MENTAL HEALTH PROFESSIONALS' ATTITUDES TOWARD RAPE SURVIVORS

A DISSERTATION SUBMITTED TO THE FACULTY OF THE ADLER SCHOOL OF PROFESSIONAL PSYCHOLOGY

BY

JACLYN M.P. PISTORIO, M.A., L.C.P.C., N.C.C.

IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF DOCTOR OF PSYCHOLOGY

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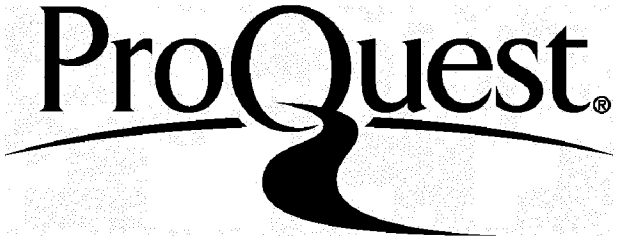

ADLER SCHOOL OF PROFESSIONAL PSYCHOLOGY DISSERTATION COMMITTEE MEMBERS

Student's Name: Jaclyn M.P. Pistorio

Dissertation Title: Mental Health Professionals' Attitudes Toward Rape Survivors

This dissertation has been defended and submitted for final submission

Certified by:

Name and Degree	Institution Affiliation
Janna A. Henning, J.D., Psy.D.	Adler School of Professional
Dissertation Chair	Psychology
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Dissertation Reader	Psychology
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Abstract

The purpose of this dissertation is to examine licensed mental health professionals' attitudes towards rape survivors. Research indicates that the attitudes of police officers, mental health professionals, and the general public may influence the psychological adjustment of rape survivors and, consequently, whether or not that person seeks mental health treatment after the assault (Vincent, 2009). The negative impacts of rape on a person may not be specific only to the act of violence, but may also include secondary victimization from the survivors' negative experiences with authorities such as legal and mental health professionals (Campbell & Raja, 1999) who may hold negative beliefs about sexual assault and rape survivors (Nagel, Matsuo, McIntyre, & Morrison, 2005). Exposure to these negative beliefs held by others may be associated with negative secondary emotions in the survivor, such as guilt; guilt associated with actions taken or not taken in the context of rape has been observed to be positively correlated with posttraumatic stress disorder, depression, low self-esteem, social anxiety, and suicidal ideation (Kubany, Abueg, Owens, Brennan, Kaplan, & Watson, 1995). It is therefore important to examine the attitudes licensed mental health workers hold towards rape survivors, as these rape survivors may seek services from mental health professionals, and the clinicians' attitudes towards these clients' experiences may significantly impact survivors' recovery from a sexual assault. In addition to measuring the acceptance of rape myths in licensed mental health providers, this

study aims to explore how demographic variables in mental health professionals, such as gender, type of graduate degree, or participant rape survivor status, are related to the attitudes participants report about sexual assault. It was hypothesized that male study participants would attribute greater responsibility to survivors than female study participants would, based on the results of the updated Illinois Rape Myth Acceptance Scale, and congruent with published research highlighting this gender difference (Grubb & Harrower, 2009). It was hypothesized that mental health providers who have had more years of training in their graduate degree program would report lower levels of rape myth acceptance compared with those who had a shorter degree program. It was also hypothesized that participants who themselves identified as a rape survivor or who had a close friend or family member who is a survivor would attribute less responsibility to rape survivors, as research supports the observation that those who identify as survivors or friends of survivors may reject negative biases towards sexual assault survivors.

After completing both independent t-tests and Mann-Whitney U statistical analyses, gender identity was the only demographic for which statistically significant mean differences were seen in total rape myth acceptance scores (p = .012). This finding is not surprising, as much of the current literature supports that men, in general, attribute more blame to rape survivors than women. Prior to the current study there was no published research using licensed mental health providers as participants in a study using the updated Illinois Rape Myth

Acceptance Scale. Data gathered from the current study will therefore offer a valuable contribution to the literature on this topic. Further, it is hoped that this data can be used in the development of graduate programs, continuing education courses, and didactic seminars that debunk rape myths and promote competency around rape survivor issues.

Acknowledgements

To my committee members, Drs. McNeilly and Kim—thank you for your guidance along the way. You both have been integral parts of my development as a clinician and a social justice practitioner.

I would like to express my deepest gratitude to my dissertation chair and mentor, Dr. Janna Henning. Thank you for putting up with my go-getter attitude for the last five years—Adler will not be the same without me. You opened my eyes to the world of traumatic stress psychology, instilled a passion in me that I never thought possible, and it has changed me forever. Thank you for teaching me that it is okay to be myself and that I can use my quirks to facilitate change in clients. I am a successful therapist due in large part to your brilliance.

Thank you to my mom, who should be getting an honorary Psy.D. for all the time and energy she has spent with me in this graduate school process. Thank you for letting me cry, vent, and being okay with my move to Tennessee to pursue my dream job. You are my biggest fan, champion, and I have never forgotten that.

Finally, I would like to thank my soon-to-be husband, Jesse. While getting my M.A. and Psy.D., I found a husband along the way and I could not be any happier. How unfortunate for our future children that they will have two psychologists as parents. Even while several hundred miles apart, you have provided me with support, wisdom, and encouragement—thank you for being one of the best parts of my life.

JACLYN M. P. PISTORIO, M.A., L.C.P.C., N.C.C.

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Knoxville, TN 37918 **jaclynpistorio@gmail.com**

EDUCATION

Adler School of Professional Psychology: Chicago, Illinois
APA-Accredited Program
Psy.D. Doctoral Candidate in Clinical Psychology
Concentration in Traumatic Stress Psychology

Adler School of Professional Psychology: Chicago, Illinois
Master of Arts in Counseling Psychology

Benedictine University: Lisle, Illinois
Bachelor of Arts in Psychology

PROFESSIONAL LICENSES

State of Illinois: Licensed Clinical Professional Counselor 09/13-Present

National Board for Certified Counselors: National Certified Counselor 12/10-Present

SUPERVISED CLINICAL TRAINING

University of Tennessee Knoxville Student Counseling Center: Knoxville, TN
08/14-Present

Doctoral Intern, APA-Accredited Program

- Engage in 20 hours of weekly direct service and provide time-limited individual and couples therapy to undergraduate and graduate student population. Offer weekly triage/crisis intervention sessions to any UT student during walk-in hours and connect students with either internal or community referral resources most appropriate for presenting issues and treatment goals.

- Co-developed and participate in both Administrative Training Track and Training and Supervision Training Track. Serve as university liaison to Transgender Treatment Team.
- Co-facilitate two weekly interpersonal therapy process groups, provide individual supervision for Counseling Psychology Ph.D. advanced practicum student, and deliver group supervision to three Counseling Psychology Ph.D. practicum students working at UT Student Counseling Center.
- Attend weekly psychopharmacology, community intervention, case conference, and professional topics seminars, as well as staff meetings. Professional topics have included Gestalt therapy, trauma-focused interventions, motivational interviewing, and professional self-care.
- Conduct on-going consultation project with intern cohort that aims to identify the best use of outcome measures at UT Student Counseling Center; interviewed university counseling centers throughout the nation regarding their use of outcome measures in treatment.

University of Illinois at Chicago Counseling Center: Chicago, IL 08/13-05/14
Advanced Therapy Practicum Extern

- Provided brief individual therapy, intake interviews, case management, and outreach program services to emerging adult population recognized as the 7th most diverse college in the United States, with the largest population of Latino/a and African American students of any Big 10 university, and in the top 25 LGBT-friendly universities in the nation.
- Focused clinical work with traumatic stress and eating disordered populations; co-led six-week Dialectical Behavior Therapy student group during spring semester.
- Attended weekly case presentations with multidisciplinary team consisting of staff psychologists, psychiatrist, and case managers in order to coordinate care of clients and manage internal and external referrals.
- Participated in four hours of weekly clinical supervision, as well as three hours per week of seminar training, including: multicultural therapy, professional issues, assessment, psychiatric issues, and outreach.

Purdue University Calumet Counseling Center: Hammond, IN 07/12-06/13
Therapy Practicum Extern

- Provided individual and couples therapy, intake assessments, and career counseling, and administered standardized psychological assessment tools (BDI-II, BAI, OQ30.1) to a largely first generation, highly diverse, non-traditional graduate and undergraduate student population.

- Performed outreach programming for university students, including weekly classroom presentations regarding time management, career counseling, and mental illness.
- Collaborated with clinicians to create monthly mental health awareness (suicide prevention, depression screenings, sexual violence) events and weekly Positive Psychology emails sent to all staff, faculty, and students.
- Updated counseling center's Twitter and Facebook accounts in order to provide mental health resources, promote advocacy, and link students to agencies and associations concerned with the promotion of mental health.

Park Ridge Psychological Services: Park Ridge, IL 08/11-06/12

Assessment Practicum Extern

- Administered and scored psychological assessment tools to children, adolescents, and adults in an outpatient private practice setting with referral questions focused on learning disability and ADHD assessment; Batteries included: WAIS-IV, WISC-IV, WIAT-III, PAI-A, TAT, Sentence Completion, and other measures of achievement, cognitive and personality functioning, and memory.
- Wrote integrative reports, which included background information of client (taken during initial interview), test results, IEP suggestions, and treatment recommendations.
- Provided individual therapy to children and adolescents presenting with difficulties managing disrupting behaviors, mood disorders, and grief counseling.
- Collaborated on assessment and treatment of clients with multi-disciplinary team of clinical psychologist, nurse practitioner, certified alcohol and drug counselor, and licensed yoga therapist.

Alexian Brothers Center for Mental Health: Arlington Heights, IL 08/09-05/10

Partial Hospitalization Program

Master's Practicum Extern

- Provided individual and group therapy for adult clients in partial hospitalization program, performed initial assessments, and collaborated with a psychiatrist during client appointments. Performed long-term individual therapy at outpatient mental health program with adult population.
- Facilitated eleven separate skills-based groups including: goals/process time, mood disorders, empowerment, anger management, positive thinking with CBT, and symptom management.

PROFESSIONAL EXPERIENCE

Park Ridge Psychological Services 08/10-07/14

Psychotherapist-Licensed Clinical Professional Counselor

- Provided short- and long-term individual psychotherapy to adolescent and adult individuals; presenting problems focused around depression, anxiety, eating disorders, grief and loss, and traumatic stress.
- Managed billing and submitting insurance claims to various third party companies.
- Attended didactic trainings in ethical practice, cultural competence, and empirically validated interventions; frequent attendance to various conventions and presentations in the field.

PROVISION OF GROUP THERAPY

Interpersonal Process Group 01/15-Present

Co-facilitator

Clinical Supervisor: Victor Barr, Ph.D.

- Interpersonal process group consisting of undergraduate students with focus on interpersonal relationships, managing distressing symptoms, and academic functioning.

Interpersonal Process Group 09/14-Present

Co-facilitator

Clinical Supervisors: Ray Sheets, M.A. and Melissa Bartsch, Ph.D.

- Interpersonal process group consisting of undergraduate students with focus on interpersonal relationships, managing distressing symptoms, and academic functioning.

Feel Better Fast 09/14-12/14

Co-facilitator

Clinical Supervisor: Sarah Park, Psy.D.

- Four-week Dialectical Behavior Therapy-based (DBT) workshop offered to client and non-client student population; focuses on mindfulness, distress tolerance, emotional regulation, and biofeedback.

Mood Masters 01/14-03/14

Co-facilitator

Clinical Supervisor: Jenna Bauer, Psy.D.

- A twelve-week, structured, DBT-focused group with emphasis on the application of skills to clients' unique presenting issues.

Alexian Brothers Partial Hospitalization Program 08/09-05/10
Facilitator
Clinical Supervisor: Katie Connolly, M.S. L.C.P.C.

- Independently facilitated daily skills-based groups provided to adult population; total of eleven groups: Goals/Process Time, What is Mental Illness?, Grief and Loss, Resilience, Depression/Mood Disorder Management, Cognitive Distortions, Empowerment, Anger Management, Symptom Management, Sleep and Nutrition, and Assertiveness.

SUPERVISORY EXPERIENCE

University of Tennessee Knoxville 01/15-Present
Supervisor, UT Advanced Practicum Student Individual Supervision

- Supervise three clinical cases of a University of Tennessee Knoxville Ph.D. Counseling Psychology Advanced Practicum student, review tape from client sessions, and sign off on progress notes from clinical cases.

University of Tennessee Knoxville 08/14-Present
Supervisor, UT Practicum Student Group Supervision
Co-Supervisor: Melissa Bartsch, Ph.D.

- Serve as group supervisor to three University of Tennessee Knoxville graduate students in Ph.D. Counseling Psychology program.
- Provide weekly group supervision of Ph.D. Counseling Psychology students' clinical cases.

University of Illinois at Chicago, InTouch Crisis Hotline 02/13-05/14
Supervisor

- Provided weekly supervision for over 10 undergraduate and graduate student paraprofessionals taking crisis calls from adults and geriatric callers to the InTouch hotline.
- Monitored calls and provided immediate feedback on content and process, as well as suggested basic intervention skills to paraprofessionals as each call is taking place.
- Held weekly psychoeducational discussions surrounding topics such as: paraphrasing, deescalating caller crises, providing empathy, and building rapport. Participated in weekly group supervision of supervision led by

clinical psychologist and social worker; reviewed and discussed scholarly articles in the field of supervision.

LEADERSHIP EXPERIENCE

Illinois Psychological Association of Graduate Students 07/13-07/14
Student Membership Chair

- Worked with Illinois Psychological Association Membership Chair to recruit new student members.
- Responsible for overseeing Association student member liaison program at all Illinois graduate schools.

Adler Student Government 07/12-07/13
President

- Presided over all monthly executive board meetings and set the agenda for the meetings, while serving as principal executive officer. Discussed activities taking place in the school's community during monthly meetings with the President of the Adler School.
- Served as liaison and representative of entire student body, spoke for students from 17 different Psy.D. and M.A. programs; oversaw and managed duties of seven executive board positions and collaborated with individuals to host events.
- Events organized included: Faculty Case Conceptualization (orientations from: Object-Relations, Relational Constructivism, and Cognitive-Behavioral), Student Cocktail Party Event, Faculty Member of the Year award and luncheon, and Student Appreciation Week.

A.C.E.P.T. Student Needs Committee 07/12-07/13
Student Representative

- Acted as an advocate between the Association of Chicagoland Externship and Practicum Training (ACEPT) and the Chicagoland Psy.D. students.
- Developed working relationships with ACEPT professionals and with students on various campuses.
- Attended meetings and maintained e-mail correspondence with students and the ACEPT board.
- Conducted formal surveys at various campuses to gauge the needs of each unique student body.

COMMUNITY ENGAGEMENT

Goodman Theatre 09/12-10/12

Post-Performance Talkback Facilitator

- Attended performances of "Black N Blue Boys: Broken Men" and facilitated debriefing sessions for the audience members, post-performance, to provide psychoeducation about the prevalence of male sexual violence, information about the myths and stigmas regarding the culture of rape, and organizations in the community that provide support for both survivors and perpetrators of sexual violence.

Community Support Services: Brookfield, IL 01/09-07/09

Community Service Practicum

- Conducted a competitive survey of services in surrounding areas being currently served by agency.
- Organized and filed client paperwork and kept an up-to-date list of mental health services offered.
- Worked targeting opportunities on expansion of site services into other communities in need of assistance for individuals with dual diagnoses of low IQ and mood/anxiety disorders.

Association for Individual Development 09/07-04/08

Crisis Line Counselor

- Attended 11-week training course in basic psychology, suicide, psychotherapeutic techniques, drugs, alcohol, rape, incest, domestic violence, adolescent and family problems.
- Provided confidential counseling, information and referral, emergency, and sunshine call services.

