REVICTIMIZATION OF SEXUAL ASSAULT SURVIVORS: CORRELATIONS BETWEEN SHAME, DISSOCIATION, RAPE MYTH CULTURE, AND REVICTIMIZATION

By

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A Dissertation Presented in Partial Fulfillment

Of the Requirements for the Degree

Doctor of Philosophy in Counselor Education and Supervision

School of Behavioral Sciences

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Abstract

Sexual assault (SA) remains a pervasive issue with profound psychological and social implications. This study investigated the relationships between shame, rape myth culture (RMC), dissociation, and revictimization among college students utilizing southern university health center counseling services. Using a quantitative, correlational, cross-sectional research design, the study addressed a gap in the existing literature by examining how these factors act together and affect SA survivors' mental health. The research questions focused on the decrease in shame following SA, the impact of revictimization on shame levels, and whether acceptance of rape myths and dissociation mediate this relationship. The study also explored whether these mediating effects are moderated by revictimization. The theoretical framework incorporated trauma theory, RMC theory, dissociation theory, and shame resilience theory. Data was collected through self-report surveys including TOSCA-3, DES II, and IRMA, and are analyzed using descriptive statistics, linear regression, and moderated mediation models. The findings within this study are expected to enhance mental health professionals' understanding of survivors' experiences and inform the development of educational and preventive measures to reduce revictimization within the college population.

Keywords: sexual assault, rape myth culture, dissociation, shame, revictimization

Dedication

This dissertation is dedicated to the survivors of sexual assault, whether it was “big” or “small”, “drastic” or “dramatic”, “stranger” or “friend”, “aggressive” or “violent”, it does not need to be classified in this space for it to have happened.

For those who were not believed, I believe you. For those who did not tell a soul, I see you. For those still struggling with the idea it happened at all, I support you. I dedicate this dissertation to those who had someone else take control of their person and violate their space. I dedicate this dissertation to those who battle the person and the demons daily.

May we find a future of support and belief without blame and shame. Survive and thrive.

Acknowledgments

My dissertation has been an incredible journey that has been more than I would have ever imagined. I am grateful and thankful for the professors who agreed to guide me through this difficult process while also helping light a fire within me to keep me going. I am forever thankful for my amazing chair, who saved me, and wonderful committee for helping me accomplish this ginormous task. Their words of kindness, encouragement, and support pushed me through difficult times and were able to get me to the point I am at today.

I am more than grateful and do not have the words to express how appreciative I am for my wonderful husband, Nathan, who supported me through this program despite the variety of unexpected unfortunate events. For sticking with me during the low times and encouraging me to prevail and for celebrating with me on the little wins. For dealing with my tired, sometimes snappy self who stayed up too late and woke up too early to crunch out work. For always being the one to provide snacks and laughs during the tough times. Thank you for sincerely supporting me through this program as you sacrificed the most. To infinity and Beyond.

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List of Abbreviations

American Psychological Association (APA)

Centers for Disease Control and Prevention (CDC)

Dissociative Disorders (DDs)

Dissociative Experiences Scale II (DES- II)

Federal Bureau of Investigation (FBI)

Illinois Rape Myth Acceptance Scale (IRMA)

Institutional Review Board (IRB)

National Center for Education Statistics (NCES)

Posttraumatic Stress Disorder (PTSD)

Rape, Abuse & Incest National Network (RAINN)

Rape Myth Acceptance (RMA)

Rape Myth Culture (RMC)

Sexual Assault (SA)

Test of Self-Consciousness Effect 3 (TOSCA-3)

Chapter One: Introduction

Overview

Sexual assault (SA) remains a critical issue worldwide, profoundly impacting individual lives and societal well-being, necessitating an in-depth review of its psychological and cultural consequences. This chapter begins by providing a background on the significance of SA in today's world, magnifying its direct impact on society's future. After this exploration, the proposed study, its significance, and the research questions are introduced. SA impacts individuals in a variety of ways, and this study will specifically look at shame, rape myth culture (RMC), dissociation, and revictimization as impacts on SA survivors.

This study addressed a gap in the existing scholarly literature by examining the relationship between shame, RMC, dissociation, and revictimization among students coming to university health centers. Utilizing a quantitative, cross-sectional, correlational research design, this study sought to answer the following research questions. How does revictimization impact the level of shame experienced by SA survivors? Does the acceptance of rape myths mediate the relationship between SA survivors and feelings of shame? Does dissociation mediate the relationship between SA survivors and feelings of shame? Does revictimization moderate the mediating effect of acceptance of rape myths on the relationship between SA survivors and feelings of shame? And finally, does revictimization moderate the mediating effect of dissociation on the relationship between SA survivors and feelings of shame? The theoretical framework for this study consists of trauma theory, RMC theory, dissociation theory, and shame resilience theory. This chapter will explore the problems addressed in this study, as well as identify the purpose and significance of the study for its readers.

