guy who did a harmful thing"; "I don't think the guy who sexually assaulted me knew what happened, I think he genuinely liked me and was interested in me", etc.).

Alcohol only seemed to increase these decisional conflicts surrounding reporting and disclosing. In fact, one participant stated that, "a lot of the time you were drunk, and you don't know if you can, or if it was an assault". Additionally, steering group members stated that students who are drinking at the time of a SA, might not report because, they are "scared of getting into trouble", particularly if they are underage. While alcohol was cited as a reason for survivors to blame and doubt themselves, it was also used to justify the behaviors of those who commit acts of SA at institutions of higher education. Specifically, when reflecting on their experience with SA while enrolled at ASU, one participant stated:

> I did say "no", and I was trying to get away, but we were both very drunk…there were a lot of elements going on, I genuinely don't think he did anything wrong, and him not knowing could potentially mean he does it again.

This idea that by not reporting, past victims of SA are somehow partly responsible for their attacker harming others in the future, was an important them that resurfaced multiple times during individual interviews, and only further complicated issues of decisional conflict about disclosure and reporting. This was most common among students who doubted whether or not the person who assaulted them knew that what they were doing was wrong, or if they were just "too drunk" or misinterpreted things. In fact, two of the four participants stated that if the people who assaulted them knew how what they did impacted them, they might not do it again. Additionally, one participant drew a line between good people who hurt people unintentionally (e.g., "get super wasted and not completely think about it"), and "bad people" who "are doing bad things" and will "continue to do bad things and [hurt] people".

Knowledge and expectations. Interviews with steering group members unveiled several potential gaps in knowledge that may prevent and delay disclosure to crisis, health, and victim services, and reporting to ASU and law enforcement agencies. In addition to being potential barriers along the information-seeking pathway, these knowledge gaps could also contribute to student disengagement over-time, as well as feelings of anger and frustration among students who do disclose and report. Specifically, results from individual interviews suggest potential gaps in knowledge that exist between: 1. ASU staff and other expert clinicians and professionals who work with

student survivors in the community surrounding university policies and procedures on sexual misconduct; 2. ASU staff and ASU students regarding university policies and procedures and Title IX investigations, and 3. Expert clinicians and professionals and student survivors concerning the criminal justice system, and in particular, expectations about rape kits, convictions, and overall length of time from start-to-finish.

First, findings revealed that student survivors have multiple (and sometimes time-sensitive) options for reporting/pursuing justice, and seeking care, advocacy, and support on campus that are not available to their unenrolled peers, in addition to the many pathways available to all survivors of SA in the community (see Tables 10-13). While interviews with expert clinicians and professionals who work with student survivors off campus yielded rich data that covered both the breadth and depth of reporting and disclosure options and outcomes in the community, many openly admitted that they did not have a lot of knowledge about university policies and procedures. Further, these steering group members expressed an active interest in learning more about ASU policies and procedures, in order to better help students navigate campus-related enablers and barriers to information-seeking, and help connect them to critical and appropriate resources. For example, while crisis workers with Trauma Healing Services (THS) receive and respond to all after-hours crisis calls from students who call the ASU-specific EMAPCT crisis line and disclose a SA after hours, the Program Manager stated that know very little about ASU policies and procedures.

Expert clinicians and professionals who work with student survivors off campus are not the only ones who are confused about university policies and procedures,

however. Specifically, interviews with both expert clinicians and professionals at ASU and members of the student survivor steering committee suggest that many students also lack the knowledge necessary to make informed choices about reporting and disclosing to ASU, with one student stating that, "there are so many options, you don't know which one to take". Additionally, interviews with members of the expert clinician/professional steering committee at ASU and student survivors pointed to a lack of clarity about mandated reporting policies and procedures (with one member of the student survivor steering committee not knowing anything about mandated reporting at all), despite the fact that all incoming students at ASU are required to take an online training about sexual misconduct.

In fact, that there seems to be a bit of confusion surrounding who is a mandated reporter at ASU (with these roles sometimes shifting depending on the context, e.g., for teaching assistants), and what happens if students disclose an incident of sexual misconduct to a mandated reporter. For example, the director of the Office of Student Rights and Responsibilities (OSRR) stated that there has been a problem with students disclosing incidences of sexual misconduct in papers they submit for class credit, without understanding that the teaching assistant (TA) or teacher responsible for grading their paper is required to report what they say to the school, who is then required to follow-up with the student to offer services and attempt to investigate. As a result, students who think they are disclosing an incident of sexual misconduct in a safe space, and/or may not know if they want ASU to investigate yet, could end up feeling betrayed, frustrated, and upset when contacted by ASU afterward.

When expert clinician and professional steering committee members at ASU were asked why, if students receive information on mandated reporting this knowledge gap still exists, many pointed to the theory underpinning Petty and Cacioppo's (1986) Elaboration Likelihood Model (ELM), which suggests that students will attend to and process information better when it is personally relevant. Essentially, given what we know about student misperceptions surrounding the prevalence of SA and therefore their risk of being sexually assaulted, they might not feel that information about mandated reporting is relevant to them until they or someone they know experiences a SA after their initial enrollment.

In addition to mandated reporting, several steering committee members stated that students at ASU may be unclear about the role of ASU PD. Specifically, participants stated that many students conflate ASU with ASU PD, and think that if you report to either one, you are reporting to both. This thinking is particularly problematic if students are underage and were drinking at the time of their assault, because they may believe it will make them "look bad", or worse, that they could get in legal trouble (e.g., get a Minor in Consumption or Possession). While ASU can hand out administrative sanctions against students and faculty/staff, they cannot charge anyone with a crime. The ASU Police Department, on the other hand, does have the power to bring criminal charges against people for crimes committed on ASU campus. Further, both staff at ASU and ASU PD who work with student survivors stated that they are not interested in busting survivors for drinking or using illicit or prescription drugs at the time of their assault.

While schools are not supposed to be concerned with drug and/or alcohol use, however, they could, recommend that students take a class on alcohol use.

Conversely, some students think that by reporting to ASU they are initiating a criminal and not administrative (i.e., Title IX) investigation. While ASU has the power to deliver administrative sanctions (e.g., suspension or expulsion for students and possible termination for faculty and staff) to persons affiliated with ASU, they cannot press criminal charges against or incarcerate anyone. As a fully functioning police force, ASU PD on the other hand does have the power to potentially arrest and incarcerate suspects, regardless of whether or not they are affiliated with ASU, as long as the crime occurred on ASU property. Despite this, steering committee members expressed that many students think of ASU PD as campus security, with one participant stating, "I do know that a lot of students do think that ASU police officers are not real police officers".

Lastly, members of the steering committees discussed how sometimes students who report to ASU or local police end up feeling frustrated, angry, and or let down for two main reasons. First, due to a lack of knowledge regarding university policies and procedures, many students have false or unrealistic expectations going into an investigation about timeframes, possible outcomes, and probabilities of achieving desired outcomes. For example, many students are unaware that it takes an average of 30 days for a school to investigate a Title IX case with another student (with investigations involving faculty members typically taking longer), and 2-4 + years to reach a conviction in a court of law-if the case ever goes to trial (which in and of itself, can take a year to determine).

Additionally, while schools are more likely to find respondents responsible

compared to the criminal justice system because the burden of proof is lower (i.e., it is easier to get an academic sanction than a guilty verdict), respondents have the right to appeal the decision, which could drag the case out longer, and result in the school's decision being overturned. Further, many students believe that rape kits can *prove* rape occurred and expect to get immediate results, when in reality they can only prove that a sex act took place (not whether or not it is consensual), and it can take months to get the results back (if the kit is even tested, which many are not), which does not include the time it takes to compare them to the DNA of a known suspect or someone in CODIS (if there even is one).

Lastly, due to the fact that Title IX investigators and detectives have to stay neutral during an investigation, sometimes student survivors feel like they are not on their side, or worse, that the system actually favors the respondent/perpetrator. While several steering committee members at ASU said they believe the reporter more often than not, and empathize with them, they have to maintain neutral and cannot express that they are "on their side". Steering committee members stated that this stance of neutrality can result in the reporter or victim feeling blamed by, and frustrated or angry with investigators and detectives. Not only do students sometimes feel like the school or the detectives are not on their side, sometimes they feel like they are on the side of the respondent or perpetrator. Specifically, because public schools have due process just like criminal justice systems, the reporters and suspects have rights afforded to them, and are considered innocent until proven guilty or responsible (beyond a reasonable doubt in a court of law or beyond a preponderance of guilt in schools). As a result, victims/survivors

may feel like the respondents/suspects have more rights than they do, which can feel unfair.

Additionally, each time a student at ASU feels let down by the school or law enforcement, it can serve as yet another barrier that can potentially delay and prevent disclosure and reporting by other students. Specifically, because we know that students tend to turn to their peers when they experience SA, hearing stories about the negative experiences of other students could deter them from disclosing or reporting themselves. For example, when one participant on the student survivor steering committee was asked about barriers to reporting and disclosing, they stated that you hear, "so many stories…you hear someone reported and nothing happened, so why should you?".

Values. Interviews with steering group members showed that not all students who experience SA share the same values and preferences surrounding care and justice. While members of the student survivor steering committee had different ways of conceptualizing what justice means to them, they all agreed that it is a subjective and fluid term that varies according to each person and situation. One student summed this up by stating, "you can't make one policy for everyone". Another student said, "my answer for me would be a lot different than it would be for anyone else" and went on to explain that when they were assaulted they just wanted to "forget about it", but when their friend was sexually assaulted they wanted that person to be incarcerated and labeled a sex offender. When this participant was asked why their perception of justice was different for them and for their friend, the participant said their friend's attacker was "a lot older"

and it happened before college in High School, and "saw him doing it to someone else again, and I didn't want him in the world-not dead-just not out in society".

Specifically, perceptions of justice ranged from restorative to punitive. Specifically, participants mentioned things like wanting respondents/perpetrators to: attend "court-mandated therapy" in an inpatient or outpatient setting depending on the case (with inpatient being an alternative to jail); apologize and/or admit to what they did to the survivor in-person (i.e., allocute in open court) or in a letter; know how what they did affected the survivor by having to listen to the survivor's victim impact statement, and be incarcerated and/or be labeled a sex offender. Additionally, participants stated that justice for some survivors may mean just being able to feel safe again (e.g., "I think that justice means what the survivor needs in order to feel safe, or to feel like they can kind of work through this safely"), or being left alone and not having the respondent/perpetrator contact them ever again. Specifically, one participant stated:

> I wanted him to know that he had done something wrong, and that he shouldn't be around me, but I also didn't want to tell him that…him being able to read my mind and stay away from me would have been my idea of justice.

Regardless of how students want to try to pursue justice, every member of the student survivor steering committee, and almost all members of the expert clinician and professional steering committees expressed that students should feel supported in deciding for themselves how they want to try to get justice, if at all. In fact, one student stated, survivors should be:

> Fully supported if justice means they have no repercussions, they don't ever have to see them again, or they have the space to go to counseling. I think it is very important that we don't impose what we think justice is on anyone else. I think it's important that survivors that don't want to report to police or on campus are still supported.

In addition to diverse perceptions and values surrounding criminal justice, steering committee members also had different views on mental and physical health care. For example, while some students stated that they were "primarily concerned with STDs and pregnancy" other students stated that they were more concerned about their mental health status. That being said, while not every student received physical care right away, every single student mentioned the value of talking to a counselor (whether on or off campus) or peer advocate, even if they "don't want to tell anyone how they feel" and it is "hard to reach out to a stranger".

Support and resources. Interviews with steering committee members demonstrated not only that students at ASU who are sexually assaulted have multiple places to go to receive care, support, and advocacy on and off campus, but that for the most part, they seemed to have positive things to say about these student support services (e.g., "on-campus there are a lot of really great resources"). In fact, students had good overall knowledge of existing campus-based resources. Specifically: all four students mentioned ASU Health Services and ASU Counseling Services as places to receive care, advocacy, support, and/or resources; one student mentioned the Counselor Training Center (CTC) as somewhere to receive counseling services that are more affordable than

at ASU Counseling Services; three of the four students mentioned the Sun Devil Support Network as somewhere to receive peer support; two students mentioned the ASU-specific EMPACT crisis line; one student brought up going to your community advisor (CA) but cautioned that "you have to be careful of what you disclose" because they are mandated reporters, and lastly, one student mentioned the ASU PD victim advocate by name.

First, students named ASU Health Services as somewhere that is "close and you could walk in, and they'll work with students". With regard to specific services provided, one participant stated:

> I believe that-this could be wrong-but I feel like I learned there are specific health-related services at the health center that relate specifically to SA and doing tests to make sure that everything is okay.

Additionally, participants mentioned that ASU Health Services can provide testing for sexually transmitted diseases and infections, testing for pregnancy and prevention of unintended pregnancy "if that applies to you", and treatment for potential injuries.

While none of the participants had any negative firsthand experiences with ASU Health services, they did express some concerns about recommending this resource to every student survivor. First, one student stated that ASU Health services might be "a little limited with what they can do" and therefore could be more appropriate for students with "minor cuts and abrasions" or students in need of "regular medical attention" versus emergency medicine. Additionally, one student stated that some people:

> May have a bad view of it, because they might think that even though [they] have extensive health services, there is an attitude that the doctors aren't good or well

trained, or resources aren't as expansive if you went to your own PCP or somewhere else.

This participant followed up by stating that they did not want to imply whether or not these beliefs were "correct or incorrect", because, "people may have those views based on bad experiences" yet cautioned that "how good you think a doctor is, is a bit subjective".

Students also mentioned fear of running into people they know on campus (e.g., "running into someone from class") that they stated would be less likely if they went somewhere to address their health concerns off campus (e.g., at Planned Parenthood). Lastly, one student stated that Planned Parenthood might be a better place for LGBTQAI+ (and in particular, trans) students who are sexually assaulted to turn to, because, "not that ASU Health Services isn't inclusive" but "I think Planned Parenthood has built a reputation for really valuing inclusivity" and "I know [trans people] face barriers because doctors don't always understand it or can't always meet their needs".

While students expressed some reticence to recommending ASU Health Services for all survivors, they also described having mostly "positive experiences" with their staff who they stated are "really supportive people". Further, one student stated that if students disclose to ASU Health Services, the staff "will hopefully be very supportive and it will be kind of like, an empowering experience, and hopefully they can answer questions about resources on campus". While all four members of the student survivor steering committee knew that ASU Health Services takes insurance, none of the students were aware that SA-related care is free if students disclose.

Next, all four members of the student survivor steering committee identified ASU Counseling Services as somewhere to get confidential support on campus. Aside from stating that some students "might not want to tell anyone how they feel", one student stated that the cost of seeing a counselor at ASU Counseling Services (at $15/session) added up and was too much for them, and that while "you can apply to [have the cost] subsidized…I could never figure out how to do that" (although ASU Counseling Services said they would help students with this and would never turn students away if they could not pay). Again, students mentioned some hesitations about being seen at ASU Counseling Services by members of their peer group, but also stated that they realized if the person was there, they were probably getting help for something too, and would not necessarily know what they were there for.