TEACHING EXPERIENCE

Adler School of Professional Psychology 08/12-12/12

Teaching Assistant

Course: Basic Intervention and Assessment Skills of Psychotherapy

Instructor: Cathy McNeilly, Psy.D

- Taught graduate-level lab course in intervention and assessment skills, including topics of: basic interviewing skills, importance of body language, rapport building, using empathy, structured interview skills, five-axial diagnosing, and treatment planning.
- Evaluated students' mock therapy taped sessions, reflection papers, midterms, and final papers.

- Offered consultation outside of class time to students wishing to increase their skills or gain better understanding of a course topic.

RESEARCH EXPERIENCE

Adler School of Professional Psychology 01/13-12/14

Doctoral Dissertation: Defended 12/10/14

Title: Mental Health Professionals' Attitudes Toward Rape Survivors

- Chair: Janna Henning, J.D., Psy.D.
- Study utilized the Illinois Rape Myth Acceptance Scale in order to assess the biases, prejudices, and attitudes that mental health professionals have about rape survivors.

Adler School of Professional Psychology 01/13-01/14

Associate Investigator

Primary Investigator: Marla Vannucci, Ph.D.

- Pilot study on assessment supervision outcomes.
- Performed literature searches in the area of student supervision and examined measures to best collect quantitative and qualitative data in this area. Assisted in writing literature review section of article, including analysis of past statistical methodologies and limitations of research.
- Conducted research with doctoral-level assessment students, faculty members, and assessment practicum supervisors to gather qualitative and quantitative data on attitudes toward supervision.

Illinois State Lottery 01/13-05/13

Research Assistant

Primary Investigators: Cathy McNeilly, Psy.D., CADC and Joseph Troiani, Ph.D., CADC

Funded By: Illinois Lottery and Northstar Lottery Group

Title: Attitudes Toward Responsible Gaming

- Research team member conducting Responsible Gaming Research Project
- Led focus groups at Illinois community colleges throughout a three-month period in order to gain diverse attitudes and perceptions of problem gambling.
- Worked with the Illinois Council on Problem Gambling to perform a qualitative analysis of gaps in gambling addiction services, attitudes of IL residents in regards to gambling addiction recovery, and the role the Illinois lottery can play in filling gaps in services; analyzed data both

manually and using SPSS-21 in order to determine trends and effects of attitudes of problem gambling on Illinois Lottery participation.

PROFESSIONAL PRESENTATIONS

Brown, A. D., Fleck, J. R., **Pistorio J.M.P.**, Ryan, R., & Waller, R. (2014, May). *Attitudes toward Responsible Gaming: Preliminary Research Results and Evaluation.* Poster session presented at the Annual Meeting of the Midwestern Psychological Association, Chicago, IL.

Brown, A.D., Fleck, J., **Pistorio, J.M.P.**, Ryan, R. & Waller, R. (2013, November). *Attitudes toward responsible gaming: Preliminary research results and evaluation.* Poster session presented at the Illinois Psychological Association Annual Convention, Schaumburg, IL.

Flores, S. & **Pistorio, J.M.P.** (2014, November). *The Future is Calling: The Psychological Implications of Advanced Technology.* Symposium conducted at the meeting of the Illinois Psychological Association, Schaumburg, IL.

Henning, J. A., Stallings, L.E., & **Pistorio, J.M.P.** (2014, July). *Incorporating Relational Constructivism with Stage-Oriented Treatment for Complex Traumatic Stress.* Paper presented at the Constructivist Psychology Network 16th Biennial Conference, Vancouver, BC, Canada.

Pistorio, J.M.P. & Fleck, J. (2013, May). *Therapeutic outcomes with clinical supervision.* Poster session presented at the 1st Annual Association of Chicagoland Externship and Practicum Training (ACEPT) Conference, Chicago, IL.

Pistorio, J.M.P. (2009, September). *Developmentally disabled individuals and availability of mental health resources.* Symposium conducted at the Adler School of Professional Psychology Community Service Practicum Fair, Chicago, IL.

Rinker, J., Stallings, L.E., & **Pistorio, J.M.P.** (2014, June). *Addressing Women's Health Issues in Practicum Settings.* Paper presented at the Adler School Women's Health Symposium, Chicago, IL.

CERTIFICATIONS AND PROFESSIONAL TRAININGS

Certified SPEAKologist 10/29/14

Provided By: Center for Health, Education, and Wellness at the University of Tennessee Knoxville

- Attended training encouraging UT community members to be active bystanders and intervene in situations perpetrating oppression, marginalization, or violence to other members of the community.

Certified Question, Persuade, & Refer (QPR) Trainer 10/24/14

Provided By: QPR Institute

- Participated in eight-hour training in QPR, a nation-wide program aimed at promoting suicide awareness and prevention. Qualified in how to provide QPR training to community-level participants.

Trans* Safe Zone 10/13

Provided by: The University of Illinois Chicago's Gender and Sexuality Center

- Addressed terminology, policies, and concepts specific to trans-identified and gender non-conforming people.

Safe Zone 101 09/13

Provided by: The University of Illinois Chicago's Gender and Sexuality Center

- Introduced an overview of vocabulary, concepts, current events, policies, and identity development models related to coming out for LGBTQ people and communities.

Eye Movement Desensitization and Reprocessing (EMDR) Basic Training 09/12-03/13

Provided By: Barbara Parrett, RN, MS, Lt. Col., USAF (RET) and Roger Solomon, Ph.D.

EMDR Institute, Inc. Faculty

- Completed 40 hours of specialized training to become familiar with a broad spectrum of EMDR applications sufficient for clinically ethical use with a wide range of populations and situations.
- Received education on the physiological information processing system, stabilization techniques across the attachment spectrum, addressed the full range of trauma and other disturbing life events, and treatment planning to address past events, current triggers, and future needs through lectures, live presentations, and videotaped demonstrations and supervised practice; format of specialized training designed by Francine Shapiro, Ph.D., the originator of EMDR.

Acceptance and Commitment Therapy: Mindfulness and Values in the Treatment of PTSD 10/31/12

Provided By: Robyn Walser, Ph.D.
National Center for PTSD, Dissemination and Training

- Attended full-day pre-meeting institute at International Society for Traumatic Stress Studies (ISTSS) annual conference full-day training in Acceptance and Commitment Therapy (ACT), a structured intervention that applies acceptance techniques to internal experience while encouraging positive behavior change that is consistent with individual values and goals.
- Participated in role-play, case formulation, and interactive exercises in order to better understand the theory and ACT's application to clients with PTSD.

PROFESSIONAL AFFLIATIONS

American College Counseling Association	2012-Present
International Society for Traumatic Stress Studies	2012-Present
International Positive Psychology Association	2009-Present
American Psychological Association	2008-Present
Illinois Psychological Association	2008-Present

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Licensed Mental Health Professionals' Attitudes Toward Rape Survivors

Chapter I: Introduction

Rape, as defined by Talbot, Neill, and Rankin (2010), is a sexual activity that a person does not consent to, or is unable to consent to or refuse; it is one of the most traumatic experiences a person can survive. Rape survivors are 6.2 times more likely to develop Posttraumatic Stress Disorder than survivors of other traumatic life events such as motor vehicle accidents or natural disasters (Kilpatrick, 2000). Although rape survivors may be traumatized from the rape itself, they may also experience additional traumatization after the assault through disbelief by others or being perceived unsympathetically by society. In some cases, others may see survivors of rape as having brought about their own victimization (Grubb & Harrower, 2009). Studies show that about 60% of rape survivors, may keep their victimization hidden, potentially due to these negative perceptions of outsiders (Grubb & Harrower, 2009; Rape, Abuse, Incest National Network [RAINN], 2014).

A significant portion of women experience sexual violence during their lifetime; current data suggest as many as one in three college-age females and, overall, one in five women across their lifespan will experience rape (Centers for Disease Control and Prevention [CDC], 2012). However, other studies have shown the prevalence of sexual assault in the adult population to be closer to 54% (Federal Bureau of Investigation [FBI], 2000). In addition, women in the general population who reported experiencing childhood sexual abuse were 1.4 - 2.1 times more likely to experience a sexual assault in

adulthood (Roodman & Clum, 2001). In clinical samples, women who reported experiencing childhood sexual abuse were 2.3-3.7 times more likely to experience a sexual assault in adulthood (Cloitre, Tardiff, Marzuk, Leon, & Potera, 1996).

The statistics concerning prevalence of sexual assault during certain periods of life (i.e. childhood, college-aged) and across the lifespan vary widely from study to study for a number of reasons, including study recruitment strategies, factors impacting disclosure, and the wording of study questions. For instance, the way a researcher recruits his or her participants can significantly affect the percentages of sexual assault survivors. A researcher who gathers participants from a religiously conservative community may find significant variations in these percentages compared with a researcher who collects participants in a more liberal, feminist-minded group. Participants may report different percentages of sexual assault due to shame or guilt that may be associated with the values of his or her community or cultural background, for instance. Another factor affecting sexual assault disclosures in studies is the identity of the researcher. For example, participants may feel reluctant to report their sexual assault to a researcher whom the participant believes may pass judgment based on gender. Furthermore, factors such as the type of research setting, race of the researcher, and even rapport between researcher and participant may all affect the report rates of participants. Finally, the wording of studies may also affect the reported rates of sexual assault. Depending on the definitions of "sexual assault" or "rape" used in a study, a participant may or may not meet criteria for being a sexual assault survivor. This dynamic is particularly true in state-level courts,

where the definitions of sexual assault vary widely in different jurisdictions; this topic will be further discussed later.

Sexual assaults are associated with a wide range of negative consequences to the survivor. During a most recent sexual assault, 31.5% of women also received an injury, such as bruises, cuts, broken bones, or injury to the genitalia (Tjaden & Thoennes, 2006) Long-term physical symptoms of rape include chronic facial, back, and neck pain, irritable bowel syndrome, and other GI distress (Basile & Smith, 2011). In addition, guilt related to the trauma of being raped has been positively correlated with post-traumatic stress disorder, depression, low self-esteem, social anxiety, and suicidal thoughts (Kubany et al., 1995). With respect to factors associated with better adjustment after rape, published research indicates that the attitudes of police officers, mental health professionals, and the general public may influence the psychological adjustment of the rape survivor and, consequently, whether or not that person seeks mental health treatment (Vincent, 2009).

Negative attitudes or prejudicial views towards rape survivors are commonly referred to as "rape myths," and are widely embedded in cultures across the world. These rape myths give a false idea about the precipitating factors or relevant information with regard to what constitutes rape (McGee, O'Higgins, Garavan, & Conroy, 2011). For example, rape myths deny that rape is injurious to the survivor, and typically place the blame for rape on the survivor (Ellis, O'Sullivan, & Sowards, 1992). Additionally, rape myths tend to shift the focus from the actual assault to aspects of the survivor's character

and role in bringing on the rape (i.e. through flirting, type of clothing worn, or past sexual activity). Some rape myths that are prevalent in Western cultures include the notions that rape is typically perpetrated by a stranger, false rape accusations are prevalent, a survivor has invited his or her victimization through revealing clothing, and that women secretly want to be raped (McMahon & Farmer, 2011). The more stereotypic views about rape and gender a person holds, the less likely he or she is to identify the event as rape, and the more likely he or she is to engage in victim blaming (Mugabyizi et al., 2010).

Compounding the effects of rape myths on survivors of rape is the continued confusion about what constitutes consent. Currently, states differ on the definition of sexual consent and utilize vague terminology to encapsulate what is defined as illegal sexual contact (Jozkowski & Peterson, 2014). For example, in 2014 California was the first state to define consent as an unambiguous, conscious decision by each participant to engage in mutually agreed upon sexual activity, with consent being "ongoing" throughout any sexual encounter; this language constitutes one of the most progressive definitions of consent in the United States (New, 2014). However, in the state of Tennessee, consent is defined as "verbal or physical communication of agreement from a competent person without coercion" (Tennessee Code Title 39, 2010). The difficulty in quantifying both verbal and non-verbal consent to sexual activity perpetuates the hard stance judicial systems often take towards survivors of rape in proving that they were raped (Jozkowski & Peterson, 2014). In court proceedings regarding rape, the survivor may have to prove that he or she did not give consent to sexual activity—a task that may be difficult to

accomplish given the way consent is typically given in society (i.e. making eye contact, both parties taking off their clothes, or no overt consent ever given by either party). Additionally, it may be difficult to prove that consent was not given when it may have, in fact, been given by a survivor who was coerced into giving consent or was not reasonably able (i.e. under the influence of a substance) to give consent.

Rape myths and the attitudes they maintain may silence the rape survivor by perpetuating beliefs that a rape survivor is partially responsible for her or his rape, which may, in turn, inhibit the survivor from reporting the rape. In addition, they may prevent the punishment of the perpetrator by increasing the reluctance of survivors to report the crime or press charges because of a fear of the scrutiny they may experience as a plaintiff, or because attorneys, judges, or juries may not believe that the perpetrator is guilty or the survivor was harmed.

Examination of rape myths, victim blame, and attitudes towards survivors is important because they are all facets of primary prevention education that must be part of the public health approach to sexual violence (Talbot, Neill, & Rankin, 2010). Primary prevention regarding rape can help to stop rape before it starts by providing education about healthy relationships and gender-based violence. Examination of rape myths and attitudes toward rape survivors can also play an integral role in primary prevention by encouraging both men and women to challenge the beliefs they may hold about rape and a person's ability to prevent rape.

Prevention efforts should ultimately decrease the number of perpetrators of sexual assault and the number of individuals who experience sexual assault. The most common prevention programs currently focus on the survivor, the perpetrator, or bystanders. For example, one program, *Safe Dates*, was created by the Substance Abuse and Mental Health Services Administration and is designed to prevent the emotional, physical, and sexual abuse in adolescent dating relationships. Another program, *Coaching Boys Into Men*, was developed by Futures Without Violence and is a dating violence prevention program that uses the relationships between high school athletes and their coaches to change social norms and behaviors (CDC, 2015). Finally, a government-wide bystander initiative, *It's On Us*, calls those on college campuses to reframe the conversation about sexual assault so that it is seen as each person's responsibility to do something to prevent it (The White House, 2014). The goal of sexual violence prevention is simple—to stop it from happening in the first place. The solutions, however, are just as complex as the problem.

Statement of the Problem

Examination of rape myths held among mental health professionals plays an integral role in bringing about such societal changes, as these professionals are oftentimes the first individuals to whom rape survivors disclose their assault (McGee, O'Higgins, Garavan, & Conroy, 2011). Getting a better idea about the attitudes and beliefs mental health professionals hold about rape and rape survivors can help professionals create

education or training models that may assist in providing more competent care, as well as providing survivors with more compassionate support. There is some indication that mental health professionals may already hold views about rape that are somewhat different from those of the general public. Feild (1978), for example, found that rape counselors tended to hold more negative views about rape than the general public, while the general public tended to hold more negative views towards rape survivors than did rape counselors. The current study therefore proposed that those with more training in working with rape survivors would hold more positive attitudes towards the rape survivor population.

Unlike rape counselors, most individuals are not aware of the short- and long-term negative effects rape has on a survivor. For example, studies show that rape survivors may be sexually re-victimized, and oppressed or marginalized due to their survivor status (Grubb & Harrower, 2009). This felt oppression and marginalization might come in the form of overt messages about worth (e.g. being "damaged goods" due to being raped) or covert messages from the media questioning the validity of a survivor's claim to rape. Tolerance toward rape or perpetuation of rape myth acceptance may contribute to the survivor blaming herself or himself for the assault. The impact of rape on a person may therefore not just be specific to the act of violence, but may also include secondary victimization from the survivors' negative experiences with authorities who may hold negative beliefs about rape survivors (Nagel, Matsuo, McIntyre, & Morrison, 2005). Secondary victimization of a rape survivor refers to exposure to beliefs

and attitudes of a social service provider that are victim blaming and insensitive, and which traumatize survivors of violence who are being served by these providers (Campbell & Raja, 1999). Examples of such negative attitudes that authorities may hold (i.e. police officers, or medical professionals) include questioning the survivor's credibility, implying that the survivor deserved to be raped, and belittling the negative impact of the rape experience. If survivors are treated insensitively, met with refusals to help, or given inadequate information, then the system (i.e. judicial or mental health) can compound the harm caused by the rape itself. This secondary victimization may magnify feelings of powerlessness, anger, and guilt, and exacerbate mental health distress (Gekoski, Adler, & Gray, 2013).