Background

SA is the action of any nonconsensual sexual act, such as groping, kissing, molestation, or rape, in which consent is not or cannot be freely given (Lathan et al., 2023). The impact on individuals that experience and acknowledge their SA can be profound. SA can have detrimental effects on victims' mental health. Following SA, victims report they experienced anxiety (Short et al., 2020), depression (Rothman et al., 2021), post-traumatic stress disorder (PTSD; Dworkin et al., 2023), and/or physical health concerns such as eating disorders (Malet-Karas et al., 2022) and sexually transmitted diseases (Dworkin, 2020). Recognizing the impact of SA on individuals reinforces the urgent need to address its alarming prevalence in our society.

The Pervasiveness of Sexual Assault

According to the Rape, Abuse & Incest National Network (RAINN), an individual is sexually assaulted every 86 seconds in the United States (RAINN, 2022). Furthermore, the Centers for Disease Control and Prevention (CDC, 2014) reported that over half of women and one in three men will experience sexual violence in their lifetime. In 2019, the Federal Bureau of Investigation (FBI) reported approximately 122,822 cases of rape in the United States (FBI, 2019). While this data indicates the number of reported SA cases, it cannot account for the significant number of unreported instances to law enforcement.

Many SAs in the United States are never reported, with only 310 of every 1,000 SAs reported to police (RAINN, 2022). Wilson and Miller's (2015) meta-analysis found that 60% of rape victims do not recognize or label their incident as SA, indicating they are experiencing an unacknowledged rape. Unacknowledged rape occurs when an individual has experienced a SA meeting the definition of rape but does not recognize themselves as a rape victim (Peterson & Muehlenhard, 2004).

Unacknowledged rape is a barrier preventing true insight into the precise impact of sexual assault on campuses as a significant amount of college survivors do not report or acknowledge their assaults. In a study consisting of 2,016 college students, 43% of the women involved in the study were identified as unacknowledged rape victims (Bannon et al., 2013). In subsequent studies, as many as 73% of all women were unacknowledged rape victims (Bannon et al., 2013; Gibson & Leitenberg, 2001; Peterson & Muehlenhard, 2004; Ports et al., 2016). Despite this limitation, it is clear that SA, a pervasive public health problem in the United States, disproportionately affects university communities, often resulting in significant trauma (Potter et al., 2020).

Young adults aged 18-34, who constitute the majority of college communities, face the highest risk for SA, accounting for 54% of all reported cases (RAINN, 2022). In a national survey of college women, 53.7% of the individuals involved reported experiencing some degree of sexual violence (Aosved & Long, 2006). In 2019, the National Center for Education Statistics (NCES) national study reported that SA has increased by 383% on college campuses since 2009 and those numbers continue to increase (Irwin et al., 2021). These statistics underscore the urgent need to understand the psychological factors affecting survivors' mental health, specifically within college communities. This study aims to address this critical issue by examining the impact of SA through four conceptual lenses: shame, RMC, dissociation, and revictimization.

Impact of SA

SA can generate feelings of shame, perpetuate RMC, create dissociation, and increase the likelihood of revictimization. Unfortunately, with each passing year, the number of victims increases, while research remains limited. This further supports the importance of conducting

additional research that helps bridge the gaps between SA and how it can impact an individual, resulting in further victimization.

Shame

Pioneers in shame research, Tangney and Dearing (2002) define shame as a self-conscious emotion characterized by feelings of guilt, embarrassment, and humiliation. They found that shame is an emotion so strong that it makes everyone involved feel uncomfortable (Dearing & Tangney, 2011). The strength of shame can be seen within the therapeutic space. Shame can be utilized as a gauge to evaluate if an individual's social self is threatened (Cibich et al., 2016); shame can hinder the therapeutic process, resulting in the therapist avoiding subjects that illicit the emotion (Dearing & Tangney, 2011). Victims of SA often indicate feelings of shame (Cibich et al., 2016). Literature shows that increased levels of shame have been linked to aggression (Wang & Sang, 2020), eating disorders (Nechita et al., 2021), PTSD (Cunningham, 2020), and depression (Callow et al., 2021), adding additional concerns for SA victims.