Lastly, all three of the four participants stated that students can get support from members of the Sun Devil Support Network (SDSN). Members of the SDSN were described as "fellow students who help you" that are "really knowledgeable" and do not "feel quite so clinical". While members of the SDSN are not professionals, they have been trained on issues such as consent and student support services, as well as how to show up for and support survivors (e.g., "not a professional or a counselor, but someone to believe you and support you"). In addition to members of the SDSN being mandated reporters (although they do not have to report names or specifics, but only report to their supervisor), participants mentioned that it can "be hard to be a voice" and initiate communication with "a stranger" online, as the only way to talk to a peer advocate is by reaching out to someone from a list published on the SDSN website. Further, one

participant mentioned that the list is not always current, and sometimes a member of the SDSN has graduated, and therefore may or may not respond to you or be able to help (this has not been verified).

While members of the student survivor steering committee seemed to know a lot about resources on campus, they were less knowledgeable about where to go to get care, advocacy, and support off campus. Specifically, when asked where to get physical health care off campus, one participant responded with "I do not know of any resources off-campus"; two participants mentioned going to the hospital, and two students mentioned Planned Parenthood. Of the students that mentioned Planned Parenthood, one stated that it was "somewhere to be trusted and refer people to" and the other student stated that it had a "pretty good reputation" and was "known for inclusivity". None of the participants were able to name a place to go to get counseling or mental health services off campus, although two did mention EMPACT's ASU-specific crisis line and the Rape Assault Incest National Network (RAINN) hotlines (although many of them were not sure of what they were called and none knew the numbers but said they would "Google it" to find out). Further, none of the participants could say off the top of their heads where to go to get victim or legal advocacy services in the community.

Decision: type, timing, state, and learning. Steering committee members revealed that students who are sexually assaulted while enrolled at ASU engage in decision making surrounding the following themes: 1. Reestablishing Safety; 2. Care Seeking; 3. Reporting/Pursuing Justice, and 4. Receiving Advocacy, Support, and

Validation. Of these four decisional themes, three (reestablishing safety, care seeking, and reporting/pursuing justice) include decisions that are time-sensitive.

First, three of the four students interviewed stated that survivors need to determine if they are in a safe space/environment (e.g., do they live in the same dorm as the person/people who assaulted them? Are they still in physical danger? Are they at-risk of re-victimization? Etc.). Specifically, steering group members clarified that safety in this sense is "that they [feel] safe, not only in their personal mental health, in their environment" too. In fact, one steering group member argued that what they called "environmental safety" should be the first concern, due to the fact that nothing else can be done if someone still feels fearful or is in immediate danger.

Next, all four steering group members agreed that students have specific decisional support needs surrounding care-seeking. When looking at decisional needs surrounding physical health specifically, all four members of the student steering committee stated that this should be a primary concern, regardless of when the assault took place. Specifically, students mentioned primary, secondary, and tertiary physical health care needs, including: receiving immediate medical attention (e.g., "like any type of tearing or physical issues"); obtaining a rape kit; being checked out [by a physician] for "minor cuts and abrasions", and screening and testing for sexually transmitted diseases/infections and pregnancy (which were described as "a huge one" with regard to decisional needs for survivors).

Additionally, students mentioned the importance of addressing mental health issues, including "suicidal ideology or things like that". Further, students mentioned the

need for individuals to determine "the extent to which they are able to be alone without necessarily being in danger", "how they are dealing with it" (referring to the SA), and how "mentally okay" or "mentally stable" they are. All four students mentioned the importance of getting counseling after experiencing an incident of SA, with one student stressing the importance of having "a support system for their emotions, fear, and trauma, to ensure they [have] a person they [can] confide in and talk to".

Steering group members also mentioned decisional support needs surrounding where students can to go to seek out care for mental and physical health issues on campus and in the community. Specifically, participants mentioned the following factors that students need to consider in order to connect with critical and appropriate resources: 1. Whether they want to see or talk to someone on or off campus; 2. What services each resource can provide (e.g., rape kits, screening for STDs/STIs, etc.), 3. Cost of services, and 4. Reputation of service providers with regard to inclusivity and to what degree they are trauma-informed.

Next, participants stated that students who are sexually assaulted while enrolled at ASU also have decisional needs surrounding whether they want to report what they experienced to the school and/or police, as well as how they want to report or disclose, which depend on: 1. Whether or not they perceive what happened to them to be an act of SA and/or a violation of ASU codes of conduct; 2. Relationship to/feelings about the person/people who attacked them (including perceptions about whether or not the person intended to harm them or not); 3. Personal values and perceptions surrounding different

options for reporting and pursuing justice, and 4. Knowledge of options, processes (including timeframes and tradeoffs), and potential outcomes.

Lastly, participants stated that ASU students who are sexually assaulted have decisional needs surrounding receiving administrative, victim, and legal advocacy; crisis and peer support, and validation from formal and informal resources. In addition to knowing what resources are available (as well as what services they can provide), participants stressed the importance of survivors knowing which resources are confidential, and which are not (i.e., which resources are mandated reporters at ASU). For example, one participant stated that while "going to your CA, or housing in general, peer mentors, well devils…are all very supportive people in my experience" they are also "mandated reporters, so you have to be careful what you disclose".

When considering timeframes and cut-offs, individual interviews with expert clinicians and professionals at ASU and in the community revealed that while students can receive advocacy, care, and/or support any time after they are sexually assaulted, and there is no statute of limitations on when they can report an incident of sexual misconduct to ASU, or an incident of SA to the police, some options are in fact, time-sensitive. First, with regard to physical health care, students only have three days to start antiretroviral therapies (ARTs) if it is determined that they were exposed to and are at-risk of contracting HIV/AIDS. Additionally, students only have 120 hours (or five days) to take emergency contraception to prevent unwanted pregnancy, and/or get a forensic nurse examination (FNE) to collect any potential DNA and trace evidence (although students

can get a strangulation exam to document injuries such as petichiae, ligature marks, and bruising after this 120-hour mark).

That being said, with regard to both Plan B and FNEs, the rule is the sooner the better, as Plan B does not terminate existing pregnancies (although it may prevent fertilized eggs from attaching to the womb), but primarily prevents fertilization of unfertilized eggs, and DNA trace evidence erodes on the body every time a survivor takes a sip of water, eats something, or showers. This is not, however, necessarily true for strangulation exams, because bruises are sometimes more visible (and therefore show up better in photographs) several days after the injury occurs. Additionally, DNA and trace evidence that may be at the scene of the crime (e.g., in the survivor's dorm room) also erodes with time, and therefore, the sooner detectives and the crime scene unit arrive on-scene the better.

Lastly, while there is no specific cut-off for screening and treatment of other mental and physical health concerns, again, the general rule is: the sooner survivors can see someone, the better. Specifically, although they may never develop symptoms, survivors may contract a sexually transmitted infection or disease that could lead to chronic health problems later in life, such as cancer or infertility. Additionally, survivors who develop acute stress disorder are at risk for posttraumatic stress disorder later if symptoms are untreated, and those with a history of mental health issues and/or prior victimizations are particularly at risk for trauma to have additive or interactive effects that could be lifelong.

While most members of the student survivor steering committee knew that there were cut-offs for certain decisions, most did not know what these were off the top of their heads. Specifically, while most participants knew the timeframe for taking emergency contraception, none knew the specific cut-offs for starting ARTs or obtaining an FNE. In fact, when asked about FNEs, students stated things like "I know there is a cut-off, I do not know if there is necessarily a cut-off to request it, but I know there is some type of cut-off"; "I remember it being pretty early, so after a couple of days maybe"; it [has] to be done quite immediately", and "I've always heard that it is as soon as possible".

Prototype Efficacy

Thirteen members of the expert clinician/professional steering group and three members of the student survivor steering group were sent anonymized links to take an electronic QUAL-quant survey in Qualtrics to assess the efficacy of the tool with regard to acceptability, comprehensibility, and usability. The response rate for the survey was 100% among student survivors on the steering committee, and 69% among expert clinicians/professionals, which led to a total of thirteen surveys included in the following analysis, three from student survivors, and nine from expert clinicians/professionals.

Acceptability. Direct feedback from the steering committee during alpha testing confirmed the hypothesis that the intervention would be well-received by the steering committee and meets the needs of the target population. In fact, 80% of respondents were "extremely" satisfied with the decision aid overall, and 90% stated that the prototype meets the needs of the target population either "extremely well" or "very well".

Specifically, steering group members expressed that they appreciated: 1. The tool's design (described as modern and comforting); 2. How thorough and intuitive the tool is; 3. The use of student/survivor-centered language which "felt like a conversation"; 4. The tool's clarity and ease of use; and 5. The delivery of the tool as a mobile-friendly website (although a few suggested it should also be offered as a Smartphone App). Lastly, several steering committee members commented that they liked the mindfulness activities that were weaved in throughout the tool, to help users breathe and feel grounded. While mostly only minor edits were suggested (e.g., the last action plans page was too long and required scrolling), some valid concerns were raised (e.g., about the length of the tool and whether or not the tool might be too overwhelming for students to use without a support person present) that will be either addressed in future redraft and redesign phases to improve the tool and make it stronger, or answered during beta testing phases with advocates and first responders.

First, every participant except one stated that they were either "extremely" (80%) or "moderately" (10%) satisfied with the decision aid overall, with only one stating that they were "moderately dissatisfied". Next, every participant except one stated that they thought the decision aid meets the needs of the target population either "extremely well" (60%) or "very well" (30%), with only one stating that it only meets the needs of the target population "moderately well". When asked about what they liked about the decision aid overall, participants cited various factors, including the tool's: 1. Thoroughness and intuitiveness; 2. Language; 3. Clarity and ease of use; 4. Confidentiality, and 5. Mindfulness activities. Specifically, with regard to thoroughness,

one participant stated that the tool "seemed to anticipate and answer questions that a person dealing with that type of trauma would be thinking about". Additionally, another said that, while "we will never meet the needs of every victim with one option…this gives a multitude of options that is adaptable and seems expandable". Further, another stated that "it's purposefully compartmental" and "thorough", and lastly, that it includes "many options for students to choose from on what avenue to take".

Next, with regard to language, participants stated they liked the use of "student-centered language" that "validated the victim's decisions" and "felt like a conversation". Participants also stated that they liked the clarity and ease of use of the tool, with one stating that the tool is "simple, clear, [and] easy-to-use", and another said "the instructions are very clear and the routing from section to section was very intuitive". Further, one participant stated that they like how it is "a confidential tool that is easy for students to use and navigate". Lastly, two participants stated that they liked the mindfulness activities, with one stating, "I loved the breathing exercise!".

Conversely, when participants were asked what they did not like about the decision aid, only two stated that they did not have any critiques to offer, with one stating "I can't think of anything", and the other stating that they only experienced a few bugs with the back button which was most likely restricted to the prototype software and not reflective of the actual tool itself. Those that did have criticisms expressed concerns about: 1. Language and order of options for reporting to the police; 2. Concerns about students becoming overwhelmed or being able to use the tool alone, and 3. Length and number of questions asked.

First, with regard to the language about reporting to police, one participant raised concerns stating that it should say "police *may* investigate" instead of "police *will* investigate" to avoid setting unrealistic expectations. Also on the topic of reporting to police, another participant stated that they felt like "the options to report the sex assault to the police were last and gave the appearance of the police not being safe". In fact, the same participant also stated that "the police are absolutely safe and it furthers a narrative the victims have something to be afraid of in reporting it to the people entrusted to bring the suspect to justice". This participant also raised concerns about routing victims to social services first instead of going directly to the police, stating that this may delay reporting to police and result in a loss of critical evidence (e.g., "exam, surveillance video, interview witnesses, process the crime scene, etc.).

Additionally, two participants expressed concern about students who have recently experienced a trauma using or being able to complete the tool, particularly if they are using the tool alone. Specifically, one participant stated that they were "unsure students would use the tool" and that it "may be overwhelming for someone who has experienced trauma". Further, another participant stated they were not sure if "people who are in a fragile state" would be able to focus long enough to answer all of the questions. Concerning the length of the tool, one participant stated that they "wondered if it would be too long for a victim to complete on their own" although they stated they did not "think this would be a problem if they had a support person with them". Another participant also commented on the length, stating that "there are a lot of options to go through" and expressed worry that "students might lose interest after a few questions" but

did not suggest removing any because “it is understandable that all the questions are needed to do a thorough job”. Lastly, one participant stated that the action plans menu page at the end is “a bit long to scroll through”.

When participants were asked how they feel about the tool’s design, they had overwhelmingly positive things to say. In fact, the tool’s design was described as “modern”, “comforting”, and “well-designed”. In addition to liking the tool’s overall design (e.g., “the design was great”; “the design was really good”; “I like the tools design”; “looks good”, and “wonderful”), multiple participants specifically expressed liking the color scheme, which was described as “calming” and “not overwhelming”. Additionally, participants stated that the minimalist design made the tool “clean, warm, simple” and the messaging “clear and easy to follow” (e.g., “I really liked the language used and that there were minimal words describing each option”).

Again, when asked about how they felt about the tool’s formatting, participants had only positive things to say (e.g., “no negative feedback about format”) and liked the format overall, stating that it was “great” and “the system worked smoothly”. Specifically, participants liked the fact that it was “very thorough”, stating that there were not only the “right amount of questions”, but that the questions asked were also “simple and clear”. Additionally, participants stated that the tool was “easy to follow” and “made sense” (e.g., “the format was simple and followed a path of questioning that made sense”).

Concerning the tool’s delivery as a mobile-friendly website as opposed to a regular website or smartphone App, participants stated that for the most part they agreed

with the choice of delivery. For example, several participants felt strongly that the use of a mobile-friendly website to deliver the tool was the "perfect choice", stating that "it is a good idea" because it makes it "accessible to more people". Further, participants stated that while they "prefer it to an App, which…many survivors would not want to download on their phone" and, that it is "really the only one that makes sense given the population and scenario". Participants also said that the tool delivery "works", is "simple and easy" and that "there is no need to use an App". Lastly, one participant stated that "it would be valuable either way" (meaning as an App or a mobile-friendly website) and another stated that it should be "a mobile friendly website with an App also available".

Lastly, when participants were asked how the tool could be improved be received better or used more they had mixed things to say. First, two participants stated that they have "no current suggestions in that regard" and "think the tool is great" and "don't think there is anything that can be changed in order to have it used more". Others, however, had suggestions for small edits that could make the tool be received better or used more, such as limiting the list at the end and having the option to save your progress as you go if the user feels comfortable doing so. Lastly, one participant stated that they still had concerns about if the tool was "too long for a victim to go through" but then stated that "they could always come back to it".

Comprehensibility. Results from the survey questions on comprehensibility confirmed the hypothesis that steering committee members would find the information included in the intervention to be easy to understand, however, there is room for improvement. Specifically, results from the survey questions on comprehensibility show

that for the most part, members of the student survivor and expert clinician/professional steering committees find the tool clear, comprehensive, and concise. Additionally, with regard to how information was presented, 100% of participants stated that the decision aid included more short pages that require users to navigate to other pages than long pages with complex content, and the majority (85%) of participants stated that they either "never" or only "sometimes" had to scroll down to access more information. Additionally, steering committee members stated that the prototype provides good descriptions without being too wordy. Potential areas for improvement include: 1. Replacing a few terms and phrases (e.g., "getting justice") that are subjective or require users to interpret meaning; 2. Adding more visual aids (e.g., pop-ups) to facilitate navigation, and 3. Making sure the tool's vernacular and vocabulary better match that of the target population.