Secondary victimization can occur at different points during a survivor's attempt to receive support and help. For example, when a woman is raped on a university campus she may attempt to reach out to others about her sexual victimization. The day after the rape, she may decide to disclose the rape to her roommates. Her roommates may or may not believe her report and may ask questions such as "Tell us what happened," "Who did it?", "Were you flirting with him?", "Did you say 'no' to him?", and "Were you drinking?" These questions may put the rape survivor on the defense, and make her feel as though she needs to defend her own actions.

If this woman is not deterred by the secondary victimization by her roommates, and decides to continue to seek support, she may reach out next to her Resident Assistant (RA), who asks the survivor to, , retell the story of her rape. At this point, the RA gets his

or her Director of RAs involved, which again involves another retelling of the rape. Subsequently, the rape survivor will meet with several offices on campus, including the Student Counseling Center, the Student Conduct Board, the Title IX office, the University Police Department, and the Center for Health, Education, and Wellness. Although many of the people working at these offices will likely be well-meaning, the rape survivor may at this point have retold her rape story more than eight times in less than 24 hours.

In the days following the rape, this survivor may decide to disclose her survivor status to her family and other friends who may place responsibility on the survivor for bringing about her own rape. By this point, the alleged perpetrator of the rape would likely be aware that this woman is taking some kind of action against him. As a result, the rape survivor may experience harassment by the alleged perpetrator as well as his friends. The survivor may be unable to attend classes in which he and his friends are also enrolled, and may have difficulty even going to a university dining hall for fear that she may run into these individuals. Per federal law, the university this survivor attends will be required to send an email to all students, staff, and faculty alerting the campus that a sexual assault has occurred. This email will include details about the date and time of the rape, as well as whether the survivor is pressing charges against the alleged perpetrator.

In addition to these different opportunities, this survivor may experience revictimization when reporting her rape to campus police. The campus police would ask the survivor to retell her story (yet again) in vivid detail, asking for evidence to support

this claim of being raped. During the process of their investigation, the campus police will likely bring in the alleged perpetrator to hear his side of the story, as well as narratives from friends on campus. The experience of having to prove that she was raped may not be the only instance of revictimization for this survivor, but having to get friends involved in reporting the events may open this survivor up to even more experiences of victim blame. This survivor may then be referred by the police, her RA, or a friend to a medical clinic on campus—another potential source of inadvertent revictimization. At the hospital, the survivor will again have to tell the events of her rape, this time while also enduring the embarrassment and trauma that may come along with a physical and pelvic examination.

These are just a few common examples of how a rape survivor may experience secondary victimization after disclosing her survivor status. These experiences do not even take into account the likely revictimization that would occur if the aforementioned survivor decides to press legal charges against her alleged perpetrator, potentially leading to revictimization during the legal proceedings as well as through publicity about the event.

Finally, after this survivor has been through all of these experiences on campus, she may also seek individual therapy services at the university counseling center. This rape survivor may then have to meet with one or two therapists before she is actually assigned to an individual therapist and will, again, have been asked to disclose her rape survivor status. Even if she has a well-meaning therapist, this individual may ask

questions about the survivor's dating relationship with the perpetrator (e.g. "Were you flirting?" or "Had you previously had sex?") and the survivor's alcohol and drug use history, along with questions about her responsibility in the events. These questions may inadvertently reinforce feelings of self-blame, rape myth acceptance, and revictimization.

Campbell and Raja (1999) proposed that secondary victimization might come from three additional sources. First, the researchers suggested that rape myth acceptance among law system personnel (i.e. police officers, prosecutors, medical doctors, or counselors) contributing to making survivors feel as though they were not believable or credible. In addition, secondary victimization was found to result from actions that legal system personnel may take or fail to take. With respect to medical care, many survivors reported not being provided with pregnancy, STD, and HIV testing, along with not being provided with information about the psychological and physical effects of sexual assault (Campbell, 1998). Finally, concerning the survivors who do obtain legal and mental health assistance, little research has been conducted concerning whether those experiences were actually helpful. Cluss, Boughton, Frank, Stewart, & West (1983) found that individuals whose cases were prosecuted endorsed higher levels of mental health distress than those whose cases were not; they attributed this difference to the fact that survivors retold the events of their rape in detail, likely faced their attacker in court, and may have experienced a lack of control in the judicial process. Frazier and Haney (1996) found that even though survivors held positive attitudes towards police officers involved in the investigation, the survivors were frustrated by the response time of the

legal system, which oftentimes took more than several years from the beginning of the judicial process to the court decision.

Statement of Purpose

The attitudes of mental health professionals towards the causes of rape may greatly influence the quality and impact of treatment survivors receive. If mental health professionals are able to challenge rape myths that they, themselves, may hold and gain a better understanding of the pain and powerlessness a survivor experiences, then a professional may be better able to provide empathy and support. For example, a mental health provider may actively check in with himself or herself about internal biases or prejudices when sitting with a survivor, examine the content of media for potential rape myth perpetuation, and challenge those who may endorse rape myths. In contrast, if a mental health professional endorses rape myths, this may lead to secondary victimization for the survivor through the types of questions a professional may ask (i.e. "Were you drinking alcohol" or "Did you lead him on in any way?") and the quality of therapy provided, e.g.,, including an evaluation of the cultural and systemic factors that contribute to rape and its negative consequences, as well as addressing the specific symptoms the survivor is experiencing. Therefore, the present study attempts to examine licensed mental health workers' attitudes toward rape survivors. It is hoped that the data gathered from this study will provide a unique and valuable contribution to this topic on which there is limited published research.

Results of this research may help mental health professionals to better understand that their attitudes towards certain populations (i.e. rape survivors) may impact the work they do with survivors; specifically, negative attitudes toward rape survivors may guide the type of questions a professional asks (i.e. away from the content of the event and more focused on the emotional experience of the rape) and the interventions utilized in the treatment (i.e. instead of challenging beliefs, as is common with cognitive modalities, the professional may focus on a survivor's narrative in order to gain a better understanding of the rape) of a survivor client. The current study also aims to provide the mental health field with more information about the demographic groups most prone to hold negative beliefs and feelings about rape survivors. With this information, it is hoped that graduate programs in psychology, education, and social work, continuing education courses for licensed clinicians, and didactic seminars (to name a few) will place more emphasis on debunking rape myths and promoting competency concerning rape survivor issues.

Hypotheses

Based on previously published literature, it is assumed that several findings from past research will also be evident in the current study. First, research examining attitudes towards rape survivors has reliably shown that men tend to hold more negative attitudes toward rape survivors than female participants, and that men are also more likely to endorse victim blaming than female participants (Ferguson & Ireland, 2012; Grubb & Harrower, 2009; Anderson & Quinn, 2009). It is therefore likely that male participants in

the current study will endorse higher levels of rape myth acceptance. Second, Talbot et al. (2010) and other researchers (Ferguson & Ireland, 2012; Klaw et al., 2005) found a lower level of rape myth accepting attitudes among college students who knew a survivor of sexual violence; this may be because knowing a survivor of sexual violence increases an individual's empathy for a survivor and increases his or her awareness of the stigma and blame that survivors typically experience. Therefore, it is likely that the current study will also find that those who identify as survivors or endorse knowing a survivor will be less likely to endorse rape myths or rape-accepting attitudes. Demographic information regarding mental healthcare providers' field of psychological work, years in the field, and degree type are not variables that have previously been examined in connection with differences in attitudes towards rape survivors; furthermore, there have been no studies published to date that have examined M.A.-level versus Doctorate-level mental health professionals' attitudes toward rape survivors. Due to this lack of data, the current study aims to fill the gap by gathering information regarding the participants' type of degree and how having a family member or friend identify as a rape survivor may be correlated with levels of rape myth acceptance.

Limitations

A limitation of the present study concerns its generalizability to the population of mental health professionals. Because participants can decline to take part in the study, those who participate may be interested in the topic for personal or professional reasons. An assumption of this self-selection is that participants in this study are less likely to

endorse rape myths and survivor blame, compared to the general mental health professional public. Additionally, participants may not respond honestly to statements about rape myths, preferring to present themselves in a favorable light.

It is assumed that mental health professional participants in this study will likely have experience in working with rape survivors, as these professionals tend to work in a variety of settings in which rape survivors may present for treatment. For instance, 22% of women in the military (i.e. VA settings; Kimerling, Gima, Smith, Street, & Frayne, 2007), 20-25% of incarcerated women (i.e. prison settings; JDI, 2009), and over 50% of Native American/Indian women (i.e. reservation settings; CDC, 2010) have experienced a sexual assault. With data gathered from the current study, conclusions may be made regarding the attitudes of individuals working to ameliorate survivors' psychological symptoms as a result of being victimized. Therefore, based on previous research with community individuals', law enforcement workers', and mental health professionals' attitudes towards rape survivors, the following hypotheses were generated for this study:

1. Male participants will score statistically significantly lower (with lower scores denoting higher acceptance of rape myths), on average, on the Illinois Rape Myth Acceptance Scale (IRMA), compared with female participants.
2. Master's-level participants will score statistically significantly lower, on average, on the IRMA than doctoral-level participants.

3. Participants identifying as rape survivors will score statistically significantly higher, on average, on the IRMA than participants that do not identify as rape survivors.
4. Participants identifying as having a close friend or family member who is a rape survivor will score statistically significantly higher, on average, on the IRMA than participants that do not identify as having a close friend or family member who is a rape survivor.

Chapter II: Review of the Literature

Definition and Prevalence of Rape

Definitions of rape vary from state to state and have changed significantly over the years (Anderson, Cooper, & Okamura, 1997). In 1980, Burt defined rape as "the act of sexual intercourse committed by a man with a woman not his wife and without her consent." (p. 218). More recently, Talbot et al. (2010) defined rape as when a "victim does not consent to the sexual activity or when the victim is unable to consent or refuse." (p. 170). In the state of Illinois, sexual assault is defined as "sexual penetration by force or threat of force or an act of sexual penetration when the victim was unable to understand the nature of the act or was unable to give knowing consent." (Illinois Criminal Code, 2012; Ch. 38, par. 10-5).

Varying perspectives on what constitutes rape often influence the blame attributed to both survivors and perpetrators. Therefore, due to the lack of consistency regarding definitions of rape and consent across countries, states, counties, and communities, attitudes toward rape survivors can widely vary (Anderson et al., 1997).

A significant portion of women experience sexual violence during their lifetime; current data suggest that this number is as high as one in three college-age females and, overall, one in five women across their lifespan (Centers for Disease Control and Prevention, 2012); of those rapes, it was estimated that 70% were perpetrated by non-

strangers. Further, 30% of college men interviewed by Briere and Malamuth (1983) reported that they would rape a female if they could be assured that they would never get caught. One study (Tjaden & Thoennes, 2000) showed that more than 300,000 women are sexually assaulted each year and that more than half the attacks (62%) are committed by someone the survivor knows. In clinical samples, women who reported childhood sexual abuse were 2.3 - 3.7 times more likely to experience sexual assault in adulthood (Cloitre, Tardiff, Marzuk, Leon, & Potera, 1996); further, 59% of women reporting sexual assault were assaulted in both adulthood and childhood (Wyatt, Guthrie, & Notgrass, 1992).

In the United States, 61% of all rapes occur before the age of 18 and 29% of forcible rapes occur before the age of 11 (Acierno, Resnick, Kilpatrick, Saunders, & Best, 1999). Additionally, oppressed or marginalized populations are at higher risk for sexual assault and rape. Specifically, about 31% of gay, lesbian, and bisexual persons reported experiencing childhood sexual abuse, 30% experiencing sexual assault in adulthood, and 38.5% had experienced both (Heidt, Marx, & Gold, 2005). Not only have individuals from the LGBTQ+ community experienced high rates of sexual assaults; women identifying as Native American endorsed a sexual assault rate of over 50%. Women in the military also experience sexual assault (while enlisted) at a rate of over 20%, (CDC, 2010), while 20-25% of incarcerated women and 4-20% incarcerated men experience rape while in custody (Wolff, Blitz, Shi, Bachman, & Siegel, 2006).

Theoretical Frameworks of Rape

In order to better understand the characteristics of both the perpetrator and survivor of rape, and the attitudes individuals associate with survivors, taking a step back to examine current theories and causes of male sexual assault is necessary. Unfortunately, little research has been published that examine the theoretical underpinnings of male on male sexual violence or females as perpetrators. This is most likely due to the higher incidence of females as survivors (one in three) versus males (one in 33; National Institute of Justice, 2010); therefore, most of the following research addresses male-on-female sexual violence.

Evolutionary, psychoanalytic, and feminist frameworks of violence toward women are useful tools to guide understanding of the relationship between individual differences (i.e. influenced by environment and biology) and rape attitudes (Anderson et al.,1997). The evolutionary perspective focuses on maximum reproductive success, and asserts that men have evolved to compete with one another for sexual access to females, increasing the perceived need for dominance over other males (Smuts, 1992). Because a male wants to maximize his success in being sexually active with a female, it is in his best interest to discourage female partners from expressing physical or sexual interest in other men, so as to decrease the likelihood of another male's success with the same mate. Anderson, Cooper, and Okamura (1997) further posited that men who hold traditional sex role views about women may believe that women with multiple sexual partners are likely to be victims of occasional violence from men, due to men's behavioral expression of their sexual needs (i.e. the more sexual partners a woman has, the greater her chances for

rape due to the fact that men cannot control their sexual urges). Their study (Anderson et al., 1997) conducted a meta-analysis of data from 72 studies of rape attitudes and individual differences, and found that, for men, a cognitive predisposition towards rape perpetration was a strong predictor of rape acceptance. Additionally, this study's meta-analysis supported a finding that traditional gender role beliefs, including a need for power and dominance, as well as high levels of aggressiveness and anger, and conservative political beliefs, predicted rape acceptance. Although these findings were consistent with more contemporary published literature, it should be noted that the 72 studies chosen utilized numerous types of attitudinal scales, versus a single common measure. Because of this limitation, there were reliability-related concerns with comparing the various findings of each study.

In addition to the evolutionary framework of male propensity for aggression towards women, another psychological framework that is congruent with Anderson et al.'s (1997) findings is a somewhat dated psychoanalytic theory that held that a women in the man's past (typically, a mother) had wronged a male perpetrator, and that he therefore exhibited violent behaviors against women as a means of retaliation against these women from the past (Check, 1988).

Finally, the feminist perspective attributes the cause of male perpetration of sexual violence to social conditions. In most contemporary cultures, sex roles and patriarchal beliefs have served to reinforce unequal power distributions between men and women (Anderson et al., 1997). Because of this unequal power distribution, it can be

theorized that men aim to maintain dominance over women for the purpose of satisfying societal norms, as men believe that this is expected of them by their dominant culture (Burt, 1980); they may therefore accept the use of force to dominate women sexually and encourage various types of exploitation, such as threatening, taking advantage of, and oppressing women (Blumberg & Lester, 1991).

A vast majority of contemporary cultures are characterized by a patriarchal system, consisting of male-dominated power structures throughout society and individual relationships (Boakye, 2009). Rape myths stemming from patriarchal systems tend to justify sexual coercion and demean and devalue women who are survivors of sexual assault (Boakye, 2009). Anderson et al. (1997) completed a theoretical paper that also found support for a political theory, positing that more conservative attitudes toward general political issues were positively correlated with rape myth acceptance, as more conservative individuals tend to support patriarchal attitudes and beliefs. In support, Talbot et al.'s (2010) study examining over 1600 college students' rape-accepting attitudes found that respondents who were more liberal in their gender role beliefs were less accepting of rape myths and rape-accepting attitudes. This finding was determined through gathering demographic information from participants, as well as having participants complete the Attitudes Toward Women Scale (Spence & Hahn, 1997) and College Date Rape Attitude Survey (Lanier & Elliott, 1997). Though the Attitudes Toward Women Scale had good internal consistency with a Cronbach's alpha of 0.83, the College Date Rape Attitude Survey reportedly had a much lower internal consistency of

0.67 (moderate), bringing into question one of the measures implemented in the study. According to Talbot et al. (2010), individuals' agreement or disagreement with rape myths, coupled with their view of gender roles, affected their attribution of responsibility for rape.