Rape Myth Culture

Rape myth culture (RMC) is a specific set of attitudes and beliefs that may contribute to ongoing sexual violence by shifting blame for SA from perpetrators to victims (Aosved & Long, 2006). RMC is normalizing SA on college campuses, which allows individuals to be more at risk as they are not as vigilant of what is going on around them. As RMC increases, the assumption of normalcy increases, resulting in college-age individuals being less concerned regarding actions that happened against their bodies (Sall et al., 2024).

Basow and Minieri (2010) shows that, the greater an individual agrees with rape myths, the less the individual interprets nonconsensual sexual behavior as rape, and the greater the chance the individual supports the behavior of the perpetrator and blames the victim. The degree

to which an individual believes in rape myth directly correlates with the perceptions that individual has regarding date rape. For example, survivors who initially consented to go out with the perpetrator feel as if the actions that occurred were "justified or expected" due to agreeing to go out with them initially and do not see those actions as nonconsensual sexual behavior (Zidenberg et al., 2021).

Dissociation

Dissociation, defined by the American Psychological Association (APA, 2022) as a "disruption and/or discontinuity in the normal integration of consciousness, memory, identity, emotion, perception, body representation, motor control, and behavior," serves as a prevalent coping mechanism among trauma survivors, including those who have experienced sexual assault (p. 329). Van der Kolk et al (2005) identified this strategy as a common coping method to reduce stress, allowing individuals to emotionally detach from their traumatic experiences. Further studies by Briere and Scott (2006) align with this finding, indicating that individuals who have been sexually assaulted are more likely to use dissociation as a way to distance themselves from their traumatic experiences.

Scott et al. (2019) connected early experiences of SA during youth and young adulthood to an increased likelihood of experiencing dissociation as an adult suggesting the impact of SA can cause prolonged effects. Additionally, studies show that individuals who do experience dissociation have an even greater rate than those who also suffer from PTSD, eating disorders, or substance abuse (Lipschitz et al., 1996). Lastly, research indicates that avoidant and disengagement methods of coping individuals exhibit after an assault result in an increase in psychological distress overall (Gibson & Leitenberg, 2001; Orchowski et al., 2013). These

studies collectively highlight the significant negative impact of SA on mental health, particularly through the coping mechanism of dissociation.

Revictimization

Women who experience sexual revictimization experience reinforced feelings of shame, often internalizing their traumatic experiences by attributing blame to themselves. These individuals might label themselves as "bad" or "dirty" and often find ways to rationalize the assaults by blaming themselves despite the events not being their fault (Gibson & Leitenberg, 2001; Pratchett & Yehuda, 2011). Survivors who have been revictimized often mistakenly feel as if they are the "common denominator," and are therefore the ones to blame for the assaults occurring in the first place (Wager, 2019).

Research supports that individuals who experienced sexual abuse in their formative years are more likely to re-experience SA in their adult years, as it is one of the strongest indicators of revictimization (Ports et al., 2016). The risk is high during the ages of 18-29, a phase referred to as "emerging adulthood," and within this timeframe, individuals experience a high rate of emotional and mental challenges (Arnett, 2000). This period of time often offers individuals various life paths and affords individuals a new level of freedom and exploration than previously met at any other time in their lives. Additionally, emerging adulthood is the time when consolidation of formal operational thought and continued integration of parts of the brain that serve social processes, planning, problem-solving, and emotion take place. During this timeframe, individuals who have not been exposed to trauma typically experience a reduction in rash decisions and risky behavior as well as an increased epistemic cognition. Individuals who have experienced trauma, however, experience a disruption of this developmental growth, impeding the emotional and mental development of individuals experiencing trauma in emerging

adulthood (Arnett, 2016; Munsey, 2006). Given these insights, it is essential to examine revictimization within the context of SA among college students as this group falls within the critical phase of emerging adulthood.

Problem Statement

A significant problem surrounding SA is the increasing rates of both initial assaults and re-victimization on college campuses. RMC affects how SA is perceived by individuals. Research studies identified that there is a high correlation between rape myth acceptance and perpetrators of SA (Black & McCloskey, 2013). Based on the number of individuals who ascribe to rape myth beliefs, both the general population of individuals and those who perpetrate, there is a large population of individuals who support and tolerate SA (Aosved & Long, 2006). This normalization of SA leads to desensitization towards its occurrence, which is often followed by a decrease in shame, thus embedding it as a cultural norm. This cultural acceptance decreases an individual's vigilance, causing them to overlook danger cues, such as being extremely close in proximity, inappropriate hand placement, inappropriate touching, kissing on different parts of the body or suggestions toward intimacy or sexual actions, particularly in environments where acquaintances are present, despite acquaintance SA having the greatest risk (Baldwin-White, 2021; Bannon et al., 2013).