First, when asked how the concepts in the decision aid were described with regard to wording, participants stated that wording was "good", "appears to flow well", and that the tool used minimal wording that was "appropriate", "encouraging" and "calming". Additionally, participants stated that while the tool used minimal wording and was "no too wordy", it was "clear", "just detailed enough" and used "good descriptions" (e.g., "the wording was simple which was relaxing but not overly minimal to the point where I didn't know what I was answering"). Participants did, however, raise concerns about the use of certain terms which they suggested changing or replacing. Specifically, several participants stated that they struggled with how the term "justice" was used. As one participant stated, "justice can look very different for victims so individually they might

be expecting a very different outcome to feel like "justice" was accomplished"; another suggested "a possible change to the terminology of "seeking justice" to something less threatening". Additionally, one participant suggested changing the phrase "tech safety" to "online safety" or just "safety".

Next, participants were asked whether or not the concepts in the decision aid were conveyed in ways that required users to interpret meaning. This section yielded mixed results among both student survivor and expert clinician/professional steering committee members. While two of the three student survivors who took the survey stated that they did have to interpret meaning, one of these stated that everything was straight forward except one phrase ("regarding the incident that brought you here"), which they stated is "an okay way to describe what happened", however did not provide a suggestion for what to replace it with. The third student on the other hand, reported that they "did not notice anything" that was confusing and stated, "this is going to be an amazing tool for so many people!".

Among the expert clinician/professional members of the steering committee, almost half (46%) of participants stated that they did not have to interpret meaning (e.g., "good-no explanations, very clear directions"), with one stating that while students "have to ultimately think about the ideas given…they have been previously explained". It should be noted, however, that one of the participants who said they did not have to interpret meaning warned that perhaps this was only because of their "lens of working with this population". Those who stated that the tool does require students to interpret

meaning only mentioned two terms specifically that could be problematic: the terms "justice" and "ASU affiliation".

Specifically, two participants expressed concerns about justice because it "is the only word that can mean different things to different people", and again suggested replacing the phrase "getting justice" with "pursuing justice". That being said, one participant who struggled with the use of the term justice stated that they do "think that the tool continues on and identifies what justice might look like". Additionally, one participant mentioned that students may not understand what it means when the tool asks it the person/people who assaulted them are affiliated with ASU, and specifically, might think "this means someone in authority at ASU, not necessarily a student". Lastly, the same participant who stated that they thought the tool prioritized social services over the preservation of forensic evidence earlier, gave the same feedback in this section, however, it will not be discussed in this section because it does not pertain to the question of comprehensibility and knowledge interpretation or translation.

Third, participants were asked about how often they had to scroll down to access more information when navigating a page. Every participant except two (85%) stated that they either "never" (15%) or only "sometimes" (69%) had to scroll down to access more information, with one participant stating that they had to "about half the time" and one saying they did "most of the time". Additionally, 100% of participants stated that there were more short pages that require users to navigate to other pages than long pages with complex content. When asked about the use of memory aids (e.g., pop-ups) to facilitate navigation, however, only three participants stated that memory aids (e.g., pop-up menus)

were used to facilitate navigation, providing an important space for potential improvement.

Lastly, the participants were asked about the comprehensibility and appropriateness of the written content and language of the tool. Specifically, when asked how much need there was to infer meaning or think abstractly in order to understand the written content presented in the decision aid, 100% of the participants stated either "none at all" (46%) or only "a little" (54%). Additionally, when asked to what degree the words used in the decision aid employed the target group's vernacular and vocabulary, 100% of students and 62% of expert clinicians and professionals said it did "a lot", with another 23% of professionals saying that it did "a great deal". In fact, only two participants stated that it only used the target group's vernacular "a moderate amount" or just "a little".

Usability. Results from survey questions regarding the usability of the tool confirmed the hypothesis that the steering committee would use the tool in "real-life" settings. In fact, the majority (84%) of steering committee members were either very likely or extremely likely to use the tool (with 100% of student survivors on the steering committee very likely to use the tool). Additionally, 100% of the participants reported that the tool was either extremely or moderately easy to navigate (again, with 100% of student survivors on the steering committee saying it was extremely easy to navigate), and just under 60% stated that there was nothing they found confusing or difficult. Participants stated several factors that make the tool easy to use and navigate, including: the way the tool guides users through questions, use of minimal wording and student-centered language, and the provision of resources and action plans at the end. In addition

to the target population, participants identified a range of individuals, communities, and agencies/organizations that could benefit from using the tool, including but not excluded to: ASU staff; community members; counselors; first responders; friends and family of student survivors; partners of student survivors; police; peer leaders, and victim and legal advocates.

Steering committee members also stated that in addition to postsecondary learning communities, they could see potential for the tool to be adapted for use with high school students, the military, and any young adults who are comfortable with technology. Further, participants stated that the tool could be used on campus, in the community, and online in the following capacities: 1. A resource to help firsthand and secondhand student survivors of SA evaluate all of their options either alone or in a mental health setting; 2. An education tool to help faculty and students become familiar with reporting options and resources; 3. A publishable link on agency/department websites, and 4. A tool to help student survivors reestablish physical and mental safety.

First, 84% of participants stated they were either "extremely likely" (38%) or "very likely" (46%) to use the tool, with 100% of members of the student survivor steering committee surveyed stating they were "very likely" to use it. In fact, only two participants stated that they were "somewhat likely to use the tool", and none stated that they were "not very likely" or "not at all likely" to use it. Next, participants were asked how easy the tool was to use or navigate. Here, 100% of participants stated that it was either "extremely easy" (77%) or "moderately easy" (23%) to navigate, with 100% of

members of the student survivor steering committee specifically stating that it was "extremely easy" to navigate.

When asked what features participants think make the tool easy to navigate, steering group members listed a range of attributes, including: 1. The way the tool guides users through the questions; 2. Clean screens and large buttons; 3. The use of student-centered language, and 4. The provision of comprehensive and individualized action plans and resource lists. Specifically, several participants stated that the decision aid "guides users through each section" using questions that are "easy to understand and follow" and "simple enough to make a decision and move forward". Additionally, participants cited features that made navigation particularly easy, such as "large buttons", back buttons, and menu buttons. Further, participants stated that they liked the clean screens that used "minimal" and "student-centered wording", and only present a few options at a time to keep things "simple", "clear", and "easy to navigate" and "follow". Lastly, participants stated that they liked that the tool provides users with "lots of resources" and that "at the end an action plan is created for you".

When asked if there was anything confusing or difficult, more than half (58%) of participants said no. Additionally, most comments in this section were specific to bugs in the prototype software (e.g., issues with the back button). In fact, for the most part, participants stated that "the tool was extremely self-explanatory and useful". That being said, a few participants offered some small suggestions increasing the clarity of the tool, such as: 1. Defining what an advocate is on the first page; 2. Changing the phrasing about reporting to law enforcement from "will investigate" to "may investigate" to avoid giving

survivors false expectations surrounding justice, and 3. Possibly rewording the emergency page because it might be confusing for users.

Next, participants were asked who they think this tool could be useful for. Specifically, participants stated that the tool would be useful for college students who are sexually assaulted, as well as experts and professionals who work with student survivors, including: advocates; ASU staff; community members; counselors; first responders; friends and family of student survivors; partners of student survivors; police, and peer leaders. While participants stated that the tool would be useful for "any sexual violence survivor", several stated it would be particularly useful for those students who are: confused; looking for options or ways to proceed; "faced with an influx of emotions"; need resources; unaware of options for reporting and receiving support; young and comfortable with technology; have not yet made decisions about reporting, and do not want to or are not willing to talk to anyone about what happened to them. In addition to the target population, steering committee members stated that they could see potential for the tool to be tailored for use with high school students, the military, and young adults who are comfortable with technology in the general public. Further, it was also suggested that the tool be adapted for use by Spanish-speakers.

Specifically, one steering group member who works with student survivors stated, "this option will give [student survivors] the power and control to develop the idea themselves and move forward as they see fit". Further, another steering committee member stated that they "definitely think this could be a useful tool for the college population. The majority of students use Apps and are constantly on their phones, so this

provides easy accessibility to resources and options". Lastly, a member of the student survivor steering group said, "I think many people could benefit from this tool. Not only individuals who had experienced a SA, but also friends and family members of survivor. This tool provides copious information that can help anyone whether they need immediate help or are simply seeking advice".

In addition to who the tool could be useful for, participants were also asked in what contexts they felt the tool would be useful in. While steering committee members discussed the potential for use among college students who have been sexually assaulted, several participants brought up potential for use in other contexts (e.g., "I think this tool could be adapted for almost any context, although right now it is clearly best tailored to students"). Specifically, within the context of campus-related SA, participants stated that it could be useful as: 1. A resource to help firsthand and secondhand student survivors of SA evaluate all of their options either alone or in a mental health setting; 2. An education tool to help faculty and students become familiar with reporting options and resources; 3. A publishable link on agency/department websites, and 4. A tool to help student survivors reestablish physical and mental safety. Specifically, participants stated that the tool could be particularly useful for firsthand and secondhand survivors who are: "unsure of where to start"; "ambivalent about whether they want to take action", and who want to become more informed about reporting procedures and want to know more about options before making any decisions.

Lastly, steering committee members were asked for feedback on how to improve the tool's usability and ease of use. When asked if there was anything participants would

change that would make the tool easier to use, 61% of participants said no, with one participant stating that, “this tool is very easy to use as is”. Additionally, only a few suggestions and edits were provided, all of which were incredibly insightful and easy to fix/incorporate, including: 1. Defining the terms “victim advocate” and “confidential resource”; 2. Changing the RAINN hotline button to “National Hotline”; 3. Somehow breaking up the last action plan screen into smaller chunks; 4. Adding a phrase like “almost done” towards the end in case students start to get overwhelmed by the amount of questions, and 5. Giving students the option to skip the justice section.

On the topic of what could be changed to make participants more likely to use the tool, 38% of steering committee members stated that they would not change anything, with one stating that they are “willing to refer all community members who seek assistance from DOC”. Additionally, another 38% repeated or referenced what they had written in previous sections (e.g., “see other comments”) or suggested only minor edits, such as: writing “if you identify as female” before talking about well woman exams/pregnancy tests to make the language even less gendered); adding a mission statement or description of the tool at the beginning, and adding more links to web addresses for people who are more likely to make appointments online. Additionally, one member of the student steering committee stated that they would be more likely to use it if a friend suggested it to them, or if it was something someone a ASU Health Services or ASU Counseling would go through it with them.

CHAPTER SIX

DISCUSSION

Overall, the current study showed that students who are sexually assaulted while enrolled at colleges and universities in the United States have multiple options for reporting and seeking care, advocacy, and support both on and off campus. Additionally, in-depth interviews with steering committee members unveiled unique decisional needs student survivors encounter as they move along an information-seeking pathway and try to make sense and meaning of what happened to them. Specifically, with numerous options, no best choice or single course of action to take, and various barriers that prevent and delay disclosure and reporting, many students struggle to make the complex, preference-sensitive choices necessary to connect with campus and community resources.

Findings from the individual interviews with steering committee members were used to inform the design and development of the prototypes, which were completed in the spring of 2018. Preliminary alpha testing of the tool confirmed all three hypotheses about accessibility, comprehensibility, and usability, and showed the tool to be overall efficacious with typical users. In fact, results from the online QUAL-quant survey demonstrated that the tool was: 1. Well-received by steering group members and meets the needs of the target population; 2. Easy to understand, and 3. Usable in "real-world" settings.

Specifically, steering committee members expressed liking the tool's modern and comforting design, clear and intuitive format, and tech savvy and accessible mode of delivery. Additionally, steering committee members stated that they appreciated the use

of minimal wording and student/survivor-centered language, which felt less clinical and more like a conversation. In addition to being appropriate for use with the target population, steering committee members also felt the tool could be expanded and adapted for use with other populations with high rates of SA (e.g., high school students and military personnel) as well as in contexts beyond secondary prevention (e.g., as a training tool for ASU faculty and staff). That being said, developing and designing such a complex decision aid is an iterative process, and while some of the edits have already been applied, there is still significant room to improve the tool during the next phases of redrafting and redesign before it is developed into a fully-functioning website and is ready for beta testing.

Broader Impacts

The current tool was developed during a critical and complicated point in history for SA awareness and activism. In the wake of #MeToo (and subsequently #YoTambien, #BalanceTonPorc, etc.), a movement originally created by Tarana Burke in 2007 predating hashtags, millions of women and allies have taken to the streets (and Twitter) in an effort to push back against decades of silence surrounding this issue. Outside of the larger national dialogue surrounding SA, however, there has been another important discourse unfolding within the walls of higher education.

In fact, over the past few years, increasing attention has been paid to SA at institutions of higher education, due to several high-profile cases in the mainstream media (e.g., *The People of the State of California v. Brock Allen Turner*; former Columbia University student Emma Sulkowicz's *Carry that Weight* mattress

performance, and the Baylor University SA scandal). This new wave of attention and awareness, however, was followed by a swift blow from the new administration, which rescinded the Dear Colleague Letter (DCL), creating a climate of uncertainty and further relaxing already laissez-faire federal guidance surrounding how colleges and universities should interpret their responsibilities under Title IX. Perhaps even more damaging, however, was the message that student survivors took away from DeVos' stance on the DCL, which is that they were not believed or heard.

It is imperative, perhaps now more than ever before, that students at colleges and universities not only know that the help they need exists, but also that there are people out there who will show up for them and believe them. As a low-cost, open-access, and non-excludable resource, internet-based decision aids like this MyChoice can inform and empower students, potentially increasing not only initial engagement with first responders and other formal resources, but also reducing disengagement over-time. Additionally, because MyChoice is trauma-informed and community-based, it is specifically tailored to meet the unique needs and culture of survivors at each college and university. Further, it can be easily updated and revised in order to stay current with shifting policies and university-specific procedures.

While right now the tool is only being tested with students at Arizona State University, if shown to be effective during beta testing, there is potential for the tool to be adapted for use at other institutions of higher education within Arizona (e.g., The University of Arizona, Northern Arizona University, the Maricopa Community College District, etc.) as well as across the country. Additionally, there has been interest in using

the methods employed during this study to develop internet-based decision aids for other SA survivor populations, such as high school students and military personnel, or anyone who experiences SA in a given community.

Limitations

With regard to the current study, there are several limitations worth mentioning. First, while the study had an impressive turnout among expert clinicians and professionals within ASU and the surrounding community (with a 100% response rate from everyone who was approached), student survivors' voices may have been underrepresented due to sampling issues. While the study initially aimed to recruit 20-40 firsthand or secondhand survivors who were either enrolled at ASU or recent graduates of ASU, only four student survivors volunteered. Additionally, of those four student survivors, one dropped off after the individual interview, and did not participate in either focus group, or the online survey.