Weiner's Attribution Model, Defensive Attribution Theory, and Just World Theory

Understanding the social forces that continue to promote rape and rape-accepting attitudes aids in combating perpetration of sexual violence (Ullman, 2010) through making it possible to take a closer look at the insidious messages about rape and challenge these social forces. An important aspect of rape that continues to perpetuate stigma for survivors is that perceived victim responsibility (i.e. victim blame) reduces the credibility of survivors. Weiner (1985) proposed an *attribution model* that suggested that individuals will tend to attribute an event to some controllable cause, thereby providing the observer with some sense of control over life events (Sperry & Siegel, 2013). Attributing an event such as rape to a controllable cause may result in reduced sympathy and increased anger towards the survivor, therefore increasing stigma and blame. Essentially, this model assumes that survivors behaved in such a way as to provoke the sexual assault, and if they had behaved in a different way, the rape would not have occurred. For example, a common scenario in which Weiner's attribution model applies would be illustrated by the belief that if a female survivor had not been drinking alcohol and flirting with her perpetrator, she would not have been raped. This way of thinking may also help explain why women also hold rape myths, even though they are likelier to

be raped than men; holding these beliefs may give them a false sense of control and safety.

Another theory, Shaver's (1970) *Defensive Attribution* model, states that attitudes of blame towards survivors decrease the more individuals perceive themselves to be more similar to the survivor. Conversely, those who see themselves as different from the survivor will increase their negative perceptions about the survivor and increase blame toward the survivor. This theory is based on ego defensiveness, or holding attitudes that protect our self-esteem or that justify actions we have taken that make us feel guilty, and the belief that if a similar event happened to the observer, that observer would not be blamed. According to Lerner and Matthews (1967), the *Just World* theory assumes that individuals have a need to believe that the world is a just place and that outcomes are deserved based on the person's behaviors. Research consistently supports the concept that rape survivors are more likely to be seen as genuine in their claims if they are perceived as having done nothing to deserve the assault (Stewart, Dobbin, & Gatowski, 1996). Similar to the theories described above, the Just World perspective also serves to maintain a sense of purpose and control over the environment in those who hold it. These theories help combat the observation that bad things can happen to good people, as this thought proves too chaotic and threatening for an individual's sense of self-control (Grubb & Harrower, 2009).

This propensity to blame victims translates into a culture in which survivors are revictimized, the actions of perpetrators are often met with insufficient consequences, and

rape is stigmatized. For example, many survivors of rape can experience revictimization in mental health settings, especially when a clinician is not competent in trauma work. A therapist who is not trauma-informed may revictimize clients by asking detailed questions about the rape without assessing if a person is ready to disclose details, may question why a person did not report the rape to the police, or may put the person on the defense about her or his actions during the time of the rape (i.e. having to explain why he or she was at a certain place, why she or he did not fight back, or why he or she did not report the rape); this revictimization of rape survivors by mental health professionals adds to the culture of victim blame. Additionally, perpetrators of rape are often met with little or no consequences; factoring in unreported rapes, only about 3% of rapists will ever serve time in jail (RAINN, 2014), sending a clear message to perpetrators that they will likely not get caught or charged with jail time.

A study by Grubb and Harrower (2009) found that the forces of the attribution and just world models continued to shape people's views towards survivors of violent crimes. These researchers conducted a study of 156 university student participants who were recruited by offering extra credit in an undergraduate psychology course, consisting of about 67% female-identified participants, and gathered information regarding gender and attitudes toward rape survivors, survivor responsibility, victim blame, and perception of survivors. Through the use of the Attitudes Towards Rape Victims Scale (Ward, 1988), demographic questions, and a vignette of a woman being raped, they found that participants endorsed a need to psychologically defend (i.e. by psychologically distancing

themselves from the survivor) against the fact that random misfortune could happen to them and that they would be held responsible if they became victims of a violent crime (Grubb & Harrower, 2009)—a belief that allowed individuals to make sense of chaos and feel in control of their futures. Unfortunately, the correlational nature of the study limited the ability to assess causality between demographic information and the various dependent variables. Additionally, the use of a vignette limited the generalizability of these findings, as the vignette was not a real-world example—the vignette was created by the researchers and reflected a story of a stereotypical survivor (i.e. raped by a stranger at night; the woman was described as dressing seductively and depicted as attractive).

Similar to the aforementioned findings, Miller, Amacker, and King (2011) reported that participants who rated themselves as more similar to sexual assault survivors attributed less culpability to survivors for their assaults. Miller et al.'s (2011) finding is congruent with the previous study from Grubb and Harrower (2009), as individuals had a tendency to either see themselves as dissimilar to a rape survivor or attributed less responsibility to a survivor similar to themselves.

Miller et al.'s (2011) sample was composed of 69 female undergraduate student participants, recruited via campus fliers, who were asked to complete a demographics questionnaire (including questions about their personal survivor statuses), asked to read a short vignette regarding a rape, and then asked to complete both the Illinois Rape Myth Acceptance Scale (McMahon & Farmer, 2011) and Rape Empathy Scale (Dietz, Blackwell, Daley, & Bentley, 1982). Although both these measures have strong internal

validity (Miller, Amacker, & King, 2011), a significant limitation of this study was that the researchers did not have participants complete the measures pre- and post-vignette. Because of this, the researchers cannot report any reliable findings regarding perceived similarity to a rape survivor, as it would be impossible to say whether or not the vignette affected perceived similarity, due to not having both pre- and post-vignette data to show any effects the vignette may have had.

Benevolent Sexism

Another mindset important to examine when looking at how attitudes towards rape survivors are shaped is *benevolent sexism*, a set of beliefs about women that are subjectively positive, but stereotypical in that notions of acceptable behavior for women are restricted by their dominant cultures (Masser, Lee, & McKimmie, 2010). These restricted roles are based on the covert and overt messages women receive throughout their lives, from what to wear and how to behave, to what careers to pursue and lifestyles to lead. Those who endorse benevolent sexism views tend to see women as ideally pure and sexually inexperienced, or disinterested in multiple sexual partners. This type of sexism is not overtly hostile against women, but instead holds the expectation that women will fit into certain roles, like being nurturing or needing protection by men. Previous research on this concept by Abrams, Viki, Masser, and Bohner (2003) considered the impact of benevolent sexism on attributions of blame for rape and found that individuals who scored highly on benevolent sexism scales attributed more victim blame when presented with rape victim scenarios; benevolent sexism was associated with

more conservative expectations about women. Abrams et al. (2003) conducted three studies investigating the relationship of benevolent sexism to acquaintance rape victim blame by utilizing a rape vignette, the Ambivalent Sexism Inventory, and the Rape Myth Acceptance Scale. The researchers found a positive relationship between benevolent sexism and victim blame for acquaintance rape ($t[32] = 4.41$, $p < .001$). It is difficult to identify significant limitations of this study, given that it was replicated three times and utilized a vignette that reflected a real-world rape scenario.

Masser, Lee, and McKimmie (2010) further explored Abrams et al's (2003) topic by conducting a pilot study examining levels of benevolent sexism in men and women, enlisting 120 participants from the general population who were recruited from psychology list-serve emails. In addition to reading a vignette, these participants were asked to complete numerous measures, including the Ambivalent Sexism Inventory (Glick & Fiske, 1996), Costins' R (a rape myth acceptance scale; Costin, 1985), and questions regarding the perceived gender of the person in the vignette and the victims' stereotypicality. In addition to benevolent sexism findings, the researchers also concluded that stereotypical victims (i.e. feminine, weak, attractive) tended to be blamed less than counter-stereotypical victims. With respect to limitations, it is possible that a counter-stereotypical rape survivor may have drawn a participant's attention away from key details of the vignette, affecting levels of victim blame due to being distracted by the identity and descriptors of the survivor.

Not only has benevolent sexism been shown to be associated with attitudes towards rape survivors, but it has also been shown to be associated with attitudes toward perpetrators. Several recent studies have found that high benevolent sexism scores were correlated with attributing less responsibility to a perpetrator (Viki, Abrams, & Masser, 2004). Viki, Abrams, and Masser (2004) posited that this attribution of less responsibility to a perpetrator was likely connected to the belief that women should typically be in situations in which the likelihood of consensual sex was high (i.e. at home) because traditional gender role expectations hold that women should be at home rather than out in the world (i.e. at a job). Additionally, the researchers posited that attributing more responsibility to a survivor may be connected to the belief that that women should be able to protect themselves in "safe" environments (i.e. at home). How benevolent sexists evaluate rape survivors is also influenced by the person's beliefs about appropriate sexual behaviors for women. Viki et al. (2004) examined the role of benevolent sexism on rape perpetrator blame with 85 university students in England. The researchers measured these constructs through the use of the Ambivalent Sexism Inventory (Glick & Fiske, 1996) and several vignettes about a rape (acquaintance and stranger as perpetrators). Viki et al. (2004) noted that "bad" girls (i.e., women who drink alcohol and engage in sexual activities) might be more often blamed for their victimization than "good" girls (i.e., women who abstain from alcohol, drugs, and sexual activities), and that rape survivors assaulted by an acquaintance may be seen as partially responsible for their own assault, due to the potential for consensual sex because the survivors may be perceived as

interested in sexual activity since they already have an established relationship with the perpetrator. A limitation of the study (Viki et al., 2004) was the use of two different vignettes that may have resulted in unintended differences in stimuli for each fictional assault; because of this, each vignette may have not been portraying exactly what the researchers intended. Because each vignette was slightly different, it is a limitation of the study to compare the data to one another given that the details of each rape were not comparable.

Viki et al.'s (2004) findings are consistent with cross-cultural literature. One study found that benevolent sexism in Turkish students also predicted more negative beliefs and increased victim blame towards rape survivors (Sakalh, Yalcin, & Glick, 2007). Sakalh, Yalcin, and Glick (2007) examined ambivalent sexism, belief in a just world, and empathy toward rape survivors in a population of 425 Turkish college students through the Ambivalent Sexism Inventory (Glick & Fiske, 1996), Belief in a Just World (Rubin & Peplau, 1975), and Rape Victim Empathy (Dietz et al., 1982) scales. In addition to benevolent sexism being related to rape victim blame, the researchers also found that men generally held less positive ($p < .05$) attitudes about rape survivors, more hostile sexism, and less empathy than female participants. A main limitation of this study, however, is the population and the inability to generalize these findings to other populations, as the participants' beliefs may have been heavily influenced by Turkish culture.

Rape Myth Acceptance

It has been established that, regardless of gender, endorsing rape myths is strongly associated with victim blaming (Blumberg & Lester, 1991). Rape myths are essentially false beliefs that are widely held and serve to justify the actions of a perpetrator and place blame on the victim (Talbot et al., 2010). According to research, those who have a high level of rape myth acceptance have a more restrictive definition of sexual violence, as they may hold more clear-cut ideas about consent (i.e. clear "no" or fighting back) or may not consider, for example, unwanted touching as a sexually violent crime. Essentially, those who endorse rape myth acceptance more narrowly define "sexual violence" and may not consider actions such as inappropriate touching or nonconsensual oral sex as part of the definition (Ferguson & Ireland, 2012). Therefore, it can be extrapolated that these individuals may not view these previously mentioned sexually aggressive behaviors as sexual violence. This is important to note, as a narrow definition of sexual violence can create a culture of acceptance and even bias against those who report sexual violence.

Rape myth acceptance has also been associated with sexism, racism, homophobia, religious intolerance, and antifat attitudes (Clarke & Stermac, 2011), all attitudes that are consistent with conservative backgrounds. Briere and Malamuth (1983) found a connection between rape myth acceptance and use of force during sex, finding that men who had a higher level of rape myth acceptance were more likely ($M = 70.9$, $p < .05$) to rape than those who had a lower level of rape myth acceptance. The researchers aimed to gather data about sexually aggressive behavior in men through the use of the Rape Myth

Acceptance (Burt, 1980) scale, Acceptance of Interpersonal Violence Scale (Burt, 1980), and Adversarial Sexual Beliefs (Burt, 1980) scale with 352 male undergraduate students. Men who held higher levels of rape myth acceptance were, it was posited, more likely to rape due to their belief that women were partially responsible for their assaults and that men had difficulty controlling their sexual urges (Briere & Malamuth, 1983).

The belief that women are partially responsible for their assaults may contribute to survivors of sexual assault being reluctant to report the crime and seek support, actions which can play an important role in a survivor's recovery. Survivors choose not to report their assaults for a multitude of reasons, including feeling responsible for the assault, experiencing mental health distress that is overwhelming, or not wanting to undergo scrutiny and questioning.

Most rape myths fall into three categories: (1) blaming the victim; (2) absolving the perpetrator of responsibility; and (3) justifying the sexual violence (Talbot et al., 2010). Blaming the victim entails individuals attributing partial (or full) responsibility to a rape survivor, based on actions or events that may have been in the survivor's control, such as alcohol or drug use or type of clothing worn. Oftentimes perpetrators are completely released by others in the culture from responsibility for a sexual assault; this absolution can occur for a number of reasons such as the power or privilege of the perpetrator (i.e. beloved athlete or powerful politician) or the belief that men have difficulty controlling their sexual urges and, as such, cannot help themselves from wanting to engage in sexual activity. Finally, rape myths can fall into the category of

justifying the sexual violence, or making excuses for the rape. Some common justifications of sexual assault include the belief that a woman was "asking for it" based on what she was wearing or that the survivor had been flirting with the perpetrator (Talbot et al., 2010).

A culture of rape acceptance continues to be widely supported in many societies due to the perpetuation of these myths that maintain power for patriarchal societies and gender role stereotyping. One study (Blumberg & Lester, 1991) found that high school males blamed the victims of rape more than their female high school counterparts, and also agreed more strongly with rape myths. Blumberg and Lester (1991) explored the rape myth acceptance in a sample of about 100 high school and college students using the Rape Myth Acceptance Scale (Burt, 1980). In addition to high school males endorsing higher levels of rape myth acceptance than high school females, the researchers found that both the male and female college student sample was less likely ($p < .001$) on average to endorse rape myth acceptance than the male high school population. However, a significant limitation of this study was the limited sample size of each of the four independent populations.

McGee, O'Higgins, Garavan, and Conroy (2011) found similar results in a study that utilized a randomized phone interview of adult participants. The design of this research was a cluster-randomized telephone study in which the researchers read to the participants' statements regarding perpetrators of rape, motives behind rape, and other statements regarding rape. There were 3,120 participants in the overall sample, with 51%

comprised of female-identified individuals. A limitation of this study was that the 20 questions created by the researchers did not undergo any rigorous qualitative methodology before implementation, calling into question the reliability and validity of the questions asked. However, McGee et al. (2011) found that, in keeping with most literature, men were more likely ($p = .031$) to endorse rape myths than women. This result was determined using a Chi-Square analysis on responses between men and women on the statements read via phone regarding rape.

Another study that supported McGee et al.'s (2011) findings regarding gender differences was one by Ellis, O'Sullivan, and Sowards (1992) that asked college students to rate the truth about rape myths. The researchers gathered data from 151 participants, 33% identified as male, and asked these participants to complete the Rape Myth Acceptance Scale (Burt, 1980), Adversarial Sexual Beliefs Scale (Burt, 1980), and Acceptance of Interpersonal Violence (Burt, 1980) scale. Similar to previous literature, the researchers found that women who participated in this study tended to disagree more strongly ($M = 5.6$) with rape myths than men ($M = 4.9$; $p < 0.001$). Of the participants, 46% knew someone who had been sexually assaulted, potentially limiting the generalizability of this data as participants may have been more emotionally invested in the subject matter. Cross-culturally, these findings seem to persist, as evidenced by a recent survey conducted in Ghana (Boakye, 2009) with 210 participants; a limitation of generalizability to the study was that the local city population consisted of over 3 million inhabitants, making this small sample size unrepresentative of the population in Ghana.