The lack of student voices in the development and design of the tool could shed light into why some of the terms were less clear or easy to understand for students on the steering committee, as opposed to the expert clinicians and professionals who work with student survivors. That being said, because survivors of SA are a vulnerable population, the study was limited in how it could reach out to or recruit student survivors. Additionally, despite the small number of survivors who participated in the study, the PI was still able to obtain rich data from the qualitative interviews that covered both the breadth and depth of experiences with SA among the target population. Further, survey

results from members of the student survivor steering committee still showed that they found the tool to be overall acceptable, comprehensible, and usable.

Next, the small size of the student steering committee also limited the diversity of student experiences captured, with regard to how intersecting factors of privilege (e.g., race/ethnicity, gender identity, sexual orientation, ability, citizenship, socioeconomic status, etc.) influence decisional needs and preferences. For example, while the student steering committee included one graduate student, and three undergraduate students, none were professional or non-degree seeking students. Additionally, while none of the students on the steering committee were asked to disclose their age, gender, sexual orientation, immigration status, socioeconomic status, or race/ethnicity (and the PI will not make assumptions about these classifications on their behalf), there was a lack of representation from students who identify as cisgender male, students of color, and/or students with disabilities. As a result, during beta testing, it will be critical to involve diverse student groups in order to ensure that the tool is culturally and linguistically appropriate for use with and effective among diverse groups of student learners.

That being said, students on the steering committee were very concerned with everything from the color schemes to the verbiage and vocabulary of the tool being gender-neutral and appropriate for diverse student learners. Further, one expert clinician/steering group member stated that they went back in and retook the tool from the perspective of a male and stated that the "language appears genderless, which is good". Additionally, a steering group member stated that they think "men may actually use [the tool] as there is so much shame in sexual violence towards men".

The study was also limited by the size restrictions placed on prototype development by the software used to develop it. Despite the fact that collectively the three prototypes demonstrated all potential pathways (including all options and action plans) available to student survivors at ASU, and walked users through every page from start-to-finish, it would have been better to have one comprehensive prototype to show users. Additionally, although the PI created a handout to help steering committee members better understand and navigate the prototypes, survey results still yielded that there was some confusion about why certain buttons that were intentionally inactive did not work (often incorrectly interpreted as "glitches" or bugs in the prototype software).

Part of this was a learning curve, however, as the PI had no previous experience in web development or design, and the web developer/designer who volunteered their time to help build the prototype had no way of knowing how complex the decision tree would be, and therefore, how many duplicate pages would need to be created. In the end, these difficulties with the prototype software resulted in a loss of critical time that could have been spent on other areas of the project, but instead were spent uploading and linking over 3,000 pages and then subsequently archiving and/or deleting over half of them. That being said, at least the PI and web developer/graphic designer were able to come up with a tangible solution to give users a feel for what the tool will look like, and demonstrate that the decision tree works.

Finally, some rich data was lost due to the fact that the PI had to evaluate the efficacy of the tool online rather than in-person during the focus groups. Specifically, because the steering committee members were all volunteering their time, and are all

extremely busy with school and/or work, it was not possible to get more than a couple committee members in the same room together for more than an hour at a time. Although important data that could have resulted from interactions between steering committee members in a didactic way was lost to the individual surveys, the PI was still able to get qualitative data on the efficacy of the tool that proved to be extremely insightful and will play a critical role in shaping the redrafting and redesign of the tool. Additionally, the current study demonstrated that quality, empirically-supported community research can be done with little-no funding, if the steering committee members are supportive of and committed to the vision of the project.

Future Directions

In following International Patient Decision Aid Standards (IPDAS) for developing decision aids, next steps for validating the tool require that it be beta (i.e., field) tested in "real-world" situations with the target population, including student survivors and expert clinicians and professionals who work with student survivors at ASU. Due to the fact that every college and university interprets their responsibilities under Title IX differently, and as such have different policies and procedures surrounding sexual misconduct, the current tool has only been shown to be efficacious with ASU students, and therefore, must be tested for effectiveness with the same target population.

Before the tool can be tested for effectiveness (which is projected to take place over the 2018-2019 Academic Year) at ASU, however, it must go through another round of redrafting and redesign, and be developed into a fully-functioning website (as opposed to a prototype). Due to the fact that the cost for coding the decision aid into a mobile-

friendly website is estimated to be at least $10,000, the PI must secure funds first in order to move forward. After beta testing at ASU is complete and shown to be effective, it is hoped that the tool can be tailored for use and tested at other institutions of higher education in Arizona and across the country.

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TABLES

Table 1

Prevalence of Sexual Violence Among Undergraduate Students in the U.S.

Type of Sexual Violence	TGQN	Female	Male	All
Nonconsensual Sexual Contact by Penetration, or Sexual Touching by Force or Incapacitation (i.e., rape and sexual battery/touching)	24%	23%	5%	26.1%
Nonconsensual Sexual Contact by Coercion	1.6%	0.4%	0.3%	<1%
Nonconsensual Sexual Contact by Absence of Affirmative Consent	14.8%	11.4%	2.4%	
Nonconsensual Sexual Contact (overall risk)	29.5%	26.1%	6.3%	16.5%
Nonconsensual Sexual Contact AND attempted forcible penetration	30.8%	27.2%	N/A	
All Four Tactics Combined (physically forced, incapacitated, coerced, and absence of affirmative consent)	39.1%	33.1%	*	21.2%
Sexual Harassment	75.2%	61.9%	*	47.7%
Stalking	12.1%	6.7%	*	4.2%
Sexual Assault and Sexual Misconduct (All Types)	60.4%	N/A	N/A	N/A

(Westat, 2015)

Table 2

Comprehensive Overview of Most Recent and Relevant Campus Surveys on Sexual Violence.

	Campus Climate Survey	**Campus Sexual Assault Study**	**NCVS**
Type of Study	Cross-sectional	Cross-sectional	Longitudinal
Institution	The Association of American Universities	U.S. Department of Justice	U.S. Department of Justice
Year	2015	2006	1995-2013
Field	Public Health	Public Health	Criminal Justice
Population Surveyed	Undergraduate, graduate, and professional students 18 years and older at 26 traditional four-year public and private IHEs in the U.S.	Undergraduate students ages 18-24 at two large public universities in the U.S.	Both non-students and Students enrolled in a college, university, trade school, or vocational school ages 18-24 in the general, non-incarcerated population.
Sample Size	150,072	5,446	Unknown
Format	Telephone Survey	Self-administered Web-based Survey	In-person and Follow-up Phone Interviews
Response Rate	16-23%	33-43%	74%-88%
Genders Measured	Female, Male, Transgender, Gender Queer, Non-gender Conforming, Questioning, and Decline to State	Male and Female Only	Primarily Female

Aim	Inform policy development and implementation	Inform targeted prevention strategies	Compare incidences of rape and sexual assault in student v. non-student populations
Major Findings	1. Not all students bear the burden of SV evenly, with risk varying by class year, gender, and type of IHE; 2. Undergraduate students, students who identify as TGQN, and/or students who identify as female have the highest rates of SV across all types and sub-types; 3. Rates of victimization are higher for undergraduate students at small private universities, and conversely for graduate/professional students at large public universities; 4. Overall, rates of reporting are relatively low, particularly for sexual touching involving physical force and incapacitation; 5. Acts of sexual harassment are reported the most; 6. Undergraduate	1. Risk is highest for undergraduate women during their freshmen and sophomore years; 2. Risk factors and perpetration characteristics vary between physically forced and incapacitated acts of SV; 3. Very few victims/survivors report; 4. Reasons for not reporting include not thinking the crime was serious enough, not knowing if what they experienced was a crime or if harm was intended, and not wanting anyone to know; 5. Very few acts of SV reported result in any disciplinary or legal action, and 6. Very few students/victims seek out and receive mental health services.	1. When more narrow legal definitions are used to measure SV, prevalence is lower among student and non-student populations; 2. Prevalence of rape is highest among college-age females (ages 18-24) compared to any other group; 3. College females were not found to be more at-risk than non-students, and 4. Students are less likely to report and receive support services for incidences of SV than non-students.

	students are more likely to be sexually harassed by peers (and in particular friends and acquaintances), while graduate/professional students are more likely to be sexually harassed by faculty or advisors; 7. The most common reason for not reporting was that students did not consider the incident important enough, even in cases of physically forced rape; 8. The most commonly victimized groups have the lowest opinions about reporting outcomes; 9. Bystander interventions are relatively low, with many students reporting they do not know how to help or get involved, and 10. >30% of students feel very or extremely knowledgeable about university SV policies and procedures, including how SV is defined by their IHE.

(Westat, 2015; Krebs et al., 2007; Breiding, Smith, Basile et al., 2014)

Table 3

Relevant Policy on Campus-related Sexual Violence (1972-Present).

Act	Year	Overview
Title IX	1972	Title IX (otherwise known as the Gender Equity Law) is a United States law that requires all federally funded colleges and universities to protect students from sex-based forms of discrimination (defined "broadly to include sexual harassment and sexual violence because of the hostile education environment they create") in order to promote and preserve education equity (Schroeder, 2016). Specifically, under Title IX, "schools are required to respond to and remedy hostile educational environments" as a condition for maintaining their federal funding, which is perhaps one of the most important and persuasive pieces of this legislation (Schroeder, 2016).
The Jean Clery Disclosure of Campus Security Policy Act (The Clery Act)	1990	The Clery Act is a federal consumer protection law that requires all schools that receive federal funding to publish and disseminate campus crime statistics, as well as information about policies, procedures, and victim rights in their Annual Security Report (ASR) (20 U.S.C. § 1092(f)(8)).
The Campus Sexual Assault Victims' Bill of Rights	1992	The Campus Sexual Assault Victims' Bill of Rights is a law that "requires that all colleges and universities (both public and private) participating in student federal aid programs afford sexual assault victims certain basic rights" (20 U.S.C. § 1092(f)(8)). Specifically, this Bill requires schools to inform students about reporting options, counseling and other student protection services; further, the Bill mandates schools to notify students about all disciplinary proceedings and outcomes in a timely manner (20 U.S.C. § 1092(f)(8)).
The Campus Crime Statistics Act	1998	Amendments made to the Clery Act to expand reporting options.
The "Dear Colleague Letter" (DCL)	2011	The DCL is a supplemental document to Title IX published by the Office for Civil Rights. The

		DCL requires schools that receive federal funding to: 1. Have a Title IX coordinator, 2. Adopt and publish procedures for filing reports and grievances with the school, 3. Provide preventive education programs and victim services, and 4. Encourage students to report incidences of SV (Office for Civil Rights, 2011).
The Campus Sexual Violence Elimination (SAVE) Act	2013	The Campus SaVE Act is a bipartisan law designed by advocates and victims/survivors in an effort to increase transparency, accountability, education, and collaboration surrounding campus-related SGBV (Carter, 2016).

Table 4

Qualifying Criteria for Decision Aids Based on The IPDASi (v4.0.)

	In Order to Qualify as a Decision Aid, the Intervention Must:
1	Describe the health condition or problem (treatment, procedure, or investigation) for which the index decision is required.
2	Explicitly state the decision that needs to be considered (index decision).
3	Describe options available for the index decision.
4	Describe the positive features (benefits or advantages) of each option.
5	Describe the negative features (harms, side effects, or disadvantages) of each option.
6	Describe what it is like to experience the consequences of the options (e.g., physical, psychological, social).

(Retrieved from Joseph-Williams et al., 2014)

Table 5

Certification Criteria for Decision Aids Based on The IPDASi (v4.0.)

	In Order to Meet Certification Criteria, Decision Aids Must:
1	Show the negative and positive features of options with equal detail (e.g., using similar fonts, sequence, presentation of statistical information).
2	Provide citations to the evidence selected.
3	Provide a production or publication date.
4	Provide information about the update policy.
5	Provide information about the levels of uncertainty around event or outcome probabilities (e.g., by giving a range or by using phrases such as "our best estimate is"…).
6	Provide information about the funding source used for development.
7	Describe what the test is designed to measure.
8	Describe the next steps typically taken (if the test detects a condition or problem).
9	Describe the next steps if the condition or problem is not detected.
10	Include information about the consequences of detecting the condition or disease that would never have caused problems if screening had not been done (lead time bias).

(Joseph-Williams et al., 2014)

Table 6

Quality Criteria for Decision Aids Based on The IPDASi (v4.0.)

	In Order to Improve Experience of Use, Decision aids Should:
1	Describe the natural course of the health condition or problem, if no action is taken (when appropriate).
2	Make it possible to compare the positive and negative features of the available options.
3	Provide information about outcome probabilities associated with the options (i.e., the likely consequences of decisions).
4	Specify the defined group (reference class) of patients for whom the outcome probabilities apply.
5	Specify the event rates for the outcome probabilities
6	Allow users to compare outcome probabilities across options using the same time period (when feasible).
7	Allow users to compare outcome probabilities across options using the same denominator (when feasible).
8	Provide more than one way of viewing the probabilities (e.g., words, numbers, and diagrams).
9	Ask patients to think about which positive and negative features of the options matter most to them (implicitly or explicitly).
10	Provide a step-by-step way to make decisions.
11	Include tools like worksheets or lists of questions to use when discussion options with a practitioner.
12	Include a needs assessment with clients or patients during the development process.
13	Include a needs assessment with health care professionals during the development process.
14	Include a review by clients/patients not involved in producing the decision support intervention during the development process.

15	Include a review by professionals not involved in producing the decision support intervention during the development process.
16	Be field tested with patients who were facing the decision.
17	Be field tested with practitioners who counsel patients who face the decision.
18	Describe how research evidence was selected or synthesized.
19	Describe the quality of research evidence used.
20	Include authors'/developers' credentials or qualifications.
21	Report readability levels (using 1 or more of the available scales).
22	Show evidence that it improves the match between the preferences of the informed patient and the option that is chosen.
23	Show evidence that it helps patients improve their knowledge about options' features.
24	Include information about the chances of having a true-positive test result.
25	Include information about the chances of having a true-negative test result.
26	Include information about chances of having a false-positive test result.
27	Include information about the chances of having a false-negative test result.
28	Describe the chances the disease is detected with and without the use of a test.

(Joseph-Williams et al., 2014)

Table 7

Measurement Instruments for Evaluating Core Constructs and Attributes of Decision Aids.

Core Construct	Attribute(s)	Measurement Instrument (and Subscales)
Quality of Decision Making Process	Recognize that a decision needs to be made	Preparation for Decision Making Scale (PDSM)
	Feel informed about the options (including associated risks, benefits, and consequences)	The "Feeling Uninformed" Subscale of the Decisional Conflict Scale (DCS)
	Be clear about what matters most to users for the decision that needs to be made	The Perceived Involvement in Care Scale (PICS)
	Be involved in decision making	The Control Preferences Scale (CPS)
Decisional Quality	Knowledge	N/A (measured by assessing factual-not perceived-knowledge of options and outcomes
	Accuracy of risk perceptions	N/A (measured by comparing perceived outcome probabilities to scientific evidence about risk)
	Congruency between informed values and care choices (values-choice agreement)	Multi-Dimensional Measure of Informed Choice

(Sepucha et al., 2013; Stacey et al., 2017; Sepucha, Thomson et al., 2012)

Table 8

Effectiveness of Known Scales on Primary Outcomes of Interest.

Construct	Scales and Sub-scales	Mean Difference (MD) or Risk Ratio (RR) (95% CI)	Number of Studies	N
Quality of Decision Making Process	Decrease decisional conflict related to feeling uninformed.	MD = -9.28/100	27	5,707
	Decrease indecision about personal values.	MD = -8.81/100	23	5,068
	Decrease the proportion of people who were passive in decision making.	RR = 0.68	16	3,180
Decisional Quality	Increase participant knowledge.	MD = 13.27/100	52	13,316
	Increase accuracy of risk perceptions.	RR = 2.10	17	5,096
	Increase congruency between informed values and care choices.	RR = 2.06	10	5,626

(Stacey et al., 2017)

Table 9

Expert Clinician/Professional Steering Committee Members.

Name	Title/Role	Organization/Affiliation	Role
Cons, Kaylen	Director of Student Advocacy & Assistance, Dean of Students (Tempe)	Arizona State University	Committee Member
Ellison, Erin	Director of the Office of Equity and Inclusion (Tempe)	Arizona State University	Committee Member
Fields, Sarah	Sergeant, Family Investigations Bureau	Phoenix PD	Committee Member
Frick, Kimberly	Program Manager, Education and Outreach	Arizona State University	Committee Member
Krasnow, Aaron	Associate Vice President of Counseling Services and Health Services	Arizona State University	Stakeholder
Hewitt, Candice	Victim Services Supervisor	Phoenix Family Advocacy Center	Committee Member
Lang, Liesl	Program Manager	Trauma Healing Services, La Frontera/EMPACT-SPC	Committee Member
Lombard, Sharon	Case Manager, Dean of Students Office, Tempe	Arizona State University	Committee Member
Menaker, Tasha	Director of Sexual Violence	Arizona Coalition to End Sexual and Domestic Violence	Committee Member

Miller, Daniel	Response Initiatives Detective with the Special Victims Unit	Arizona State University	Committee Member
Palmisano, Amy	Crisis Coordinator/Case Manager	Trauma Healing Services, La Frontera/EMPACT-SPC	Committee Member
Preudhomme, Jodi	Title IX Coordinator	Arizona State University	Committee Member
Rable, Jill	Forensic Nursing Supervisor	Honor Health	Committee Member
Spillers, Lynn	Victim Advocate with the Special Victims Unit	Arizona State University	Committee Member
Ward, Shelly	Victim Services Coordinator	Mesa Family Advocacy Center	Committee Member
Trujillo, Erin	Associate Director, ASU Counseling Services	Arizona State University	Committee Member

Table 10

Pathways for Seeking Physical Health Care On and Off Campus (Options 1-3).

Level of Care	Options	Action Plans
Tertiary	1. Go To the Hospital to Receive Immediate Medical Care	(1A) Call 9-1-1 or find the nearest hospital and check-in at the Emergency Department to receive immediate medical care for injuries or health concerns.
	2. Get a Forensic Nurse Examination	(2A.1) Call 9-1-1 or the ASU PD non-emergency line 480-965-3456. (2A.2) Call the ASU PD Victim Advocate directly at 480-965-0107. (2B.1) Call 9-1-1 or the non-emergency line for the police department in the city/town where the crime occurred. (2B.2) Call the Family Advocacy Center at 1-888-246-0303. (2C) Call Honor Health directly at 480-312-6339.
Primary	3. Get a physical exam and receive screening and treatment for non-emergent health concerns on or off campus	(3A) Walk into ASU Health Services in Tempe, or schedule an appointment by calling 480-965-3349 or logging onto your MyASU Student Health Portal. Click here for a list of all ASU Health Services locations (3B) Call Planned Parenthood at 1-800-230-PLAN or schedule an appointment here. (3C) Contact Your Primary Care Physician or OB/GYN.

Table 11

Pathways for Seeking Mental Health Care On and Off Campus (Options 4-6).

Level of Care	Options	Action Plans
Tertiary	4. Talk to someone now over the phone, online, or in-person.	(4A) Call the National Suicide Prevention Lifeline at 1-800-273-8255 or chat with a crisis specialist 24/7 by visiting https://suicidepreventionlifeline.org/chat/ (4B) Call Empact's ASU Hotline at 480-921-1006 to speak to a crisis specialist or schedule for a mobile crisis team to visit you 24/7 (4C) Call the TrevorLine if you identify as LGBTQAI+ youth and want to speak to a crisis or suicide prevention specialist (4D) Call the Rape Incest Abuse National Network (RAINN) sexual assault hotline at 1800-656-HOPE(4673) or chat with someone online 24/7 by visiting https://hotline.rainn.org/online/terms-of-service.jsp
	5. Go to the hospital to receive immediate psychiatric care	(5A) Call 9-1-1 or find the nearest hospital and check-in at the Emergency Department
Primary Care	6. Talk to a counselor on or off campus	(6A) Walk-in to any one of ASU's four counseling centers (Downtown, Polytechnic, Tempe, and West) in-person during office hours (M-F 8AM-5PM) (no appointment necessary) or schedule an appointment to see a counselor or request to talk to a counselor over the phone by calling 480-965-6146. Click here for a list of ASU Counseling hours and locations

	(6B) Call EMPACT's ASU Hotline at 480-921-1006 or the non-ASU THS Hotline at 480-736-4949 to schedule an intake to receive individual or group counseling for free off campus (6C) Call your mental health care provider to schedule an appointment with them

Table 12

Pathways for Pursuing Justice On and Off Campus (Options 7-8).

Type	Option	Action Plan
Administrative	7. Report the incident to ASU	(7A) If the person (or people) who did this to you is a student at ASU, visit or call the Dean of Student's Office on the campus where the incident occurred or where you attend during office hours to file an incident report with the Office of Student Rights and Responsibilities. You can download and fill out a PDF of the incident report ahead of time and bring it with you here. Click here for a list of Dean of Students' Offices at ASU. (7B) If the person (or people) who did this to you works for ASU, contact the Office of Equity and Inclusion to file an incident report by calling 480-965-5057 or sending an email to EquityandInclusion@exchange.asu.edu (7C) Make an anonymous report by calling the ASU Hotline at 1-877-SUN-DEVL (786-3385) (7D) Speak to someone confidentially at ASU Counseling Services, ASU Health Services, or the ASU PD Victim Advocate to find out more about your reporting options at ASU. *Note: most people who work for ASU are mandated reporters (including teachers, TAs, CAs, coaches, and administrators), meaning they are required to report incidences sexual assault to the school regardless of whether you want them to or not. The only confidential resources available to you on campus are ASU Counseling Services, ASU Health Services, and the*

		ASU PD Victim Advocate. This means that anything you say to them about your sexual assault will be kept private, and they will not report what you say to the school <u>unless you want them to</u>. *ASU Counseling Services* Walk-in to any one of ASU's four counseling centers (Downtown, Polytechnic, Tempe, and West) in-person during office hours (M-F 8AM-5PM) (no appointment necessary) or schedule an appointment to see a counselor or request to talk to a counselor over the phone by calling 480-965-6146. Click here for a list of ASU Counseling hours and locations. *ASU Health Services* Walk into ASU Health Services in Tempe at 451 E. University Drive, Tempe, AZ 85281 to see someone or schedule an appointment in-person during business hours (M-F 8AM-6PM; SAT 10AM-4PM). Click here for list of ASU Health Services locations and hours or call ASU Health Services at 480-965-3349 or use your patient portal online through My ASU to schedule an appointment at any of the four campus health locations. Click here for a list of all ASU Health Services locations. *The ASU PD Victim Advocate* Contact the ASU PD Victim Advocate in the Special Victims Unit (SVU) at 480-965-0107
Criminal	8. Report the incident to the police	(8A) Call 9-1-1 to have a dispatcher connect you to ASU PD, or call the ASU PD non-emergency line at 480-965-3456 to report a crime committed on ASU campus. If you don't feel comfortable calling the police and you

	want to speak to a confidential advocate first, you can reach the ASU PD Victim Advocate directly at 480-965-0107. (8B) Call 9-1-1 to have a dispatcher connect you to local police, or call the non-emergency line of the local police department in the city/town where the crime took place to file a criminal report.

Table 13

Pathways for Receiving Support and Advocacy On and Off Campus (Options 9-11)

Type	Option	Action Plan
Administrative Support	9. Speak with someone at ASU about changing dorms, switching out of a class, and/or receiving a medical withdrawal or leave of absence	(9A) If you are planning to or have already filed an incident report with ASU, you can contact the Office of Student Rights and Responsibilities. (9B) If you do not want to file an incident report with ASU, you can still receive support services through ASU Counseling. To speak with a counselor at ASU about changing dorms, switching classes, and/or receiving a medical withdrawal or leave of absence, walk into any one of ASU's four counseling centers (Downtown, Polytechnic, Tempe, and West) in-person during office hours (M-F 8AM-5PM) (no appointment necessary) or schedule an appointment to see a counselor or request to talk to a counselor over the phone by calling 480-965-6146. Click here for a list of ASU Counseling hours and locations.
Legal Advocacy	10. Speak with a confidential legal advocate to receive advocacy and support, obtain an order of protection or injunction against harassment, for help writing your victim impact statement, and/or apply for victims compensation	(10A) Contact the ASU PD Victim Advocate in the Special Victims Unit (SVU) at 480-965-0107 to speak to someone confidentially at ASU. (10B) Contact a victim advocate with the Family Advocacy Center by calling 1-888-246-0303 or if you are in the downtown Phoenix area, you can walk into the City of Phoenix Family Advocacy center located at 2120 N Central Avenue, Phoenix AZ 85004 during business hours (M-F 8AM-5PM) (no appointment necessary) or request to speak to an advocate over the phone by calling them directly at

602-534-2120 even if the crime did not occur in the city of Phoenix.

(10C) Contact Trauma Healing Services by calling either the ASU Student Hotline at 480-921-1006 or the community line at 1-800-656-HOPE.

(10D) Call 602-279-2900 M-F (8:30AM-5PM) to speak to a legal advocate with the Arizona Coalition to End Sexual and Domestic Violence.

(10E) Call 602-279-2900 or email victimsrights@acesdv.org for free legal representation and social services with the Crime Victim's Rights Project with the Arizona Coalition to End Sexual and Domestic Violence.

(10F) Receive plain-language legal information by state and types of abuse, get safety tips, prepare for court by visiting WomensLaw.org and find help in Arizona (including shelters, lawyers, courthouse locations, and sheriff's departments) by going here or by visiting the Rape Abuse Incest National Network (RAINN) website here.

(10G) Find out how to preserve evidence of Cyber Exploitation, have images of you taken down off the internet, register to copyright your images, get restraining orders, and learn about statutes and resources pertaining to cyber exploitation/revenge porn in AZ by visiting Without My Consent here

Campus and Community Support Services	11. Receive support on campus or in the community	(11A) Walk-in to any one of ASU's four counseling centers (Downtown, Polytechnic, Tempe, and West) in-person during office hours (M-F 8AM-5PM) (no appointment necessary) or schedule an appointment to see a counselor or request to talk to a counselor over the phone by calling 480-965-6146. Click here for a list of ASU Counseling hours and locations. (11B) Reach out to a member of the Sun Devil Support Network (SDSN) for support via phone or email. Click here for a list of SDSN members and their contact information. (11C) Call EMPACT's ASU Hotline at 480-921-1006 or the THS hotline at 480-784-1514 to speak to a crisis specialist or schedule for a mobile crisis team to visit you 24/7; call the Rape Incest Abuse National Network (RAINN) sexual assault hotline at 1800-656-HOPE (4673), or chat with someone online 24/7 by visiting https://hotline.rainn.org/online/terms-of-service.jsp.

Table 14

Pros and Cons of Seeing a Mental Health Professional On Campus at ASU Counseling Services

Pros	Cons
Counselors are people outside of your friends and family who are trained to listen non-judgmentally and support you, and will keep what you say to them private.	You may have negative views about counseling or not want to see a counselor because of a bad experience in the past, or because of how your family, community, or culture views counseling.
In addition to individual therapy, ASU Counseling Services offers students support groups where you can connect with other survivors on campus and receive peer support.	Not everyone is appropriate for groups, and there might be a waitlist to start a group.
If you don't want to report the incident to ASU, ASU Counseling Services is the only place that can help you confidentially change dorms or classes, or receive a medical withdrawal or absence.	In order to have someone at ASU Counseling Services advocate for you, you have to disclose what happened to you.
Counselors and staff at ASU Counseling Services are not mandated reporters, which means they will keep what you say private.	Your counselor can break your confidence, but only in extreme circumstances, such as if you disclose a plan to hurt yourself or someone else. If you choose to meet with a counselor, they will explain how confidentiality works with you, and will tell you under what circumstances they would have to break your confidence.
If you report what happened to you to ASU, or disclose to ASU Counseling Services, the cost of your services will be free. If what happened to you is not considered a Title IX case (e.g., it happened before you were enrolled as a student, etc.) they will work with you on payment options and will never turn you away because you can't pay for services.	If you don't disclose, or if what happened isn't a Title IX case (e.g., it didn't happen while you were a student) you may not be eligible for free sessions. The fee per session at ASU Counseling Services is $15/session.

Seeing someone at ASU counseling is convenient if you are already on campus, because you don't have to travel.	You may be worried about being seen or running into people at the counseling center, even if they won't know why you are there-just like you won't know why they are there.
ASU Counseling Services have counselors on-staff that represent diverse racial/ethnic groups, and speak multiple languages. Even if there isn't someone there who you feel you can connect with, that doesn't mean there isn't someone who can help you and support you. Additionally, if no one speaks your native language, they have language lines they can use to help translate for you.	While ASU Counseling tries hard to represent the diversity of its students, and has counselors on staff who represent multiple racial/ethnic groups and speak many different languages, there might not be someone there you feel you can connect with, or who speaks your native language.
It can be really helpful in the long-run to have a trained mental health professional listen to you and help you. Plus, counselors can provide you with resources on and off campus.	It can feel like there are a lot of steps to complete in the beginning before you get to see a counselor (e.g., intakes, etc.). Therefore, if you need to speak with a counselor immediately, you will need to let the front desk know you are in crisis.
There are counselors on-staff that specialize in sexual violence.	Even though ASU has counselors that specialize in sexual violence and trauma, they might refer you to someone else off campus who is better trained to help you if they feel you need a higher level of care than they can provide.