These participants were asked to complete both the Illinois Rape Myth Acceptance Scale (McMahon & Farmer, 2011) and the Attitudes Towards Rape Victims Scale (Ward, 1988), along with a demographics questionnaire. Boakye (2009) found that male respondents more commonly trivialized rape by downplaying its physical and psychological effects on a survivor and were less likely to believe that rape was on the increase, even though official studies in Ghana suggested that this was the case.

Male Survivor Rape Myth Acceptance

In the late 1980s, researchers began to look at the association between gender and individuals' attitudes towards the survivor. Research suggested that male rape survivors who did not fight back against a male perpetrator were assigned more victim blame than the perpetrators themselves (Sleath & Bull, 2010), as the participants felt that male survivors either could have fought back or must have played a large role in their own sexual assault by sending mixed signals to their perpetrators. The biases projected onto male rape survivors are likely to be a main motivator for the underreporting of rape by men who have been raped (Sleath & Bull, 2010). Some male rape myths noted by Pretorius (2009) included: (1) men's physical size and strength means that they are unable to be overpowered into having sex; (2) men cannot be targeted for rape since they are the instigators of sexual activity; (3) male rape is rare; and (4) men only get raped in prison. The Male Rape Myth Acceptance Scale, developed by Melanson (1999), is similar to the Illinois Rape Myth Acceptance Scale (McMahon & Farmer, 2011) in that it utilizes 22 statements about male rape survivors and has participants rate their level of

belief on a Likert Scale. An example of one male rape myth item is "A man can enjoy sex even if it is being forced on him." By utilizing the Male Rape Myth Acceptance Scale with 116 male and female participants, Sleath and Bull (2010) found that male rape myth acceptance was a strong predictor for victim blaming, just as it is in the case of female rape survivors. Further, they found that the more male rape myths were accepted, the less participants blamed perpetrators for the sexual violence. A limitation of their findings was that research in the area of male rape myth acceptance is scarce, making it difficult to compare these findings with other studies, as there is little previously published research to compare it to.

Davies, Gilston, and Rogers (2012) conducted a study with undergraduate students, examining their attitudes toward both male and female rape survivors, as well as rape myths for both genders. The respondents were 323 undergraduate students from a large university that completed several scales, including: Male Rape Myth Scale (Melanson, 1999) and Illinois Rape Myth Acceptance Scale (McMahon & Farmer, 2011), Affective Reactions Toward Gay Men Scale (Davies, 2004), Social Roles Questionnaire (Baber & Tucker, 2006), Ambivalent Sexism Inventory (Glick & Fiske, 1996), and Ambivalence Toward Men Inventory (Glick & Fiske, 1999). Study results found that men were more blaming ($p < .05$) of a hypothetical male rape survivor and considered sexual assault to be less severe than female participants did. However, even though men expressed more negative bias toward male survivors, the study found that females also held more negative biases toward male survivors versus female survivors (Davies,

Gilston, & Rogers, 2012). This may be due to the relatively limited amount of public discussion related to male sexual assault survivors. Because of this, it may be that both men and women hold higher levels of victim blame towards male rape survivors. Though the authors incorporated valid and reliable scales to cover various constructs, the Ambivalent Sexism Inventory and Ambivalence Toward Men Inventory were not used in their entirety, which could have led to incomplete conclusions on the participants' attitudes about these constructs.

Male survivors of rape are less well represented in published studies than are females (Abbas & Macfie, 2013). This lack of literature may likely be due to the lower occurrence of rape in males and the unwillingness of men to report rape or seek treatment for it, due to previously mentioned stigma surrounding male rape survivors. McGee et al. (2011) reported that even though 90% of their 3,120-person telephone sample agreed that men could be raped, several male (as survivors) rape myths were highly endorsed by the sample. Some examples include a 25% endorsement rate by male participants of the statement, "A man who is sexually assaulted by another man must be homosexual or have been acting in a gay manner,." and a 40.3% endorsement rate by male participants of the statement, "Men are less affected by the experience of sexual assault than women." Based on this current finding, it would seem that the gap in general knowledge about male rape myths still must be addressed.

Physical Appearance, Sex, Age, Education Level, and Survivor Status

In addition to gaps on research regarding men as survivors of sexual assault, little research has been published regarding the connection between attitudes toward rape survivors and other variables such as physical appearance, age, and education level. Past research has consistently found that when survivors are depicted as attractive (versus unattractive), these survivors are seen as careless, provocative, and responsible for bringing their assault upon themselves (Clarke & Stermac, 2011), potentially due to the assumption that an attractive woman may wear revealing clothing or behave in a flirtatious manner.

Conversely, some studies have found that attractive people were viewed as less responsible for their assault and more credible than those seen as unattractive (Vrij & Firmin, 2001). Vrij and Firmin (2001) measured the impact of physical attractiveness of rape survivors on impression formation in alleged rape cases. In the study, 80 participants were exposed to an extract of a rape survivor's disclosure about her alleged rape case and information about the survivor's appearance. The Rape Myth Acceptance Scale (Burt, 1980) was used in conjunction with several questions (i.e. "How careful do you think the woman was?", "Do you think the man is guilty?", and "Do you believe the story of the woman?") to assess attitudes toward the survivor. In general, both genders in this study showed a tendency to perceive evidence against a perpetrator as stronger when the rape survivor was seen as physically attractive, though gender findings were congruent with other literature in that men in this study still held more negative attitudes toward rape survivors than females. A limitation of this study was the conclusion made about the

connection of physical attractiveness and victim blame; this data was not correlational and, therefore, cannot be viewed as physical attractiveness having a direct impact on a rape survivor's responsibility.

Like physical attractiveness, data regarding survivor weight seems to be contradictory with respect to assigning more blame to thin versus overweight survivors. Some studies found that participants see an overweight survivor as undesirable and, thus, an unlikely victim, who may have provoked his or her assailant (Clarke & Lawson, 2009). Clarke and Lawson (2009) measured 173 female participants' judgments of a sexual assault scenario using a vignette of a rape, the Anti-Fat Attitudes Scale (Morrison & O'Connor, 1999), and the Rape Myth Acceptance Scale (Burt, 1980). Participants from this same study felt that a heavier individual should have had the size and strength to ward off a perpetrator, while an individual depicted as thin may have been less likely to be able to defend himself or herself. However, a more recent study performed by the same first author, Clarke and Stermac (2011), found that participants, regardless of participant gender, attributed greater responsibility ($p < .05$) to the survivor and less responsibility to the perpetrator when the survivor was depicted as thin. A possible explanation for this finding is that a thin woman may be deemed a more likely target for rape due to her stereotypically attractive physique; participants may have also expected a thin survivor to be more cautious in interpersonal relationships, so as not to invite an unwanted sexual experience (Clarke & Stermac, 2011).

The research conducted by Clarke and Stermac (2011) included a sample of over 400 Canadian residents, with about 70% of the participants identifying as female. This study utilized a mock police report, the Illinois Rape Myth Acceptance Scale (McMahon & Farmer, 2011), the Antifat Attitudes Scale (Morrison & O'Connor, 1999), and a social desirability scale to measure attitudes toward rape survivors. In addition to body size, data in this sample supported that men held more negative attitudes towards rape survivors ($p < 0.001$), stronger anti-fat attitudes ($p = 0.024$), and a greater degree of rape myth acceptance than women ($p < 0.001$). A limitation of this study was the use of a hypothetical scenario comprised of various clinical reports, as the researchers stated that the findings would likely be more accurate with the implementation of a real-world vignette shaped by consultations with rape survivors and legal professionals. Although the literature on gender supports men holding more negative bias towards rape survivors than women, the literature on both physical attractiveness and weight is not as conclusive.

The gender of the participant is a variable that has consistently been shown to be associated with attitudes toward rape survivors. Nagel, Matsuo, McIntyre, and Morrison (2005) conducted a study focusing on how the relationship between gender, race, and culture and the attitudes individuals held towards survivors. This study gathered data from 220 participants in the Midwest and utilized the Attitudes Toward Rape Victim Scale (Ward, 1988) and a demographic questionnaire to measures attitudes toward rape survivors; of this sample, about half of the participants identified as male. The

researchers found a significant relationship between the gender of the participant and attitudes toward survivors, indicating that men (M = 49.43 White-identified, M = 58.67 African American-identified) held more negative views ($p < 0.001$) about rape survivors than females (M = 45.40 White-identified, M = 45.74 African American-identified). Additionally, the researchers found that African American male participants were more likely ($p < 0.05$) to attribute blame to rape survivors than their White-identified counterparts. Several limitations of this study should be considered when interpreting these results. First, a majority of the respondents identified as highly educated, which may have affected their views on rape survivors (though there is currently insufficient published literature to support this limitation), as they may have had more access to literature about the effects of rape. Additionally, the researchers had a 20% response rate which highlighted the fact that many may not have self-selected into the study due to exceptionally negative attitudes toward rape survivors; including these individuals in data collection and analysis may have shown even greater differences in mean scores.

Another study found similar results, in that females held more rape-intolerant attitudes than males, and reported higher empathy scores than males (Ching & Burke, 1999). These researchers gathered attitudinal data from 387 college students using the Attitudes Toward Rape (Burt, 1980) questionnaire and the Rape Empathy Scale (Dietz et al., 1982). Although Ching and Burke's (1999) findings that women held more rape-intolerant attitudes than males ($p < .05$) and reported higher empathy scores than males ($p < .05$) were consistent with other published literature on the subject, a limitation of this

study was that the sample population was from a Human Sexuality course, which may have resulted in selection bias due to the students' probable preexisting interest in the topic—it may be that participants who were enrolled in the Human Sexuality course have a greater understanding of sexuality and, potentially, sexual assault, than other college students not enrolled in the course. .

Other variables assessed in previous studies about attitudes toward rape were age, level of education, and survivor status. Nagel et al. (2005) found that younger participants expressed less negative attitudes toward victims of rape than older participants ($p = .03$). Another study supported this finding, showing that older (age 26 and above) participants of either gender were twice as likely ($M = 2.23$ versus $M = 4.20$) to show negative social reactions (as assessed by the College Date Rape Survey; Lanier & Elliott, 1997) to rape survivors as participants age 25 and below (Mugabyizi et al., 2010). Mugabyizi et al. (2010) gathered data from a population over 1,000 Tanzanian individuals regarding their attitudes about rape survivors. Though this study was consistent with more contemporary findings (Nagel et al., 2005), the Tanzanian population is not representative of most populations, making Mugabyizi et al.'s data non-generalizable to other populations, as East African attitudes may not be representative of most cultures across the world. It is worth noting that Ching and Burke (1999) did not find a significant difference by age on attitudes toward rape survivors. It is possible that explanations for the age differences may be attributed to cohort effects and the growing trend to educate the public about the consequences of rape.

Level of education was isolated in one study and found to have no significant relationship with attitudes toward rape survivors (Mugabyizi et al., 2010). However, another study found that participants with more education held more positive ($p < .05$) attitudes towards rape survivors than those who were less educated (Miller et al., 2011). As with physical appearance, weight, and age, level of education is a variable that seems to have different associations in different studies. As previously stated, there has been extremely limited published research that examines these variables. One variable that seemed to be consistent across published literature was participant survivor status. Several studies have found that participants who identified as survivors of rape reported greater empathy, rape-intolerant attitudes, and increased perceived similarity toward rape survivors than participants who did not identify as survivors, as measured by the Attitudes Towards Rape Victims Scale (Miller et al., 2011; Talbot et al., 2010; Nagel et al., 2005).

Professional Status

Examining the attitudes that police officers, medical doctors, and mental health professionals hold toward rape survivors is important, as these individuals are likely to interact with survivors and thereby impact survivors' physical and psychological functioning. The attitudes that medical professionals hold about rape survivors may affect the likelihood of a survivor seeking medical attention for a rape or associated complications of the rape. These professionals may affect a survivor's likelihood of seeking services due to experiences of secondary victimization perpetrated by the

professional or, conversely, having an experience with a trauma-informed professional who helps the survivor feel comfortable and safe. Additionally, police officers, medical professionals, and mental health professionals who engage in revictimization of rape survivors may impair a survivor's psychological functioning (Feild, 1978). For example, revictimization of a survivor by any of these professionals may include repeatedly asking the survivor to recount his or her rape. By requiring a survivor to repeatedly recount his or her assault, this may result in increases in anxiety or depressed mood. Feild (1978) collected data from 1,448 police officers, crisis counselors, and community citizens in one of the first studies examining attitudes toward rape and found that police officers who had not attended any psychoeducation courses concerning sexual violence were more likely to report that rape survivors had a responsibility to thwart a perpetrator's advances. The attitudinal data was collected through the use of the Attitudes Toward Rape (Burt, 1980) questionnaire, a rape knowledge test, the Attitudes Toward Women Scale (Spence & Helmreich, 1972), and a demographic survey. Due to the large sample size, many of Feild's (1978) significant findings may have been observed simply due to the large sample size of this study. However, this study also found that the rape counselors held the strongest beliefs against rape ($p = .003$; a finding congruent with more current literature), while citizens tended to attach a negative stigma ($p = .07$; i.e. promiscuous or asking for the assault) to rape survivors (Feild, 1978).

White and Kurpis (1999) surveyed 123 medical (n = 78) and mental health trainees (n = 45) and 740 medical and mental health professionals in an effort to examine

their attitudes towards rape survivors. The researchers measured attitudes using the Attitudes Toward Rape Victims Scale (Ward, 1988) and found that male mental health professionals held more negative attitudes ($p < 0.05$) toward rape survivors than female professionals, and both male professionals and trainees held more favorable ($p = .023$) views towards rape than female professionals and trainees. It was also found that, compared to professionals and graduate-level trainees, undergraduate medical and mental health students held the most ($p < .001$) negative attitudes towards rape survivors (White & Kurpis, 1999). Although the data is especially interesting, given the differing levels of education of participants, a significant limitation of the research was the disproportionate amount of professionals that participated in the study versus trainees or students; due to the disproportionate cell size, the researchers statistically had a more difficult time in finding significant differences in the mean scores of professionals given the large number of participants.

Resick and Jackson (1981) aimed to gather mental health professionals' attitudes toward rape utilizing the Attribution of Rape Blame Scale (Ward & Resick, 1979) and a demographic survey among a population of 38 professionals. This study (Resick & Jackson, 1981) found that mental health professionals did not support the myth that women can simply avoid sexual assault by avoiding dangerous situations; instead, they tended to attribute sexually violent crimes to societal values. Resick and Jackson (1981) found that female participants tended to blame societal values for rape more than male participants did ($p = 0.032$), proposing that this sample may have endorsed the feminist

belief that any woman could be attacked and that society encouraged both violence and the treatment of women as sex objects.

Resick and Jackson's (1981) findings support the role societal values and implicit biases can have on attitudes toward rape survivors. However, a limitation of this study was the small participant (n = 38) size not being a representative sample of mental health professionals as a whole. Another study examined the connection between mental health professionals' attitudes and secondary victimization of survivors (Campbell & Raja, 1999) in a sample of 415 licensed mental health professionals in the Midwest. These researchers utilized an extensive demographic questionnaire that included questions about secondary victimization, as no established instrument to measure this existed at the time. Campbell and Raja (1999) found that being denied help or receiving poor care was, in fact, associated with survivors reporting having been revictimized ($p < 0.01$), or experienced additional violation or oppression in the mental health setting. Campbell and Raja (1999) also found that therapists who had engaged in formal training on sexual assault, had more experience working with survivors, and endorsed a feminist perspective were more apt to believe that mental health professionals often engage in harmful, revictimizing, behaviors. In fact, over half (58%) of those surveyed endorsed the belief that therapists engaged in harmful therapeutic behaviors, such as microaggressions (i.e. everyday insults, indignities, and demeaning messages made about a group of people [American Psychological Association {APA}, 2009]), with rape survivors, and 85% of participants felt that therapists needed further training on sexual violence against women.