Table 15

Pros and Cons of Seeing a Mental Health Professional in the Community at Trauma Healing Services

Pros	Cons
Counselors are people outside of your friends and family who are trained to listen non-judgmentally and support you, and will keep what you say to them private.	You may have negative views about counseling or not want to see a counselor because of a bad experience in the past, or because of how your family, community, or culture views counseling.
THS provides up to 6 months of trauma-intensive therapy and mindfulness for free (including but not limited to: acceptance and commitment therapy (ACT), cognitive behavioral therapy (CBT), cognitive processing therapy (CPT), dialectical behavioral therapy (DBT), exposure therapy (ET), eye movement desensitization and reprocessing (EMDR), somatic experiencing (SE), trauma focused cognitive behavioral therapy (TFCBT), trauma incident reduction (TIR).	THS does not provide long-term therapy, and trauma-intensive therapy may not be appropriate for everyone (e.g., someone with an open/active court case; someone in an abusive relationship or who lacks a safe place to live; someone who struggles with substance use, or someone who could benefit from learning more coping skills or strengthening their stronger support system first).
In addition to individual therapy, THS also offers the following groups: dialectical behavioral therapy (DBT), crisis survival skills, processing, and Trauma-informed Yoga.	Not everyone is appropriate for every group, and there might be a waitlist to start a group.
THS services are 100% free, which means it won't show up on your insurance and you never have to pay fees out-of-pocket, and they will never ask about your documentation or immigration status.	Even though THS provides free trauma-intensive services, they may not be able to provide the type of help you want or need, in which case they would refer you someplace else that can.
There are English- and Spanish-speaking counselors and advocates. As a community organization, THS has locations near campus (in Tempe, downtown at the Phoenix Family Advocacy Center, and in Glendale) but is not on campus, so you don't have to	THS might not have a counselor who speaks your native language. Due to transportation or scheduling issues, it might not be easy or convenient for you to go somewhere off campus.

worry so much about running into people
or being seen by other students.

Table 16

Pros and Cons of Filing a Title IX Report with the OSRR/Dean of Students at ASU

Pros	Cons
While criminal courts have to prove that a crime occurred beyond a reasonable doubt, colleges and universities only have to prove preponderance of evidence, which means they only have to show that a student conduct issue more than likely occurred (i.e., there is more than a 50% chance a student conduct issue occurred- sometimes called 'the feather rule'). As a result, you are more likely to get an outcome that finds the person/people who did this to you responsible when you pursue administrative channels, than if you go through the criminal court system.	Just because the burden of proof is less at institutions of higher education, does not guarantee that the person/people who did this to you will be found responsible. Even if you get the outcome you want, you may still not feel comfortable staying at ASU, and they can always appeal or file a Title IX lawsuit against the school if they feel the school mishandled the case.
You may not want the person/people who did this to you to face legal trouble (e.g., be put in jail or labeled as a sex offender), but you still might want them to face consequences with the school (e.g., be suspended or kicked out of school; have to move dorms, etc.).	You might be worried that the person/people who did this to you will do it to someone else if you don't press criminal charges, and therefore, facing consequences at school aren't enough. While ASU can suspend and expel students, they can't charge anyone with a felony, put them in jail, or label them a sex offender.
If the decision does go to suspension or expulsion, you will be asked to testify. While you don't have to do this, it could be empowering to bear witness in front of others, and it could help your case.	You may not want to testify, and although you don't have to, not testifying could help the respondent's case.
Going through ASU is much quicker compared to the criminal court system. In fact, the average case takes about 30 days to settle from start-finish.	Even though from start to finish the whole process only takes about 30 days, if the respondent appeals it could take longer.
Regardless of the outcome of the investigation, the OSRR can provide you with higher-level support and advocacy, such as helping you: change dorms or	In order to receive student support and advocacy from the OSRR, you have to disclose, which could lead to an investigation.

switch classes; obtain a medical leave or withdrawal, and receive extensions and exceptions for scholarships and graduation deadlines.	
You don't have to cooperate, even if an investigation has already begun.	Even though ASU can't force you to cooperate, they can still pursue the investigation without your cooperation (they just might not get very far without you).
You can ask to remain anonymous and not have your name printed on reports.	ASU can never guarantee anonymity, and the school cannot suspend or expel anyone without telling them the name of the person who has filed a complaint against them.
The people who investigate incident reports for the OSRR are not faculty, but instead, employees trained in Title IX policies and procedures.	You might feel let down or unsupported by ASU, and/or like ASU isn't on your side, because the investigators have to stay neutral until a decision is made.
The OSRR can issue a no contact order during the investigation, in which the person/people who did this to you will not be allowed to contact you. Contacting you after a no contact order is issued is a student code of conduct violation, and they will be held accountable.	If you violate the no contact order, you could also be held accountable, as this also violates the student code of conduct.
You may feel like it's more private to handle it within the school than with the police.	You may feel like it is less private you handle it with the school, because people at school hear about what happened to you.
ASU says you should not get into trouble if you were drinking or doing drugs at the time of the incident. They don't ever want you to feel like what happened to you was your fault, and want you to know that the person who did this to you was in the wrong, not you, regardless of whether or not you were doing anything illegal.	While ASU says they won't get you in trouble for drinking or doing drugs at the time of the incident, ASU may ask or require you to take a course on substance use/abuse, or attend a substance abuse group on campus. While this is intended to help not punish you, it may feel like you are being punished or blamed.

Filing an incident report through the OSRR is not a criminal process, so you don't need to hire a lawyer.	The respondent (person who did this to you) has the right to hire an attorney, and often they do, because they are being charged with a serious offense and have a lot to lose.

Table 17

Pros and Cons of Filing a Title IX Report with the OEI at ASU

Pros	Cons
While criminal courts have to prove that a crime occurred beyond a reasonable doubt, colleges and universities only have to prove preponderance of evidence, which means they only have to show that a student conduct issue more than likely occurred (i.e., there is more than a 50% chance a student conduct issue occurred-sometimes called 'the feather rule'). As a result, you are more likely to get an outcome that finds the person/people who did this to you responsible when you pursue administrative channels, than if you go through the criminal court system.	Just because the burden of proof is lower, doesn't mean it is guaranteed (or even likely) that a faculty or staff member will be found responsible and terminated. It is particularly difficult to fire faculty members who are tenured.
The OEI can connect you with critical resources on campus (e.g., help you change classes or advisors). It can feel good to know that you have someone working with you whose primary concern is your safety and well-being, even if an investigation doesn't ever take place.	In order to access these resources, you have to disclose what happened to you to ASU. You might feel let down or disappointed if there isn't sufficient evidence to investigate a claim.
If there is sufficient evidence to support your claims, prompt and effective action will be taken. At the very least, your complaint will go on record, so if someone else comes forward, a pattern can be established.	Too often there isn't any evidence of these claims. When there is little-no evidence, it often comes down to who is more credible, you or the person who did this to you. This can be particularly challenging if you are up against a well-respected and/or tenured faculty member who is deemed to be very credible.
ASU states that student success is the primary focus, and you can't be successful if someone is making you feel uncomfortable.	You may not always feel like your success is more important than someone keeping their job-especially if they are allowed to keep their job.
Coming forward-regardless of the outcome-may feel empowering, because	You might feel powerless if you come forward and feel the school doesn't do

you are able to tell your story and bear witness to what happened to you.	anything to hold the person who harmed you responsible.

Table 18

Pros and Cons of Filing an Anonymous Title IX Report with ASU

Pros	Cons
You don't have to disclose your name.	Without disclosing your name, ASU cannot conduct a thorough investigation, and as a result the person/people who did this to you can't be suspended, expelled, or fired.
It only stays anonymous if you choose to not disclose your name at any point during the report.	If you disclose your name at any point during the report, ASU will investigate and it will not remain anonymous.
You don't have to participate in any investigation that may result from your anonymous report.	While ASU will look into every anonymous report, they often don't have enough information to thoroughly investigate.
You may not want to disclose for yourself, but instead report someone to protect other students now or in the future.	Filing an anonymous report does not guarantee that your report will be linked to past or future reports.

Table 19

Pros and Cons of Filing a Criminal Report with ASU PD

Pros	Cons
Reporting to ASU (e.g., OSRR or OEI) and reporting to ASU police is not the same. While ASU can suspend or expel a student, only ASU PD can file criminal charges against them. If probable cause is established, the person who did this to you could be arrested, and if your case goes to court and they are found guilty, they could face jail time, probation, and/or be labeled as a sex offender.	Only 18% of sexual assault cases reported to police lead to an arrest, and there is a very small chance that they will be convicted. In fact, only 2% are convicted and/or incarcerated.
While nationally, only 3% of all cases of sexual assault reported to police are forwarded to the county prosecutor's office, ASU PD forwards 100% of cases, meaning your chances of going to trial if you report to ASU PD may be higher.	Just because your case gets forwarded to the county prosecutor doesn't mean it will go to court. In fact, often cases don't get brought forward because there isn't enough evidence to establish probable cause.
Once the person who did this to you is in the system they could be connected to other past or future investigations, which can establish a pattern even if your case doesn't go to trial or end in a conviction (i.e., it could help someone else's case in the future, at which time your case could potentially be reopened).	Not every person who is accused of sexual assault is entered into the system, and not all rape kits are tested. Even of those kits that are tested, not all results are entered into CODIS.
Going to the police might make you feel safe in the short-term, especially if it leads to an immediate arrest.	Even if you go to the police and the person who did this to you is arrested, you still might not feel safe.
At any point during the investigation you can ask them to stop investigating and they will.	While it's true that while the police are investigating you can ask them to stop and they will, once the case gets turned over to the county prosecutor you no longer have control over it. If they decide to take it to court they will, with or without your consent, and if you refuse to testify, they can subpoena you.

If the person/people who did this to you are labeled a sex offender, they will be removed from campus and will carry that label with them for the rest of their lives.	Most cases (97%) don't make it to court, and most people (98%) who are accused of sexual assault are never convicted.
Filing a report with the police gives you an opportunity to bear witness and tell your story, which can start the healing process and help you take back some of the power you lost, even if you don't get the outcome you want.	Telling your story over and over again can be emotionally draining and triggering (as one person said, "you gotta bear your soul, and that isn't easy").
If you file a police report and press charges, you may be able to write a victim impact statement, and possibly read it in front of a judge and/or in open court.	If the person/people who did this to you take a plea bargain, they may not be sentenced in open court, and may never hear your statement.
It can be empowering to be informed and know about the process.	Going through the criminal system can take 2-4 + years from start to finish. As one ASU detective said "it's a marathon, not a sprint", and it takes a lot of energy and effort.
If you file a police report immediately after an incident occurs, the officers can begin an investigation, collect any evidence that would degrade over time, and interview potential witnesses, and you can decide later whether or not you want to press charges or pursue the case further.	Many people don't process that what happened to them is sexual assault immediately, or even know for sure that what happened to them was a crime, and therefore don't think to go to the police.
Everyone who works for ASU PD is trauma-informed, from dispatchers to detectives and sergeants, meaning they receive special training to work with victims of sexual assault and other traumas.	During the forensic interview (which can take anywhere from 30 minutes to 3 hours), you may feel like you are being judged or blamed, even if that is not the intention of the detectives, due to the nature of the questions they have to ask (e.g., Did you drink? If so, what? How many drinks did you have? etc.).
It is the job of the criminal justice system to determine what happens to the person/people who did this to you after you disclose to police. In fact, the	You may fear that you will "ruin someone's life" if you report what happened to the police and doubt whether

statistics show that most people (97-98%) accused of sexual assault are never convicted or incarcerated, so if they are, there must be a lot of evidence to support your claim that what they did was wrong.	or not they meant to hurt you or knew they were doing something wrong.
ASU PD uses a victim/survivor-centered process. This means ASU PD does things to make things more comfortable for you that will help your case, like waiting several sleep cycles before conducting the forensic interview, allowing you to have advocates present for everything but the forensic interviews, and having a special room for survivors/victims that is more soothing than an interrogation room.	Even with a survivor-centered process it can sometimes feel like the person/people that did this to you have more rights than you do, because the criminal justice system has to preserve their rights too, and in the eyes of the law, they are innocent until proven guilty.
If you think you might want to file a report with ASU PD, but don't feel safe or comfortable going to the police, you can contact the ASU PD victim advocate first.	Not everyone feels safe going to the police.
ASU PD has a victim advocate who is dedicated to helping and supporting students who are assaulted on ASU property, and who come forward.	There is only one ASU PD victim advocate for all of ASU, and as a result, she can only help students who file criminal reports for ASU PD.

Table 20

Pros and Cons of Filing a Criminal Report with the Local Police

Pros	Cons
If your case goes to court and the person (or people) who did this to you are found guilty, they could face jail time, probation, and/or be labeled as a sex offender.	There is a very small likelihood (3%) that your case will go to court, and an even smaller chance (2%) that the person/people who did this to you will be convicted and/or incarcerated.
Once the person who did this to you is in the system, they may be connected to other past or future investigations, even if your case doesn't go to trial or end in a conviction.	Not every person who is accused of sexual assault is entered into the system, and not all rape kits are tested. Even of those kits that are tested, not all results are entered into CODIS.
Going to the police might make you feel safe in the short-term, especially if it leads to an immediate arrest.	Even if you go to the police and the person who did this to you is arrested, you still might not feel safe.
At any point during the investigation you can ask them to stop investigating and they will.	While it's true that while the police are investigating you can ask them to stop and they will, once the case gets turned over to the county prosecutor you no longer have control over it. If they decide to take it to court they will, with or without your consent, and if you refuse to testify, they can subpoena you.
If the person/people who did this to you are labeled a sex offender, they will be removed from campus and will carry that label with them for the rest of their lives.	Most cases don't make it to court, and therefore most people who are accused of sexual assault are not labeled sex offenders.
Filing a report with the police gives you an opportunity to bear witness and tell your story, which can start the healing process and help you take back some of the power you lost, even if you don't get the outcome you want.	Telling your story over and over again can be emotionally draining and triggering (as one person said, "you gotta bear your soul, and that isn't ever easy").
If you file a police report and press charges, you may be able to write a victim	If the person/people who did this to you take a plea bargain, they may not be

impact statement, and possibly read it in front of a judge and/or in open court.	sentenced in open court, and may never hear your statement.
By going to the police you may feel like you are getting justice, regardless of the outcome if that's what justice means to you. For example, you might find comfort in bearing witness, letting them know that you aren't going to stay silent, or that you did everything you could.	Because everyone has different ideas of justice, you might not feel like justice was served just by calling someone out or doing everything you could if your case is not taken to trial or if the person/people who did this to you are not found guilty.
It can be empowering to be informed and know about the process.	Going through the criminal system can take 2-4 + years from start to finish. As one ASU detective said "it's a marathon, not a sprint", and it takes a lot of energy and effort.
You may be eligible for victim's compensation if you file a police report (you cannot access victim's compensation without one).	You are only eligible for victim's compensation if you file a police report.
If you file a police report immediately after an incident occurs, the officers can begin an investigation, collect important evidence that degrades over time, and interview potential witnesses.	Many people don't process that what happened to them is sexual assault immediately, or even know for sure that what happened to them was criminal (and therefore don't think to go to the police). The longer you wait, the more DNA and trace evidence degrades and is lost.

Table 21

Pros and Cons of Getting a Forensic Nurse Examination (i.e., rape kit)

Pros	Cons
Having a rape kit done can prove that a sex act took place, which is helpful in cases where the person/people who did this to you deny having sex with you or assaulting you.	Results from rape kits can never prove that you were raped/sexual assaulted; they can only prove that a sex act took place (not whether or not it was consensual). As a result, findings from rape kits are less helpful in cases where the person/people admit a sex act took place, but claim it was consensual.
During a forensic nurse exam, nurses can collect potential DNA and trace evidence, and document any injuries (e.g., bruises or tearing), which could be helpful if you file a police report and your case goes to trial.	Your kit won't be tested if you choose not to file a police report, and even if you do file a report, there is no guarantee your kit will ever be tested.
If the DNA from your kit is tested and it matches someone in the system, it could attest to a pattern.	The DNA from your kit won't be entered into CODIS unless you choose to file a police report. Since there is no guarantee your kit will be tested, there is no guarantee the results from your kit will be entered into CODIS.
The forensic nurse will explain everything before they do it, and nothing will ever be done without your consent. Additionally, you can stop the exam at any time if you want.	You don't really have control over what happens to your kit afterwards; it may never get tested, and it could be discarded before you make up your mind about whether or not to file a police report. Your forensic nurse examiner will provide you with details about how long your kit will be stored for if you choose not to file immediately, or if you go through Honor Health directly.
While forensic nurse examiners are specially trained to collect DNA and trace evidence, they are primarily charged with providing you with medical care. In fact, the exam is a lot like a well woman's check or physical exam, and your part	Some people say the exam can feel invasive and potentially re-traumatizing, despite the fact that forensic nurse examiners are trauma-informed and try to make you feel as comfortable and safe as possible.

only takes about one hour from start to finish.	
Even if your case doesn't go to trial, or your kit isn't tested or entered into CODIS, there are still benefits of getting a rape kit, such as determining your risk of HIV/AIDS, and receiving a physical exam by a health professional trained in sexual assault. Plus, it could be empowering to exercise choice and receive reliable health information and important resources.	Getting a rape kit done could feel like a waste of time if your case doesn't go to trial, or your kit never gets tested or entered into CODIS, if the only reason you got it was to increase odds of a conviction.
The testimony of Forensic Nurse Examiners who conduct your kit often plays a key role if your case goes to trial, as they can attest to your physical state at the time of the exam, and educate jurors about common rape myths and misconceptions.	Even documentation of injuries sustained during the incident can't prove it was rape.
The forensic nurse examiner can help you determine your risk of HIV/AIDS using a model from the Centers for Disease Control.	The forensic nurse examiners cannot give you Antiretroviral Therapy (ART), but instead will refer you somewhere that can.
You can get a pregnancy test.	Rape kits can only test for preexisting pregnancies, because you can't detect pregnancy within 120 hours.
You can have an advocate or friend with you during the exam for extra support.	You have to discuss your medical history, details about the assault, and all post-assault activities with the nurse, so you might not want to have anyone else in the room with you.
You can choose not to have swabs collected, and just get the head-to-toe exam.	Forensic nurse examinations only cover the cost of certain things, and nothing beyond the exam is free, so you may still have to go to another doctor to receive treatment for other injuries or issues (e.g., a broken arm or chronic health problems).

FIGURES

Figure 1. Arizona State University Reporting Flowchart (Retrieved at https://sexualviolenceprevention.asu.edu/sites/default/files/sexualassault_flowchart.pdf)

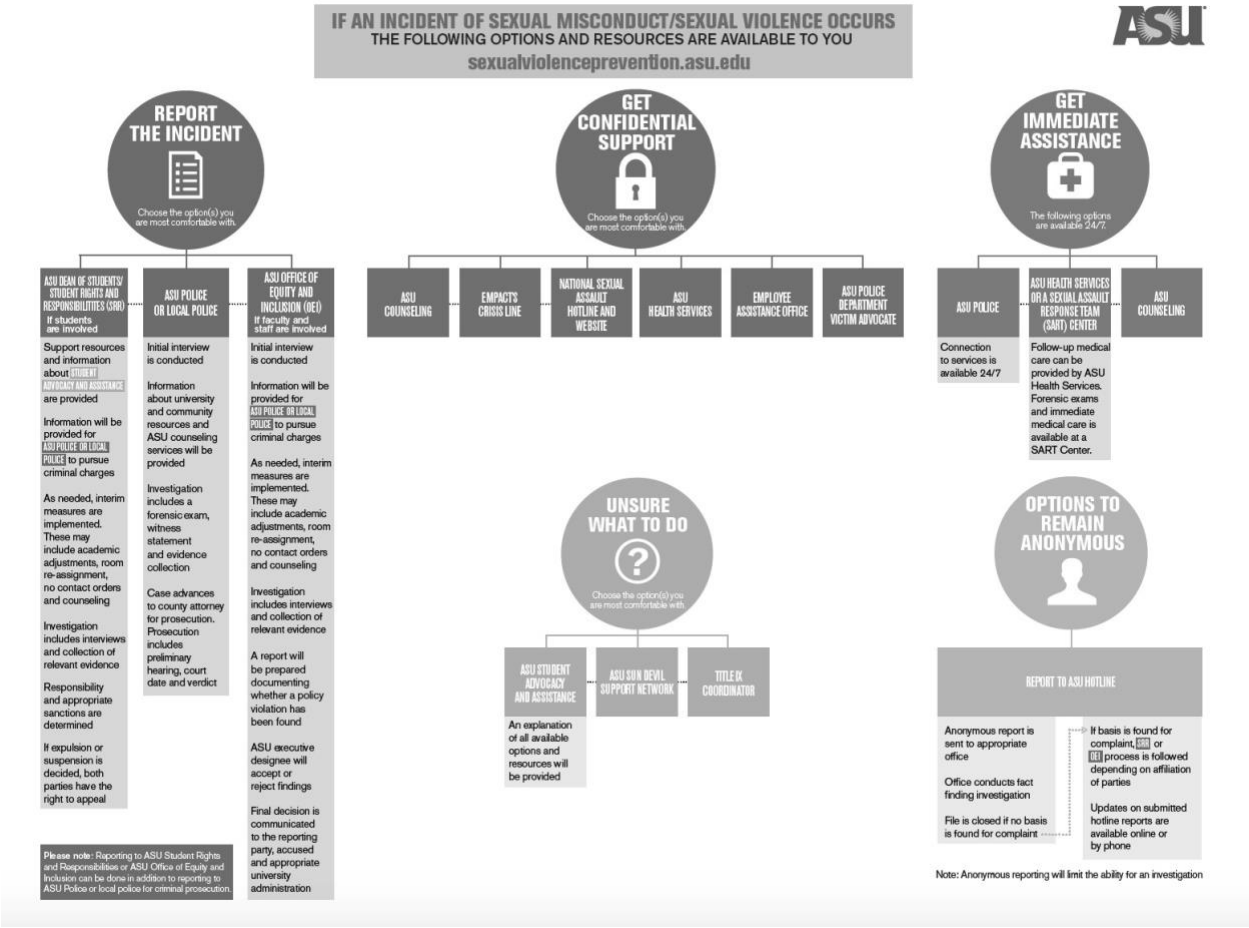


Figure 2. IPDAS Decision Aid Development Guidelines (Coulter et al., 2013)

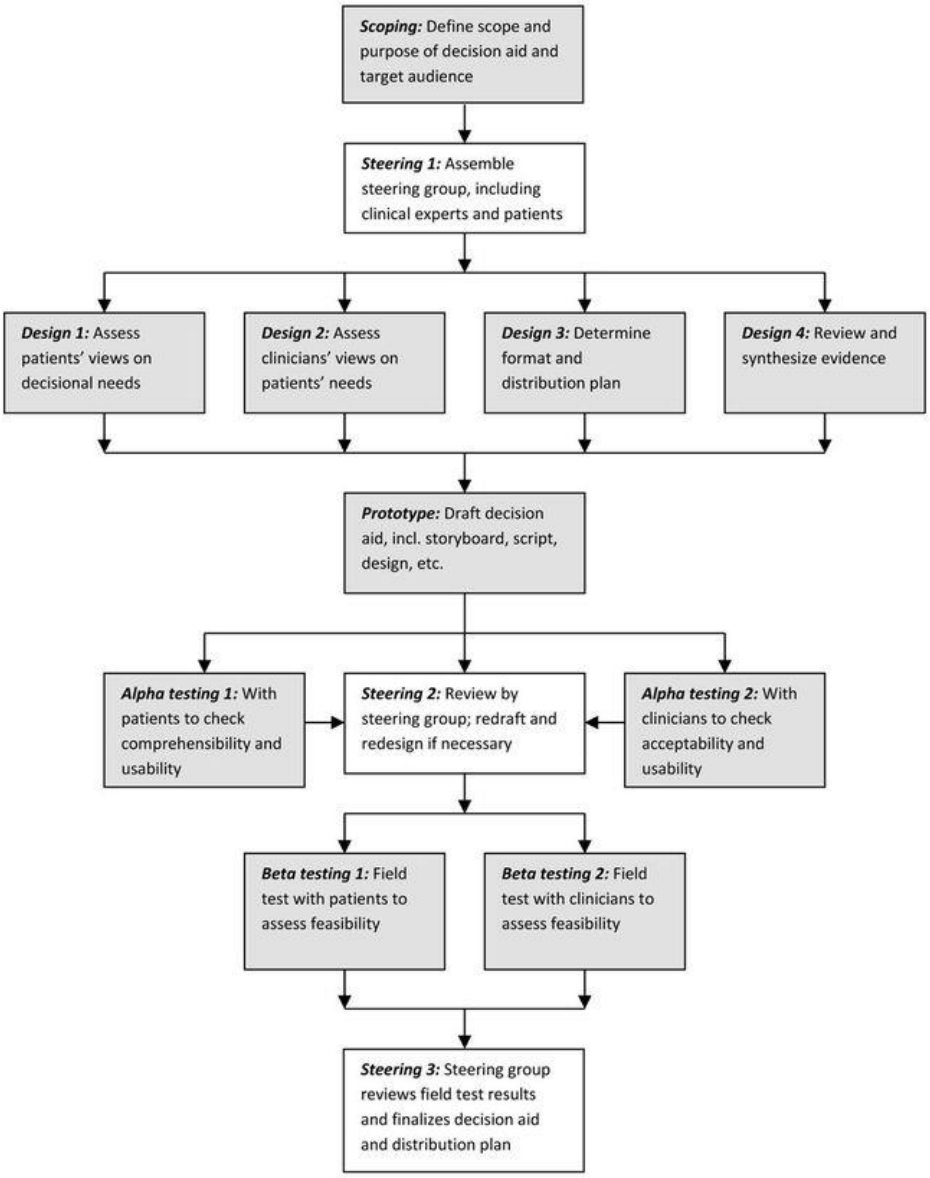
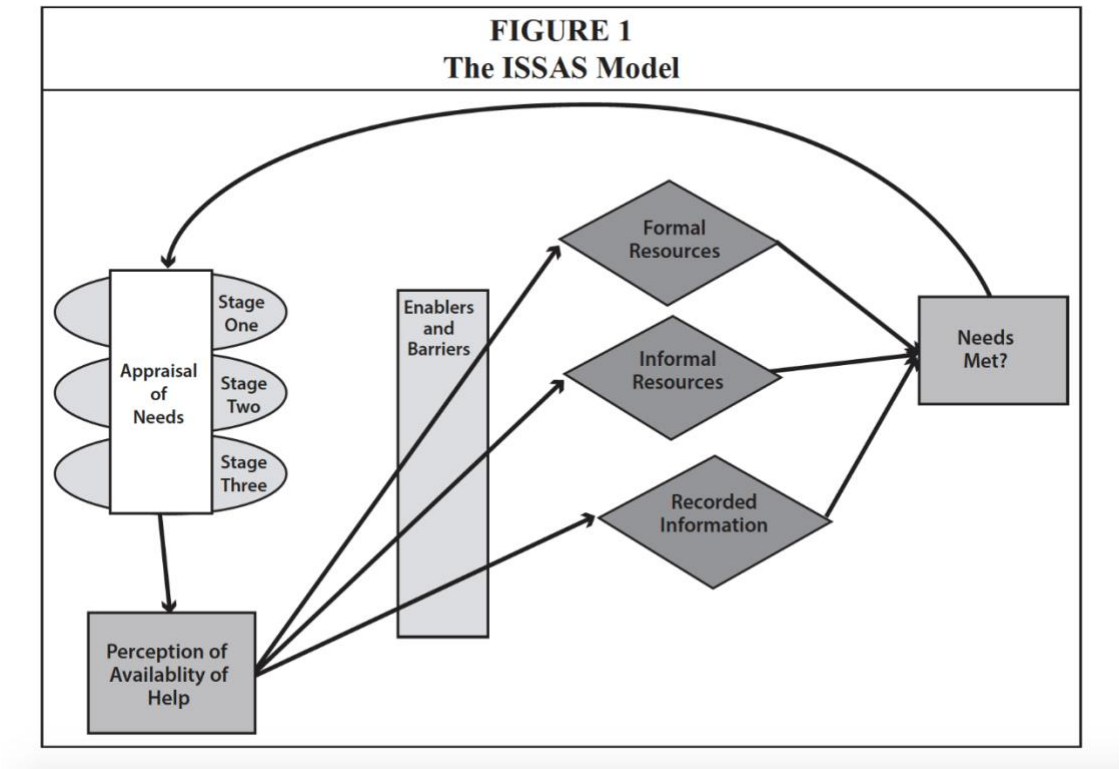


Figure 3. The Information Seeking of Sexual Assault Survivors (ISSAS) Model (Skinner & Gross, 2017).



APPENDIX A

STEERING COMMITTEE RECRUITMENT LETTER

To Whom This May Concern,

My name is Michelle Villegas-Gold, MC, MPH and I am a PhD student at Arizona State University (ASU) in Global Health in the School of Human Evolution and Social Change. For my dissertation I am creating an online decision aid for student victims/survivors of sexual violence at ASU, that hopefully can later be expanded to students throughout Arizona and the nation.

Sexual violence at colleges and universities in the United States is a significant public health and human rights issue with far-reaching impacts on the overall well-being, safety, and social embeddedness of entire postsecondary learning communities. Individuals who experience sexual violence while enrolled in college have multiple options for health care screening and treatment, and pursuing justice both on and off campus. While postsecondary learners prefer to access information on sexual health and violence online, they often have difficulty retrieving reliable information and connecting to campus and community resources. As a result, very few students disclose to crisis, counseling, or health care services, or report incidences to campus or local law enforcement agencies.

The proposed tool aims to suture the knowledge-behavior gap by helping students make choices that match with their values and preferences, and connect them to appropriate campus and community resources in real-time. In order to create a prototype of the decision aid, I am putting together a steering committee of expert clinicians, professionals, and student victims/survivors at ASU and within the greater Phoenix metropolitan area to guide development and design.

So far the members of the steering committee include: Kimberly Frick (Director of ASU Education and Outreach Services at ASU), Jodi Preudhomme (Title IX Director at ASU), Maria Grimshaw-Clark (ASU Counseling) Lynn Spillers (ASU Legal Advocate), Detective Daniel Miller (ASU PD), Shelly Ward (Mesa Family Advocacy Center), Liesl Lang (Clinical Coordinator at Trauma Healing Services with Empact-La Frontera), and Amy Palmisano (Crisis Coordinator/Case Manager at Trauma Healing Services with La Frontera-EMPACT).

If you are interested in learning more about what I am doing, and/or potentially joining the steering committee please feel free to call me at 520-247-1780 or email me at mlroger2@gmail.com any time.