An example of a harmful, revictimizing behavior that participants believed other therapists engaged in included perpetration of microaggressions, subtle body or verbal language that conveyed oppressive ideology about power and privilege against marginalized identities, regarding survivor status and covert rape myth acceptance (i.e. asking survivors if they had been consuming alcohol at the time of their sexual assault) (Campbell & Raja, 1999). The most salient limitation of this study was that the researchers created their own survey to gather attitudes about secondary victimization, as there was no previously established scale.

One study (Anderson & Quinn, 2009) looked at attitudes towards rape survivors in a sample of UK medical students (n = 240), and found that male medical students have more negative attitudes ($p < 0.001$) towards rape survivors than female medical students. The researchers used the Attitudes Towards Rape Victims Scale (Ward, 1988) and a demographic questionnaire in order to measure the medical student participants' endorsement of rape myth. Anderson and Quinn (2009) described the importance of measuring rape myth acceptance with this population, as medical professionals are oftentimes the first set of individuals that a rape survivor may disclose her status to, making this finding especially pertinent to the care of rape survivors. Additionally, the study reported a significant difference ($p < 0.001$) in attitudes toward male rape survivors, versus female rape survivors, for both study participant sexes. A limitation to this study is that the findings cannot be generalized to the population of all medical professionals, as this sample was recruited from a single hospital.

Rape Survivor Disclosures to Mental Health Professionals

The national movement of *trauma-informed care* aims to encourage health care providers to respond to trauma survivors in a sensitive and competent manner (Woody & Beldin, 2012). Harvey (2013) defined trauma-informed care as involving relationships and interventions that take into account a survivor's trauma history. This includes understanding the connection between an individual's presenting problem(s) and previous trauma and the triggers of trauma symptoms that traditional health service delivery approaches may exacerbate.

Although providers are now more aware of trauma-informed care and its necessity, the lack of sexual assault training in mental health schooling may be related to the fact that rape survivors continue to have negative experiences in disclosing their assault to providers (Starzynski & Ullman, 2014). In fact, one study of Illinois mental health professionals (Campbell & Raja, 1999) found that only 56% of clinicians had received training on sexual assault. Though lack of training in trauma-informed care and levels of rape myth acceptance have not been directly linked by any current published literature, it is possible that the lack of awareness of this sensitive care leads professionals to continue to endorse victim blame and accept rape myths.

Though feminist and trauma-informed care models are increasing in popularity among health service providers, early models of psychotherapy treatment were male-dominated and psychoanalytically-oriented, directly opposing many of the independent, feminist philosophies that current trauma-informed treatment tends to incorporate, such

as gender equality (Woody & Beldin, 2012.). As such, much of both the current mainstream and mental healthcare cultures continue to perpetuate these early models when with respect to mental health services (such as group and individual therapies), as well as in movies and television series, potentially alienating rape survivors from seeking support. The reactions from society that rape survivors experience when they disclose the assault can affect whether they choose to disclose to mental health professionals. Women who receive negative social reactions, such as disbelief or blame from the people they initially tell, will oftentimes stop disclosing to others (Starzynski, Ullman, Townsend, & Long, 2007). One study (Starzynski et al., 2007) found that women who blamed their own past behaviors for the assault were less likely to disclose to a mental health professional. This study's sample included over 1,000 female participants and utilized a demographics questionnaire, the Stressful Life Events Screening Questionnaire (Goodman, Cocoran, Turner, Yuan, & Green, 1998), Social Reactions Questionnaire (Ullman, 2000), and Rape Attribution Questionnaire (Frazier, 2003). In addition to finding that women who blamed their own past behaviors for a sexual assault were less likely to disclose to a mental health professional ($p = 0.008$), the researchers also found that older women were more likely ($p = 0.012$) to disclose to a professional compared with younger women. This finding may be related to increased financial access to mental health services as participants aged, or changes in cultural views over time that concern the acceptability of seeking therapy. Though this study had several strengths, such as large sample size and use of valid and reliable measures, a noticeable limitation was its

cross-sectional design and nonrepresentative sampling strategy, as the population was gathered from a specific city in the Midwest.

Another study (Starzynski & Ullman, 2014) found that sexual assaults that had been perpetrated by strangers were significantly related ($p = 0.003$) to survivors perceiving mental health professionals as unsupportive throughout the disclosure and processing of an assault. Starzynski and Ullman (2014) gathered data from a sample of over 1,000 individuals about their demographics, and attitudes toward seeking help from mental health professionals; specifically, these attitudes were examined using the Sexual Experiences Survey (Koss & Gidycz, 1985), Rape Attribution Questionnaire (Frazier, 2003), and Social Reactions Questionnaire (Ullman, 2000). In addition to their findings about perceived helpfulness of mental health professionals, women who were survivors of sexual assault reported having experienced subsequent blame from social supports (i.e. family or friends) and tended to find mental health professionals less helpful (Starzynski & Ullman, 2014). This finding may be due to survivors being more guarded in treatment and potentially reporting less information to mental health professionals (i.e. about symptoms) due to their previous negative experiences with social supports. The use of cross-sectional data in this study limited the researchers' abilities to make causal arguments. Further, this sample may not be representative of the general population, as participants were gathered on a volunteer basis in one city in the Midwest.

Survivors who have experienced a mental health professional as unhelpful may also be less likely to seek out another, potentially more positive, experience with another

mental health professional due to the blame, shame, and guilt they may have experienced during the initial interaction. However, female rape survivors who experienced positive social reactions from family members and friends after a disclosure reported finding mental health clinicians helpful and were significantly more likely ($p = 0.024$) to seek mental health support than those with negative social experiences (Starzynski & Ullman, 2014).

Due to the high prevalence of rape, it is likely accurate to assume that many therapists may be trauma survivors themselves (Wilson & Jones, 2010). Schauben and Frazier (1995) conducted a qualitative study of about 20 female psychologists and counselors and found that 70% of female psychologists and 83% of sexual violence counselors in their sample endorsed experiencing at least one type of sexual victimization. This may be because survivors of sexual assault may subsequently desire to advocate for, protect, or empower other survivors and, as such, choose a career that will allow them to do so. With respect to causality, rather than psychologists and sexual violence counselors later being at higher risk for sexual assault, it is likely that these individuals first experienced an assault and then became mental health professionals. Additionally, the researchers found that the participants who had a higher percentage of rape survivors on their caseload reported more negative beliefs ($p = 0.02$) about the goodness of people, more symptoms ($p = 0.04$) of posttraumatic stress disorder, and more ($p < 0.001$) self-reported vicarious trauma. A limitation of this research is that a correlation between past sexual victimization and mental health career choice cannot be

made, making it difficult to say that a participant's survivor status is related to choosing a mental health career.

Violence Against Women Act

The results of the previously mentioned literature support the statement that various groups and individuals attempt to provide support and care to rape survivors. Though individuals and communities have made sustained efforts toward awareness about rape myths and victim blame, it is essential that governmental systems also work to increase awareness about sexual assault and provide assistance to survivors. The first United States federal law that focused on the protection of victims of violence, the Violence Against Women Act (VAWA), was enacted as public law in 1994 (Conyers, 2007). The introduction of this law was important, as it brought sexually violent crimes into the national spotlight and provided funding for crisis hotlines and domestic abuse centers. Additionally, this federal law was designed to improve the carrying out of criminal justice enforcement (Cho & Wilke, 2005). In 2005, the Violence Against Women Act (VAWA) was reauthorized and expanded its protections and programs to cover immigrant sexual violence survivors and victims of stalking, to name a few (Conyers, 2007). A study conducted by Cho and Wilke (2005) examined data from the National Crime Victimization Survey and looked at domestic violence incidence rates, rates of reporting interpersonal violence to the police, arrest rates, and rate of contact with other authorities. Although VAWA has aided in expanding protection to a wide variety of violence survivors, this examination (Cho & Wilke, 2005) found that the VAWA

enactment did not appear to have had an impact on most of the current domestic violence trends, such as rate of reporting to the police, domestic violence incidence rate, and arrest rate; this may be due to the fact that government officials have allowed the VAWA to lapse and then be reinstated several times in the past two decades. There are several potential reasons why VAWA has been allowed to lapse in recent years, although the U.S. government has made no official statement. However, a prominent thought about why VAWA has been allowed to lapse is that protecting women against violence and offering these women support is not a priority for the U.S. government (Murray, 2013). Numerous times both funding and support for VAWA from the House of Representatives have diminished and been placed elsewhere (i.e., U.S. defense spending). Therefore, a limitation of looking at the data in this way is that the researchers could not say whether this lack of impact on domestic violence trends was due to the VAWA or some other variable.

Nevertheless, a more current study found that a 1% increase in VAWA funding was associated with a 0.1% reduction in rape and a 0.116% reduction in aggravated assault (Boba & Lilley, 2009). Boba and Lilley (2009) performed panel data regressions in order to assess changes in annual rates of reported crime as predicted by grant funding from the years 1996 to 2002. The study looked at effects of reported crime potentially influenced by the Office of Community-Oriented Policing Services and Government Accountability Office. The study found that increased funding from these grants did increase enforcement action, and also increased ($t = 0.006$) incapacitation of domestic

and sexual violence offenders who were violent toward women. Unfortunately, a limitation of the study was that the researchers were not able to determine which programs within VAWA were specific to the changes in statistics, as these programs were too difficult to isolate and study within the community.

Teaching Attitudinal Change

Sexual assault is, statistically, an issue that will impact most individuals at some point in their lives due to reported prevalence rates being as high as one in three women (Foubert & Newberry, 2006). Whether an individual is, himself or herself, a survivor or knows someone who identifies as such, sexual assault is a salient issue in the lives of most people. Peer education programs, or public health promotions in which community members promote health-enhancing education and awareness to peers, have been utilized as avenues to provide information and debunk myths about rape, while increasing awareness and decreasing the prevalence of sexual assault.

One study provided a Peer Education Project to 253 high school students, focusing on risk reduction, rape culture, laws regarding rape, and male responsibility in preventing sexual assault (Smith & Welchans, 2000). High school students, trained by the researchers, conducted a 45-minute presentation about these topics in order to decrease rape tolerant attitudes, and later assessed participants' attitudes through the use of pre- and post-test measures. Attendance at this presentation was shown to be significantly associated (males, $p = .0003$ and females, $p = .0021$) with changes in short-term (45 minutes) attitudes regarding sexual assault. The study found that males showed a greater

decrease ($p < .05$) in rape-accepting attitudes than females post-presentation, though males had endorsed more ($p < .05$) rape-accepting attitudes prior to the program implementation. However, a common finding with these types of interventions is that short-term programs do not produce long lasting attitudinal change, whereas long-term programs usually produce significant attitudinal changes over time (Currier & Carlson, 2009).

For instance, Currier and Carlson (2009) utilized a long-term program consisting of a semester-long course on violence against women, then measured attitudinal changes; their study utilized a pre- and post-test of 137 undergraduate students and examined changes in attitudes toward rape survivors through the use of the Attitudes Toward Rape Victims Scale (Ward, 1988), Marlowe-Crowne Social Desirability Scale (Crowne & Marlowe, 1960), Ambivalent Sexism Inventory (Glick & Fiske, 1996), and James Madison University College Data Rape Attitudes and Behaviors Survey (Lanier & Elliott, 1997). The researchers found that attitudes toward violence against women decreased, ($p < 0.05$) and this finding supported the fact that workshops, annual psychoeducation, and continuing education courses about sexual violence should be provided to all individuals, regardless of age or profession. Further, although long-term programs seemed to be more significantly related to attitudinal changes than short-term programs, the implementation of either type of program may be associated with decreases in ambivalent sexism and negative attitudes toward rape survivors, in future studies (Currier & Carlson, 2009).

Survivors of sexual assault are faced with many obstacles in reporting the crime and seeking medical and mental health services. Although research in the area of attitudes towards rape survivors is growing (Vincent, 2009), research on the attitudes that mental health professionals hold about rape survivors is sparse. In fact, currently only one study that examines female rape survivors' experiences with mental health support has been published (Starzynski & Ullman, 2014). Gathering additional information on this topic is important, as it will help to inform clinicians about verbal and non-verbal interactions with rape survivors that may affect a survivor's recovery process. Additionally, gathering information about mental health professionals' attitudes towards rape survivors will help to inform best practices with survivor clients. At this point there is no published research concerning demographic information that would guide the framing of a hypothesis about the individual factors that shape a mental health professional's attitudes towards rape survivors. This study attempted to close that gap in the research by collecting demographic information and measuring rape myth acceptance of licensed mental health professionals through using an online questionnaire distributed to participants.

Chapter III: Methodology

The independent variables of this quantitative study investigated were gender, level of graduate degree (Master's or Doctorate), participant survivor status, and participant close friend or family member survivor status(es). The dependent variable in this study was the participant's attitudes toward rape survivors, as measured by the Illinois Rape Myth Acceptance Scale (IRMA) (McMahon & Farmer, 2011). Institutional Review Board full approval was received on June 22, 2014, and protocol number 14-083 was assigned.

Participants

Licensed master's- and doctoral-level mental health professionals practicing in the field of psychology were asked to participate in this study. Participants were recruited online through use of a state-level psychology list serve, the Illinois Psychological Association. For the purposes of this study, "mental health professionals practicing" was defined as licensed mental health workers engaging in at least one clinical, face-to-face contact with a client per week. "Rape" was defined as an event occurring without the survivor's consent, involving the use or threat of force, or intimidation, or when the survivor was incapable of giving consent due to illness or intoxication, and involving sexual penetration of the survivor's vagina, mouth, or rectum (Mugabyizi et al., 2010). This definition was chosen as it provides an inclusive list of different assaults that may be termed rape. This definition has been used by current literature cited throughout the current study's literature review.

Participants were notified that the present study involves attitudes towards rape. Further, participants were warned of the sensitive nature of the topic and allowed the choice to terminate completion of the survey if they became uncomfortable with the subject matter. At entry to the study, each participant was also provided with an electronic informed consent form, which outlined the potential risks of participating in the survey, along with electronic referrals to various rape and sexual assault resources. Participants indicated their consent to participate in the present study by checking "I Agree to Participate" at the end of the electronic informed consent (Appendix A).

Instruments

An online survey was designed for the purpose of this study (Appendix B), with both specific demographic items and all attitude-gathering items taken from the updated Illinois Rape Myth Acceptance Scale (IRMA; McMahon & Farmer, 2011) (Appendix B). The online survey contained nine demographic questions and all 22 items from the IRMA; the demographic questions from the survey included gender identity, age, ethnic identity, whether or not the participant held a graduate degree, type of graduate degree held, average clinical hours worked per week, years with mental health license, personal survivor status, and family/friend survivor status(es). The IRMA is one of the most reliable and psychometrically sound rape myth scales (Payne, Lonsway, & Fitzgerald, 1999). Updated in 2011, the IRMA contains culturally accurate language and has been shown to capture current subtle rape myths (McMahon & Farmer, 2011). The IRMA contains four different subscales (*She asked for it*, *He didn't mean to*, *It wasn't really*

rape, and *She lied*) with 22 rape myths addressed in total, and is aimed at assessing an individual's levels of rape myth acceptance ($\alpha = .96$) and utilizes a 5-point Likert scale (1 = *strongly agree* and 5 = *strongly disagree*), where lower scores reflect more adherence to rape myths.

Procedure

A link to the online survey in PsychData designed for this study was sent out through the Illinois Psychological Association's list serve, inviting licensed master's- and doctoral-level mental health professionals to participate (Appendix E). Participants were informed that the survey would take approximately 5-7 minutes to complete and that participation was voluntary. Mental health professionals who were over the age of 18, held a current mental health license in any U.S. state or territory, and endorsed having weekly direct client contact were asked to read and sign a consent form for their participation. Participants were urged to print or save a copy of this consent for their records. Identifying information associated with responses to the questionnaire was not collected. In the consent form, the potential physical and psychological risks were outlined, as well as referral sources related to sexual assault, which was made available to all participants (Appendix D). After completion of the consent form, participants were asked to complete a questionnaire that began with basic demographic questions designed to gather information about each participant surveyed. In addition, participants were asked about their own rape survivor status, as well as if they knew a family member or close friend who identified as a rape survivor.

Each participant was asked to complete identical online questionnaires assessing his or her attitudes towards rape survivors. Participants were asked to rate whether or not they agreed with statements related to myths and attitudes towards rape survivors. Included in the consent form, participants were given the researcher's e-mail address to contact regarding questions, results, or concerns about the present study. The data collected from this study was kept in a password-protected Microsoft Word document, saved within a password-protected personal laptop computer that only the researcher had access to. The data collected for the purposes of this study will be confidentially maintained for a seven-year period and then destroyed.

Data Analysis

This study analyzed several variables in order to examine attitudes towards rape survivors. The independent variables were: gender of participant, type of participants' graduate degree (master's or doctorate), participant rape survivor status, and participant family or friend survivor status(es). The dependent variable was the total score on the IRMA; four separate independent sample t-tests were conducted examine the differences in mean scores between the categorical variables. A power analysis was also implemented in order to determine that 150 participants were needed to produce an adequate effect size. The mean scores were compared between levels of the independent variables previously described; participants' total scores measuring reported attitudes toward rape survivors were the focus of attention for data analysis.

Chapter IV: Results

Sample Characteristics

The survey recruitment email yielded 162 participants, and from this group, 153 participants' data were selected. Those excluded from data analyses either did not meet inclusion criteria (providing less than one clinical hour per week; n = 4) or self-selected out before completing the survey (n = 5). All participated voluntarily. Of the 153 participants, 79.7% (n = 122) identified as female while 20.3% (n = 31) identified as male. The average age of the participants was 43, with a range from 24 years old to over 75 years of age. About 87% (n = 134) of the participants identified as non-Hispanic White or Euro-American, 2% as Black or Afro-Caribbean, 3.9% as Hispanic or Latino(a), 3.3% as East Asian or Asian American, 2% as Native American or Alaskan Native, and 1.3% as "Other."

Of the 153 participants, 33.3% (n = 51) reported holding a master's degree in mental health, while 66.7% (n = 102) reported holding a doctoral degree (Psy.D., Ph.D., or Ed.D.). On average, most participants (40.5%) reported working between 16 and 25 clinical hours per week. The number of years each participant had held licensure was representative of all choices (less than one year to 26 years or more), with no one licensure group constituting a majority. Regarding participants' personal survivor statuses, 13.7% (n = 21) identified themselves as rape survivors, 79.7% (n = 122) did not identify as rape survivors,

and 6.5% (n = 10) chose not to disclose survivor status. Regarding the rape survivor statuses of a participant's family member or close friend, 47.1% (n = 72) endorsed rape survivor status, 49.0% (n = 75) did not endorse rape survivor status, and 3.9% (n = 6) chose not to disclose. All 153 participants fully completed the 22 items of the IRMA. The sample characteristics of participants can be found in Table 1.

Four separate, independent sample t-tests were utilized to examine differences in mean scores of rape myth acceptance with each independent variable. The assumptions for confident use of the t-test, normally distributed data and homogeneity of variance, were not both met by the present data. Variance within each of the populations was unequal throughout the four different t-test analyses, and the rape myth acceptance means for each independent variable were negatively skewed. Mean scores on the IRMA were skewed high, indicating rejection of rape myths. Although the IRMA scores have the potential to range from 22-110, the present data ranged from 95-105 for a majority of participants, supporting the observation of high scores and a negatively skewed distribution of data (Figure 1).

Due to both assumptions of an independent t-test not being met, four separate Mann-Whitney U tests were also performed to analyze the data (Howell, 2010). The assumptions of a Mann-Whitney U test were all met, including: the dependent variable is at the ordinal or continuous level, the independent

variable(s) are categorical, and that the dependent variable data is not normally distributed.

Impact of Participant Gender

An independent sample t-test was conducted to examine the difference in mean scores by gender on measures of rape myth acceptance. The test showed a significant difference by gender on total mean scores of rape myth acceptance; scores were significantly different at the $p < .05$ level for the two gender identities [$F(1,151) = 6.420$, $p = .012$], with the mean female participant score higher than the mean male participant score. In the measure of rape myth acceptance, determined through use of the IRMA, the results suggested that male participants tended to attribute greater responsibility ($p = 0.002$) to rape survivors ($M = 99.58$) than female participants ($M = 103.07$). This can be seen in Table 2, in which the mean of IRMA scores for male participants was lower than that of the female participants.

Due to IRMA mean scores falling in a non-normal distribution, a Mann-Whitney U test was conducted to examine the difference in mean scores by gender on measures of rape myth acceptance. The test showed a statistically significant difference by gender (female = 82.68, male = 54.63) on total mean scores of rape myth acceptance, $p < .05$ [$U(151) = -3.16$, $p = .002$]; the mean female participant score was higher than the mean male participant score. This analysis was consistent with the findings of the t-test statistic, supporting the

finding that there was a statistically significant difference between IRMA total score means by gender (Table 3).

In addition, four independent sample t-tests were conducted to examine the difference in mean scores by gender on each subscale of the Illinois Rape Myth Acceptance Scale; the four scales included: *She Asked For It*, *He Didn't Mean To*, *It Wasn't Really Rape*, and *She Lied*. The test on the subscale, "She Asked For It" showed a significant difference by gender on total scores of rape myth acceptance; scores were significantly different at the $p < .05$ level for the two gender identities [$F(1,151) = 2.669$, $p = .008$], with the mean female participant score higher than the mean male participant score. This finding suggests that male participants tended to endorse rape myths on the *She Asked For It* subscale at a higher rate than female participants. There was no statistically significant difference by gender on any of the other three subscales of the IRMA (Table 10).

Impact of Participant Graduate Degree Level

An independent sample t-test was conducted to examine the difference between mean scores of rape myth acceptance by type of graduate degree. The test showed no statistically significant difference by type of graduate degree on rape myth acceptance at the $p < .05$ level for the two different graduate degrees, [$F(1,151)$] = .161, $p = .689$. These results suggest that the type of graduate degree (master's or doctorate) held by a participant was not associated with a statistically

significant difference on the mean score of a participant's level of rape myth acceptance (master's = 102.04, doctorate = 102.52). Numerically, doctoral-level participants were slightly less likely to endorse rape myths than master's-level participants; this can be seen in Table 4, which indicates that the mean of IRMA scores for master's- and doctoral-level participants was not statistically significantly different.

Due to IRMA mean scores falling in a non-normal distribution, a Mann-Whitney U test was conducted to examine the difference in mean scores by graduate degree types on measures of rape myth acceptance. The test did not show a statistically significant difference by type of graduate degree (Master's = 75.04, Doctorate = 77.98) on total mean scores of rape myth acceptance at the $p < .05$ level for the two types of degrees [$U(151) = -0.39$, $p = .698$]. This analysis was consistent with the findings of the t-test statistic, supporting that there was no statistically significant difference between IRMA score means by type of graduate degree (Table 5).

Impact of Participant Personal Survivor Status

An independent sample t-test was conducted to examine the difference between personal rape survivor status or non-survivor status on mean scores of rape myth acceptance. The test showed no statistically significant difference between mean scores of levels of rape myth acceptance by personal survivor status ([$F(2,150)$] = 2.081, $p = .128$). Based on these results, it seems that a

participant's personal rape survivor status was not associated with a statistically significant difference on mean scores by level of rape myth acceptance (survivor = 102.57, non-survivor = 101.98); although numerically, survivors were less likely to endorse rape myths. This can be seen in Table 6, in which the mean of IRMA scores for rape survivor and non-rape survivor identified participants is not significantly different.

Due to IRMA mean scores falling in a non-normal distribution, a Mann-Whitney U test was also conducted to examine the difference in mean scores by participant survivor status on the measure of rape myth acceptance. The test did not show a statistically significant difference by survivor status (survivor = 76.12, non-survivor = 71.29) between total mean scores of rape myth acceptance at the $p < .05$ level for the two types of survivor statuses [$U(151) = -0.50$, $p = .621$]. This analysis was consistent with the findings of the t-test statistic, supporting the observation that there was not a statistically significant difference between IRMA score means by participant survivor status (Table 7).

Impact of Participant Family or Close Friend Survivor Status(es)

An independent sample t-test was conducted to examine the difference between family or friend rape survivor status(es) or non-survivor status(es)means scores of rape myth acceptance. The test showed no statistically significant differences between means by family or friend survivor status(es) on participant rape myth acceptance ([$F(2,150)$] = .228, $p = .796$). These findings suggest that

having a family member or close friend identified as a rape survivor was not associated with a statistically significant difference on mean scores of a participant's level of rape myth acceptance (family/friend survivor = 102.40, family/friend non-survivor = 102.17). This can be seen in Table 8, in which the mean of IRMA scores for family or friend rape survivor and family or friend non-survivor of participants is seen to be not significantly different.

Due to IRMA mean scores being in a non-normal distribution, a Mann-Whitney U test was also conducted to examine the difference in mean scores by participant family/friend survivor status(es) on measures of rape myth acceptance. The test did not show a statistically significant difference by family/friend survivor status(es) (family/friend survivor = 75.69, no family/friend survivor = 72.38) on total mean scores of rape myth acceptance scores at the $p < .05$ level for the two types of family/friend survivor status(es) [$U(151) = -0.47$, $p = .637$]. This analysis was consistent with the findings of the t-test statistic, supporting that the observation that there was not a statistically significant difference of IRMA means by participants' family/friend survivor status(es) (Table 9).

Exploratory Analysis

It should be noted that exploratory analyses revealed no significant effect with respect to age, number of clinical hours performed per week, or number of years with licensure on levels of rape myth acceptance.

Chapter V: Discussion

This study examined licensed mental health professionals' attitudes towards rape survivors by gathering both demographic information and reported levels of rape myth acceptance among mental health professional participants. Based on previous literature, it was hypothesized that male participants would attribute greater responsibility to rape survivors than female participants. The data gathered supported this hypothesis, finding that the male participants did endorse statistically significantly higher levels of rape myth acceptance. It was hypothesized that doctoral-level participants would attribute less responsibility to rape survivors than master's-level participants; this was not supported by the data, as both groups endorsed statistically similar levels of rape myth acceptance. Participants who identified as rape survivors were hypothesized to attribute less responsibility to a rape survivor than participants who did not identify themselves as such. This hypothesis was not supported, as there was no statistically significant difference in rape myth acceptance scores between the two groups. Finally, the hypothesis that participants who identify as having a close friend or family member who is a rape survivor will attribute less responsibility to a survivor than those that do not identify as such was not supported; both groups endorsed similar rates of rape myth acceptance.

Gender identity was the single demographic that showed statistically significant mean differences in total rape myth acceptance scores. This finding is

not surprising, as much of the current literature supports that men, in general, attribute more blame to rape survivors than women. Because women more commonly report rape, it is possible that men may view the issue of sexual assault as gendered and something that women are responsible to avoid. Further, the Western patriarchal society in which these male participants live typically sends messages about the responsibility women carry to prevent rape, leading to questions about what they had been drinking, or wearing, or where they were located at the time of the assault; these are all covert messages supporting victim blame and rape myth acceptance. Currently, the US culture around rape focuses on ways to educate women on how to stay safe and avoid becoming a victim, a dynamic that sets women up to be seen as responsible to avoid being raped.

In addition to the finding of a statistically significant mean score difference on the IRMA by gender, there was a statistically significant difference by gender on the scores of the subscale *She Asked For It* (Table 10). There are, in total, six questions on this subscale: 1) If a girl gets raped while she is drunk, she is at least somewhat responsible for letting things get out of hand, 2) When girls go to parties wearing slutty clothes, they are asking for trouble, 3) If a girl goes to a room alone with a guy at a party, it is her own fault if she is raped, 4) If a girl acts like a slut, eventually she is going to get into trouble, 5) When girls get raped, it's often because the way they said "no" was unclear, and 6) If a girl initiates kissing or hooking up, she should not be surprised if a guy assumes she wants to

have sex.

This finding in difference by gender on the "She Asked For It" subscale supports the current rhetoric in most cultures regarding women bringing upon themselves their own rapes, and serves to release men from responsibility for rape. This difference highlights the need for rape public health initiatives to provide education about responsibility and the importance of men and women not raping, versus women and men avoiding being raped.

The type of graduate degree, personal survivor status, and status(es) of loved ones were not associated with a statistically significant difference in mean scores of participants' levels of rape myth acceptance. Those with mental health graduate degrees may all receive training around working with rape survivors and the role of rape myth acceptance. It is also possible that any potential difference between these two groups was bridged after engaging in face-to-face clinical work and gathering real world experience. Participants endorsing or not endorsing personal rape survivor statuses were not differentiated statistically by this identity.

Overall, scores on the IRMA were so high (indicating low levels of rape myth acceptance) that it finding a statistically significant difference between graduate degree, survivor status, and family/friend survivor status(es) identities was unlikely; this same reasoning supports the statistically nonsignificant findings of a participant's close friend or family member status or non-status. Specifically, the IRMA scores have the potential to range from a score of 22-110 and mean

scores for a majority of the participants ranged from 95-105, supporting the statement of high scores and negatively skewed distribution of data.

Several limitations should be considered when applying these findings in real-world mental health settings. First, it should be noted that there were markedly fewer male than female participants, as well as fewer master's- than doctoral-level clinicians, both potentially accounting for the lack of a statistically significant difference in rape myth acceptance levels. Additionally, though gender differences in mean scores of rape myth acceptance were found to be statistically different, there was no practical significance of this finding, as IRMA mean scores differed by only 3.49 points on a 110-point scale. Nevertheless, this statistically significant finding warrants future research utilizing more equal cell sizes with respect to gender.

Another limitation of the study is that no causal deductions can be made due to the nature of the research. Therefore, it would be difficult to definitively state that, because some participants were men, they attributed greater blame to rape survivors. Overall, IRMA mean scores were high, indicating general low levels of rape myth acceptance with this population. This may be because participation was volunteer-based and participants self-selected. Those who may have held higher levels of rape myth acceptance may have chosen not to be part of this study. Conceivably, those with strongly held negative beliefs about rape survivors might be less open to pursuing mental health as a profession, as they

may attribute more responsibility to survivors and be less willing to offer support.

It is recommended that future research gather more data on levels of rape myth acceptance among male mental health professionals, as this gender was a minority variable in this study. As previously mentioned, men tend to hold much more negative views about rape survivors than females, and collecting data about rape myths in male mental health professionals would add useful data to a currently small body of literature. Additionally, it would be useful to compare responses between different subscales of the IRMA among mental health professionals. Other demographics such as socioeconomic status and type of professional setting would be useful variables to isolate and examine, as little data has been gathered in this area. Having additional information on these demographics may shed light on how certain identities of a mental health professional may influence the attitudes held about rape survivors and, subsequently, the quality of therapeutic work done with the rape survivor population.

Another area for future study may include looking at a similar sample of mental health professionals and gathering information about their training in treating survivors of sexual assault, as well as their actual experience in working with survivors of sexual assault. For instance, gathering information about continuing education or graduate program training regarding working with sexual assault survivors or participants' experience working with rape survivors may

help to provide information about where mental health professionals are receiving information from concerning how to provide trauma-informed care to survivors, and shed light on the kinds of programs that should be developed or implemented to fill any observed gaps.

In summary, the findings of this study suggest that male mental health professionals attribute more blame to rape survivors than their female counterparts. This information can be used to help educate those in the mental health profession about working with the unique presentation of a rape survivor and the potential covert messages therapists may send to their clients about victim blame. Specifically, dissemination of these findings would be a useful start in creating awareness about certain identities (i.e. gender) that seem to be related to greater levels of rape myth acceptance. Graduate school courses, training settings, and didactic seminars would be convenient places to reach budding mental health professionals and allow for a dialogue about working with trauma survivors and biases that clinicians-in-training hold. It may even be useful to target specific rape myths (e.g. "She asked for it" or "He didn't mean to rape her") in an effort to increase primary prevention efforts. It is more difficult to target already licensed mental health professionals, as making training in working with rape survivors mandatory would be unlikely to occur. Additionally, those who would select into those trainings would, potentially, already be educated on victim blame and rape myths. Focusing on creating increased awareness about rape myths in our society

and engaging in dialogues regarding the damage victim blame can cause are appropriate steps toward the goal of examining mental health professionals' attitudes toward rape survivors and can help to challenge the biases these professionals may carry.