Thank you so much for your time and consideration! I look forward to hearing back from you!

Sincerely,

Michelle Villegas-Gold, MC, MPH

APPENDIX B

SEMI-STRUCTURED INTERVIEW SCRIPTS

Semi-structured Interview Script: Expert Clinician and Professional Version

Q1. What options do students enrolled at ASU have for receiving health care screening and treatment after experiencing an incident of sexual violence both on campus and within the surrounding Phoenix metropolitan area? (prompt: forensic nurse examinations, visiting a PCP, obtaining STD/STI screening and treatment at the student health center or a community health center such as Planned Parenthood, etc.)

- 1.1 Who has access to these services? (prompt: undocumented students?)
- 1.2 How do students access these services? (prompts: do they call 911? Is there a toll-free hotline? Can they walk-in? Do they need to schedule an appointment? etc.)
- 1.3 When can and should students access these services?
- 1.4 Are there any known cut offs for accessing or following through with these services? (prompt: within 120 hours; 90 days, etc.)
- 1.5 What specifically do these services provide? (e.g., STI/STD screening; treatment of injury; pregnancy prevention, etc.)
- 1.6 What is the cost of these services?
- 1.7 What are the pros or known benefits of engaging or not engaging in each option discussed? (prompts: early detection and treatment of STIs/STDs and pregnancy, collecting trace and DNA evidence, etc.)
- 1.8 What are the potential risks or consequences of engaging or not engaging in each option? (prompts: FNEs can be invasive and can take hours)

Q2. What options do students enrolled at ASU have for pursing justice on and off campus? (prompt: disclosing to the Office of the Dean of Students; filing a Title IX report; filing a Title IX lawsuit; filing a police report with ASU? Filing a police report in the city where the crime occurred, etc.)

- 2.1 Who has access to pursue these pathways? (prompt: for example, only crimes committed on campus go through ASU PD, while off-campus crimes require students to file/press charges through the city where the crime occurred)
- 2.2 How do students start the process of going down each of these pathways? (prompt: do they call 911? Do they walk in somewhere? Is there a number they call?)
- 2.3 When should students first initiate engagement with each of these pathways (prompt: immediately? If so, within what time frame?)
- 2.4 Are there any known critical cut-offs for pursuing certain pathways?
- 2.5 Please describe what a student can expect to experience (procedures, etc.) for each of these pathways.
- 2.6 What are the likely outcomes that can be expected for each of these pathways? (e.g., conviction-if so what are the rates; academic discipline, etc.)
- 2.7 How long does it take to pursue each of these pathways on average? (e.g., a month? A year? Several years?)

2.8 What are the pros or known benefits of pursuing or not pursuing each of the pathways described here? (prompts: getting to tell your story; feeling empowered; obtaining justice; getting your perpetrator off the streets or kicked out of school; being able to confront your perpetrator, etc.)

2.9 What are the potential risks or consequences of pursuing or not pursuing each of the pathways described here? (prompts: not getting to tell your story; having to tell your story; waiting years for resolution; having your case dropped, etc.)

Q3. Are there any other pathways you can think of available to students for receiving support services (such as advocacy, support groups, etc.) at ASU and within the surrounding community? If so, please explain.

Q4. Based on your professional experiences, what do you think are the biggest barriers students face that delay and prevent disclosing and reporting? Please explain. (prompt: feeling embarrassed or ashamed; using major search engines like Google; not thinking the act of violence was serious enough; not understanding university policies and procedures, etc.).

4.1 What can be done to reduce these barriers?

Q5. Based on your professional experiences, what do you think are the biggest barriers students face when trying to connect to campus and community resources? Please explain.

5.1 What can be done to better connect students to critical campus and community resources?

Q6. What do you think would be the best way to deliver the proposed internet-based decision aid? Please explain why you think this format would be best (prompts: mobile-friendly website or app).

Q7. Do you think the tool should be more text-heavy or include more graphs, images and videos? Please explain.

Q8. Please share any other information you think we missed or might be relevant or helpful.

Primary and Secondary Student Victim/Survivor Version

Q1. If you or a friend were sexually assaulted while enrolled in college at ASU, what options would you have for receiving care on and off campus? (prompt: forensic nurse examinations, visiting a PCP, obtaining STD/STI screening and treatment at the student health center or a community health center such as Planned Parenthood, etc.)

- 1.1 How would you find information on what to do? (prompt: go online-if so, what website, etc.)
- 1.2 Do all students have access to these services? (prompt: undocumented students?)
- 1.3 How would you go about accessing these services? (prompts: do they call 911? Is there a toll-free hotline? Can they walk-in? Do they need to schedule an appointment? etc.)
- 1.4 When can and should you access these services?
- 1.5 Are there any known cut offs for accessing or following through with these services? (prompt: within 120 hours; 90 days, etc.)
- 1.6 What specifically do these services provide? (prompt: STI/STD screening; treatment of injury; pregnancy prevention, etc.)
- 1.7 What is the cost of these services? (prompt: is it free to you?)
- 1.8 What issues would be most concerning/important for you to address after experiencing an incident of sexual violence? (prompt: screening for STDs/STIs/pregnancy, etc.)
- 1.9 What issues would be least concerning/important for you to address after experiencing an incident of sexual violence?
- 1.10 What would be the benefits of engaging or not engaging in each option discussed? (prompts: early detection and treatment of STIs/STDs and pregnancy, collecting trace and DNA evidence, etc.)
- 1.11 What are the potential risks or consequences of engaging or not engaging in each option? (prompts: FNEs can be invasive and can take hours)

Q2. If you or a friend were sexually assaulted while enrolled in college at ASU, what options would you have for pursuing justice on and off campus? (prompt: disclosing to the Office of the Dean of Students; filing a Title IX report; filing a Title IX lawsuit; filing a police report with ASU? Filing a police report in the city where the crime occurred, etc.)

- 2.1 Under what circumstances would it be most appropriate to pursue each of these pathways? (prompt: for example, only crimes committed on campus go through ASU PD, while off-campus crimes require students to file/press charges through the city where the crime occurred)
- 2.2 How would you go about starting the process of going down each of these pathways? (prompt: would you call 911? Could you walk in somewhere? Is there another number to call?)
- 2.3 When would it be best to first initiate engagement with each of these pathways (prompt: immediately? If so, within what time frame?)

2.4 Are there any known critical cut-offs for pursuing any of these pathways?
2.5 Please describe what someone should expect to experience (procedures, etc.) for if they choose to pursue each of these pathways.
2.6 What are the likely outcomes that can be expected for each of these pathways? (e.g., conviction-if so what are the rates; academic discipline, etc.)
2.7 How long does it take to pursue each of these pathways on average? (e.g., a month? A year? Several years?)
2.8 What are the pros or known benefits of pursuing or not pursuing each of the pathways described here? (prompts: getting to tell your story; feeling empowered; obtaining justice; getting your perpetrator off the streets or kicked out of school; being able to confront your perpetrator, etc.)
2.9 What are the potential risks or consequences of pursuing or not pursuing each of the pathways described here? (prompts: not getting to tell your story; having to tell your story; waiting years for resolution; having your case dropped, etc.)

Q3. Are there any other pathways you can think of available to students for receiving support services (such as advocacy, support groups, etc.) at ASU and within the surrounding community? If so, please explain.

Q4. Based on your experiences, what do you think are the biggest barriers students face that delay and prevent disclosing and reporting? Please explain. (prompt: feeling embarrassed or ashamed; using major search engines like Google; not thinking the act of violence was serious enough; not understanding university policies and procedures, etc.).

4.1 What do you think can be done to reduce these barriers?

Q5. Based on your experiences, what do you think are the biggest barriers students face when trying to connect to campus and community resources? Please explain.

5.1 What can be done to better connect students to critical campus and community resources?

Q6. What do you think would be the best way to deliver and use the proposed internet-based decision aid? Please explain why you think this format would be best (prompts: mobile-friendly website or app).

Q7. Do you think the tool should be more text-heavy or include more graphs, images and videos? Please explain.

Q8. Please share any other information you think we missed or might be relevant or helpful.

APPENDIX C

PROTOTYPE HANDOUT

Cheat Sheet for Navigating MyChoice Prototypes

Q & A:

Why are There Three Prototypes?

- Due to size restrictions posed by the software used to create the prototype, when the prototype was created it was too large and crashed the program.
- In fact, after mapping out all potential pathways for aid, justice, and advocacy/support, I came up with 11 options, 40 action plans, & 294+ possible outcomes.
- This resulted in over 3,000 pages each with several links/hot spots.
- In order to create a working user experience, and show you what the prototype could look like for different users, I broke it up and created three separate prototypes, however, the actual website that will be developed will be one comprehensive decision aid.

Why Did You choose These Three?

- Together these three pathways take users through almost all of the pages created in the comprehensive prototype-they just don't lead to all possible outcomes/combinations of action plans.

Why Can't I Choose Certain Answers within the Prototypes?

- Because we needed to avoid duplicating each page multiple times, each prototype will only allow you to choose certain answers, so if you click on a button and it doesn't work, that's okay, it's intentional (i.e., it isn't coded to go that way).

Why Don't the Pros and Cons Links, Progress Bar, or Breathing Animations Work?

- We couldn't get the pros and cons to work properly as an overlay in the decision aid in a way that made sense, so instead, we provided you with copies of it, but in the final tool they will work. We're hoping you can help us edit and even eliminate some of the options in the pros and cons lists that will be used in the website. Please feel free to add comments/edits using track changes and email them back or just send an email with your comments/concerns. While you have been provided with all lists-and should feel free to review them all, you only need to review the ones that specifically pertain to you (which have been highlighted for your convenience).
- We also couldn't get the progress bar to work on the prototype software, but in the actual tool, it will show users how they are progressing in the decision aid.
- Additionally, the breathing animation was too big for the prototype, so it is attached separately as a file in the email you received.

Can You Still See All the Options and Action Plans?

- Yes, each prototype will first take you through the options and action plans that best match what you said was important to you
- After, it will give you an option to see all options and action plans

Key Features/Helpful Hints:

- The menu bar in the right hand corner allows you to immediately be connected with an advocate

- You can use the back button to explore different options and what pages they take you to
- At the end, you will be taken through all the options and action plans that match what is said is most important THEN you will be given the option to view all options and action plans
- The all options/action plans page has buttons with each option/action plan. You can click on each one to read/explore, and then click the back button to return to the main page and see more.
- Try not to scroll by swiping left or right (like you would if reading an eBook on your phone or tablet), but instead use the buttons. You might not end up at the right page in the prototype, but instead, at the next page in the series.
- There are some minor typos and edits that need to be made-we are working on them, but feel free to point them out anyways in case we didn't catch them already!

Tips for Navigating the Prototypes:

1. OSRR/ASU PD
    a. *Scenario*: for someone assaulted on campus, by another student who is also a current or former intimate partner, within the past 120 hours, who is interested in filing a report with OSRR & ASU PD, and learning more about red flags of abuse
        i. *Hint:* you can say that you want to remain anonymous with ASU, but after going through the pros and cons, you have to say that you want to disclose your name JUST for the prototype, in the actual tool you can file an anonymous report (see the list of all options and action plans at the end).
    b. *Link*: https://invis.io/8EG3QK8MPAH

2. OEI/ASU PD
    a. Scenario: for someone assaulted on campus by an ASU employee (e.g., teacher or coach) who is not a current or former intimate partner, not within the past 120 hours, who is interested in filing a report with the OEI and ASU PD.
        i. Hint: again, you can say that you want to remain anonymous with ASU, but after going through the pros and cons, you have to say that you want to disclose your name JUST for the prototype, in the actual tool you can file an anonymous report (see the list of all options and action plans at the end).
    b. Link: https://invis.io/28G3QUCEFXT

3. No Title IX/Local PD

a. Scenario: Scenario: for someone who was not assaulted by anyone affiliated with ASU off campus, and who is interested in a forensic nurse exam and filing a report with local PD.
b. Link: https://invis.io/BWG3QJZNMKS

APPENDIX D

ELECTRONIC SURVEYS

Electronic Survey: Student Version

Questions About Usability:

1. How likely are you to use this tool (e.g., if you or someone you know was sexually assaulted?) (5-point Likert scale, where 0 = not at all likely and 5 = extremely likely)
2. How easy was it to use and navigate the tool? (7-point Likert scale, where 0 = extremely easy and 7 = extremely difficult)
3. What features specifically do you think make the tool easy to use/navigate? (open text box)
4. Was there anything that was confusing or difficult? (open text box)
5. Who do you think this tool could be used for? (open text box)
6. In what contexts do you think this tool would be useful? (e.g., if you or someone you know were sexually assaulted?) (open text box)
7. Is there anything you would change that would make the tool easier to use? (open text box)
8. Is there anything you would change that would make you more likely to use the tool? (open text box)

Questions About Comprehensibility:

1. How were concepts in the decision aid described with regard to wording? (e.g., did it use minimal wording, was it too wordy?) (open text box)
2. Were the concepts in the decision aid conveyed in ways that required users to interpret meaning? Please explain. (open text box)
3. When navigating a page, how often did you need to scroll down to access more information? (5-point Likert scale where 0 = never and 5 = always)
4. There were more long pages with complex content, than short pages that required users to navigate to other pages. (T/F)
5. Memory aids (e.g., pop-up menus) were used to facilitate navigation. (T/F)
6. How much need was there to infer meaning or think abstractly in order to understand the written content presented in the decision aid? (5-point Likert scale where 0 = none at all and 5 = a great deal)
7. To what degree did the words use in the decision aid employ the target group's vernacular and vocabulary? (5-point Likert scale, where 0 = none at all and 5 = a great deal)

Electronic Survey: Expert Clinician/Professional Version

Questions About Acceptability:

1. How satisfied were you with the decision aid overall? (7-point Likert scale where 0 = extremely dissatisfied and 7 = extremely satisfied)
2. How well do you think the decision aid meets the needs of the target population? (5-point Likert scale, where 0 = not well at all and 5 = extremely well)
3. What did you like best about the decision aid? (open text box)
4. What did you not like about the decision aid? (open text box)
5. How did you feel about the tool's design? (e.g., graphics, colors, images, font, etc.) (open text box)
6. How did you feel about the tool's format? (e.g., text, anonymity, interactivity, linear format, etc.) (open text box)
7. What did you think about the delivery of the tool using a mobile-friendly website? (open text box)
8. How can the tool be improved to be received better and used more? (open text box)

Questions About Usability:

1. How likely are you to use this tool (e.g., in practice/for work or if someone you know experienced an act of sexual violence?) (5-point Likert scale, where 0 = not at all likely and 5 = extremely likely)
2. How easy was it to use and navigate the tool? (7-point Likert scale, where 0 = extremely easy and 7 = extremely difficult)
3. What features specifically do you think make the tool easy to use/navigate? (open text box)
4. Was there anything that was confusing or difficult? (open text box)
5. Who do you think this tool could be used for? (open text box)
6. In what contexts do you think this tool would be useful? (e.g., if you or someone you know were sexually assaulted?)
7. Is there anything you would change that would make the tool easier to use? (Open text box)
8. Is there anything you would change that would make you more likely to use the tool? (Open text box)