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Appendix A

Consent Form

This study is being completed to fulfill the requirements for Jaclyn M.P. Pistorio's doctoral dissertation. I have been recruited for this study because I am a licensed mental health worker in psychology, counseling, or social work in any of the 50 United States or territories. In addition to holding a license in psychology, counseling, or social work, I also am 18 years or older, hold a graduate degree in psychology, counseling, or social work, and currently work at least one clinical hour per week on average. I understand that I will be asked to complete a confidential online survey created by Jaclyn M.P. Pistorio to explore attitudes held by licensed mental health workers about sexual assault with the goal of facilitating clinical work with sexual assault survivor populations.

My participation in the study is voluntary and can be withdrawn at any time without negative consequence by simply closing my browser. My decision whether or not to participate in the study will not affect my current or future relationship with the Adler School or affiliated dissertation committee members. I may terminate my participation in the online survey at any time by closing my browser.

The data will be gathered through a confidential online survey program and later examined through a statistics computer program. The data collected from this research will be keep confidential and subject to the following conditions:

1. The principal investigator will not collect any identifying information about any participant in the study.
2. Demographic information will be summarized to indicate the demographic characteristics of all the participants in the study.
3. Aggregated or averaged data from the online survey results will be incorporated into the drafts of the dissertation, which will be submitted to three faculty members of Jaclyn M.P. Pistorio's dissertation committee for their review and comments.
4. A copy of the statistical analysis will be saved in a password protected Word document on a laptop that is password protected and accessible only by the principal investigator.
5. I will be able to print off a copy of this consent form for my records.

My risk and discomfort because of participating in this online survey are expected to be minimal. However, because several of the questions within the online survey

are personal in nature and focus on a sensitive topic, there is a chance I might experience some emotional discomfort. Should it be apparent to me that I am distressed, I have the right to stop the online survey immediately with no penalty and notify the principal investigator or contact a resource provided in the Resource List at the end of the online survey.

It is hoped that my participation in the study will contribute the current literature regarding licensed mental health workers' attitudes about sexual assault. It is hoped that licensed mental health workers, including myself, may be able to incorporate findings from the present research into their work with survivors of sexual assault. Additionally, it is hoped that psychology, counseling, and social work graduate or training programs may utilize the findings from this research in order to better prepare their students to work with survivors of rape.

If I am interested in receiving a summary of the results of the study, I can provide Jaclyn M.P. Pistorio with my contact information. If I should do so, my contact information will be kept confidential and will be stored in a password-protected file separate from all other research data on Jaclyn M.P. Pistorio's personal laptop computer.

The protocol number for this study is 14-083. Further questions about this study can be directed to Jaclyn M.P. Pistorio at jpistorio@my.adler.edu or Dr. Janna Henning, JD, PsyD at jhenning@adler.edu . Questions or concerns about my rights as a research participant should be directed to Dr. Peter Ji, PhD, Chair of the Adler School of Professional Psychology Institutional Review Board at pji@adler.edu

Consent:

I agree to participate
I decline participation

Appendix B

Online Survey

1. **What is your gender identity?**
   Female
   Male
   Other
2. **What is your age?**
   Select (18-75&up)
3. **Which of the following best represents your racial or ethnic identity? Choose all that apply.**
   Non-Hispanic White or Euro-American
   Black, Afro-Caribbean, or African American
   Hispanic or Latino(a)
   East Asian or Asian American
   South Asian or Indian American
   Middle Eastern or Arab American
   Native American or Alaskan Native
   Hawaiian/Pacific Islander
   Other
4. **Do you hold a graduate degree in psychology, social work, counseling, or a related field?**
   Yes
   No
5. **What type of graduate degree do you hold?**
   Masters Degree (e.g. clinical, counseling, social, or school psychology, social work, or education)
   Psy.D.
   Ph.D.
   Ed.D.
   None
6. **On average, how many hours <u>per week</u> do you participate in direct clinical work (e.g. individual, group, couples, family therapy, milieu treatment, psychological testing, case management)?**
   < 1 hour
   1-5 hours
   6-15 hours
   16-25 hours
   26-35 hours
   36-45 hours

46 hours or more

7. **How many years have you held your licensure (not just degree)?**
   Less than 1 year
   2-5 years
   6-10 years
   11-15 years
   16-20 years
   21-25 years
   26 year or more
8. **What is your personal sexual assault survivor status?**
   I identify myself as a survivor of sexual assault
   I do not identify myself as a survivor of sexual assault
   I prefer not to disclose my survivor status
9. **Do you have a family member or close friend who identifies as a sexual assault survivor?**
   I have a family member or close friend who identifies as a sexual assault survivor.
   I do not have a family member or close friend who identifies as a sexual assault survivor.
   I prefer not to disclose the survivor status(es) of any family member or close friend.

Please respond to the following questions using:

1 = Strongly Agree
2 = Agree
3 = Neutral
4 = Disagree
5 = Strongly Disagree

1. If a girl is raped while she is drunk, she is at least somewhat responsible for letting things get out of hand.
2. When girls go to parties wearing slutty clothes, they are asking for trouble.
3. If a girl goes to a room alone with a guy at a party, it is her own fault if she is raped.
4. If a girl acts like a slut, eventually she is going to get into trouble.
5. When girls get raped, it's often because the way they said "no" was unclear.
6. If a girl initiates kissing or hooking up, she should not be surprised if a guy assumes she wants to have sex.
7. When guys rape, it is usually because of their strong desire for sex.

8. Guys don't usually intend to force sex on a girl, but sometimes they get too sexually carried away.
9. Rape happens when a guy's sex drive goes out of control.
10. If a guy is drunk, he might rape someone unintentionally.
11. It shouldn't be considered rape if a guy is drunk and didn't realize what he was doing.
12. If both people are drunk, it can't be rape.
13. If a girl doesn't physically resist sex—even if protesting verbally—it can't be considered rape.
14. If a girl doesn't physically fight back, you can't really say it was rape.
15. A rape probably doesn't happen if a girl doesn't have any bruises or marks.
16. If the accused "rapist" doesn't have a weapon, you really can't call it rape.
17. If a girl doesn't say "no" she can't claim rape.
18. A lot of times, girls who say they were raped agreed to have sex and then regret it.
19. Rape accusations are often used as a way of getting back at guys.
20. A lot of times, girls who say they were raped often led the guy on and then had regrets.
21. A lot of times, girls who claim they were raped have emotional problems.
22. Girls who are caught cheating on their boyfriends sometimes claim it was rape.

Appendix C

Resource List

If you would like to receive sexual assault survivor resources, please explore the list below:

International Society for the Study of Trauma and Dissociation
http://www.isst-d.org/default.asp?contentID=18

The Sidran Institute
http://www.sidran.org/sub.cfm?contentID=19&sectionid=5

National Sexual Violence Resource Center
http://www.nsvrc.org/

National Sexual Assault Online Hotline
https://ohl.rainn.org/online/

The United States Department of Justice: Office on Violence Against Women
http://www.ovw.usdoj.gov/sexassault.htm

Resources for Male Survivors
http://www.mencanstoprape.org/Resources/resources-for-male-survivors.html

Appendix D

Recruitment Email

Dear Colleague,

My name is Jaclyn Pistorio and I am a fifth-year Clinical PsyD student at the Adler School of Professional Psychology. I am conducting a doctoral dissertation study examining licensed mental health workers' attitudes about sexual assault. The information obtained from this research may shed light on attitudes held by licensed mental health workers about sexual assault, with the goal of facilitating clinical work with sexual assault survivor populations and development of education programs that graduate programs may consider incorporating into their curricula.

You are eligible to participate if you are a licensed mental health worker (e.g., LCPC, LPC, LCSW, LSW, CADC, PsyD, PhD, or EdD) in a psychology, counseling, or social work field. You must also be 18 years of age or older and perform at least one face-to-face clinical hour per week. You will be asked to complete a confidential online survey, which should take 5-7 minutes to complete.

If you wish to participate please click this link:
https://www.psychdata.com/s.asp?SID=161714

The protocol number for this study is 14-083. Further questions about this study can be directed to Jaclyn M.P. Pistorio at jpistorio@my.adler.edu or Dr. Janna Henning, JD, PsyD at jhenning@adler.edu . Questions or concerns about your rights as a research participant should be directed to Dr. Peter Ji, PhD, Chair of the Adler School of Professional Psychology Institutional Review Board at pji@adler.edu

Thank you for your consideration in participating in this research project.

Best regards,

Appendix E

IRB Approval Letter

July 3, 2014

Dear Jaclyn Pistorio,

The Institutional Review Board evaluated the changes to your protocol **#14-083**, *Mental Health Professionals' Attitudes Towards Rape Survivors*. Your protocol has now received **Full Approval**. This decision means that you may proceed with your plan of research as it is proposed in your protocol.

Please note that if you wish to make changes to your protocol, you must provide written notification to the IRB in advance of the changes, co-signed by your Dissertation Chair, Dr. Henning. **You may not implement those changes until you have received a Full Approval letter from the IRB**. Please feel free to contact myself or other IRB committee members should you have any questions.

Sincerely,

Peter Ji

Peter Ji, Ph.D.
Associate Professor
Core Faculty, Psy.D. Program in Clinical Psychology
Co-Chair, Institutional Review Board

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Table 1

Demographic Information of Participants

	Number of Participants
Participant Variable	*N*
Gender Identity	
Female	122
Male	31
Ethnic/Racial Identity	134
Non-Hispanic White or Euro-American	3
Black, Afro-Caribbean, African American	6
Hispanic or Latino(a)	5
East Asian or Asian American	0
South Asian or Indian American	0
Middle Eastern or Arab American	3
Native American or Alaskan Native	0
Hawaiian or Pacific Islander	2
Other	
Type of Graduate Degree	51
Masters	102
Doctorate	
Clinical Hours per Week	
1-5 hours	12
6-15 hours	37
16-25 hours	63
26-35 hours	29
36-45 hours	12
46 hours or more	0
Years with Licensure	25
<1 year	41
2-5 years	24
6-10 years	19
11-15 years	15
16-20 years	20
21-25 years	9

26 years or more	
Participant Survivor Status	21
Survivor	122
Not Survivor	10
Prefer not to Disclose	
Family or Friend Survivor Status	72
Survivor	75
Not Survivor	6
Prefer not to Disclose	

Table 2

Levels of Rape Myth Acceptance for Male and Female Participants: Means and Standard Deviations

Gender Identity	*N*	*M*	*SD*
Female	122	103.07	6.95
Male	31	99.58	6.37
Total	153	102.36	6.99

Table 3

Levels of Rape Myth Acceptance for Male and Female Participants: Means (Mann-Whitney U)

Gender Identity	*N*	*M*
Female	122	82.68
Male	31	54.63
Total	153	102.36

Table 4

Levels of Rape Myth Acceptance for Master's- and Doctoral-Level Participants: Means and Standard Deviations

Type of Degree	*N*	*M*	*SD*
Master's	51	102.04	7.16
Doctorate	102	102.52	6.89
Total	153	102.36	6.96

Table 5

Levels of Rape Myth Acceptance for Master's- and Doctoral-Level Participants: Means (Mann-Whitney U)

Type of Degree	*N*	*M*
Master's	51	75.04
Doctorate	102	77.98
Total	153	102.36

Table 6

Levels of Rape Myth Acceptance for Rape Survivor and Non-Rape Survivor Participants: Means and Standard Deviations

Survivor Status	*N*	*M*	*SD*
Survivor	21	102.57	7.01
Not Survivor	122	102.98	6.99
Total	143	102.76	6.96

Note. Total number of participants takes into account ten (N = 10) participants that chose not to disclose their survivor statuses.

Table 7

Levels of Rape Myth Acceptance for Rape Survivor and Non-Rape Survivor Participants: Means (Mann-Whitney U)

Survivor Status	*N*	*M*
Survivor	21	76.12
Not Survivor	122	71.29
Total	143	102.36

Note. Total number of participants takes into account ten (N = 10) participants that chose not to disclose their survivor statuses.

Table 8

Levels of Rape Myth Acceptance for Family or Friend Rape Survivor and Family or Friend Non-Rape Survivor of Participants: Means and Standard Deviations

Family or Friend Survivor Status	*N*	*M*	*SD*
Survivor	72	102.40	7.24
Not Survivor	75	102.17	6.77
Total	147	102.29	6.96

Note. The total number of participants takes into account the six (N = 6) participants who chose not to disclose the survivor statuses of their family members or close friends.

Table 9

Levels of Rape Myth Acceptance for Family or Friend Rape Survivor and Family or Friend Non-Rape Survivor of Participants: Means (Mann-Whitney U)

Family or Friend Survivor Status	*N*	*M*
Survivor	72	75.69
Not Survivor	75	72.38
Total	147	102.36

Note. The total number of participants takes into account the six (N = 6) participants who chose not to disclose the survivor statuses of their family members or close friends.

Table 10

Independent Samples Tests for IRMA Subscales on Gender

IRMA Subscale	*p*
She Asked For It	0.004
He Didn't Mean It	0.249
It Wasn't Really Rape	0.594
She Lied	0.06

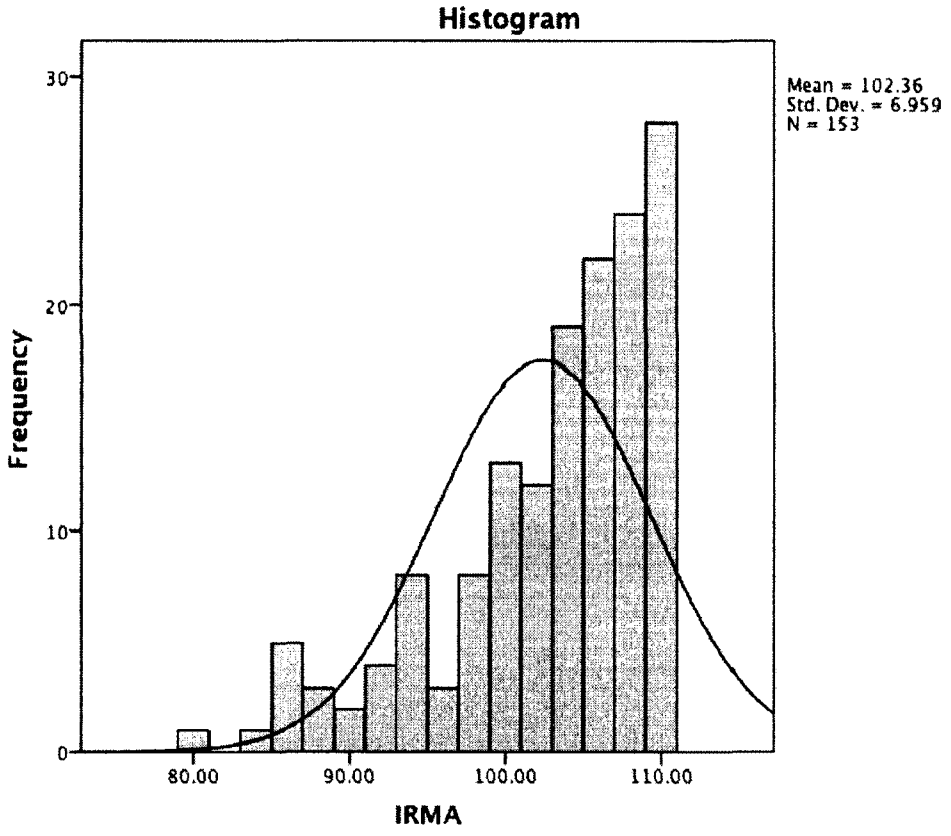

Figure 1. Frequency of distribution of Illinois Rape Myth Acceptance mean scores