Additional concerns include the well-documented acute and chronic health consequences such as chronic illness, depression, PTSD, eating disorders, sexually transmitted infections, depression, and suicidal ideation (Black et al., 2011; Campbell et al., 2009; Gidycz et al., 2008; Kaura & Lohnman, 2007). Additionally, students who have been assaulted are more likely to develop substance use disorders and engage in high-risk behaviors (Combs et al., 2014; Fisher et al., 2000; Gidycz et al., 1995; Jordan et al., 2014). Academic performance is also adversely

affected, as studies show that individuals who experienced SA while attending college have lower GPAs than those who have not experienced SA (Molstad et al., 2023). Consequently, there is an increased rate of survivors not finishing their degree and dropping out of their university as a whole due to the SA they have experienced (Molstad et al., 2023).

Considering these factors, the increasing prevalence and societal tolerance of SA have devastating psychological impacts on SA survivors, highlighting the need for research and intervention strategies. While much is known about the prevalence and impact of SA, there is a critical need to understand the psychological factors that impact survivors' mental health, particularly how shame, dissociation, RMC, and revictimization contribute to these outcomes.

Purpose Statement

This study aims to address the urgent need for understanding the psychological factors impacting SA survivors' mental health. By investigating the relationships between shame, dissociation, RMC, and revictimization among college students utilizing SA counseling services at a southern U.S. university, this study provides insights into effective interventions and support systems for survivors, ultimately contributing to a reduction in SA prevalence and its impact. To understand the correlations between shame, dissociation, RMC, and revictimization, this study conducted evidence-based inventories to evaluate the age of the first incident, determine if individuals have been re-victimized, and, if so, identify at which age subsequent incidents occurred. Additionally, this study provides better insight into current trends that are impacting the safety and wellbeing of individuals while also evaluating the potential correlation between beliefs and re-victimization. Assessing the participants' beliefs surrounding shame, dissociation, and RMC is important as it will allow mental health professionals to better understand the beliefs of participants and their own experiences. This study directly compares shame, dissociation, and

RMC and how they correlate with a survivor's risk for re-victimization. This study seeks to provide mental health professionals insight into how the beliefs of individuals correlate with revictimization, thus utilizing this information to better educate students on campus through prevention materials, in hopes of decreasing revictimization among the college population.

Significance of the Study

The study is significant, as it will provide mental health professionals with a deeper understanding of components that affect revictimization, potentially changing therapeutic approaches and prevention strategies. Researching the relationship between these concepts allows knowledge surrounding beliefs, trends, and impressions to be added to the existing literature on SA. Additionally, this information could be the knowledge that is needed to help decrease and prevent revictimization.

Overall, this study provides a better understanding to assist with minimizing the effect on the SA survivor, as mitigating these impacts allows them to have a better quality of life, in addition to limiting the trauma they experienced. This study also allows mental health professionals to have a better understanding of survivors they treat regarding their beliefs and experiences. Individuals who are currently impacted by their trauma have instances of decreased shame, increased dissociation, and increased RMC, which leads them to situations of revictimization, therefore, this understanding could assist with ending the cycle of revictimization.

Research Questions

This study presents the following questions:

RQ1: How does revictimization impact the level of shame, measured by the TOSCA-3 (Tangney & Dearing, 2002), experienced by sexual assault survivors?

RQ2: Does the acceptance of rape myths, as measured by the Illinois Rape Myth Acceptance Scale (IRMA; McMahon & Farmer, 2011), mediate the relationship between sexual assault survivors and feelings of shame, measured by the TOSCA-3 (Tangney & Dearing, 2002)?

RQ3: Does dissociation, as measured by the Dissociative Experiences Scale II (DES II; Carlson & Putnam, 1993), mediate the relationship between sexual assault survivors and feelings of shame, measured by the TOSCA-3 (Tangney & Dearing, 2002)?

RQ4: Does revictimization moderate the mediating effect of acceptance of rape myths, measured by the IRMA, on the relationship between sexual assault survivors and feelings of shame, measured by the TOSCA-3 (Tangney & Dearing, 2002)?

RQ5: Does revictimization moderate the mediating effect of dissociation, measured by the DES-II, on the relationship between sexual assault survivors and feelings of shame, measured by the TOSCA-3 (Tangney & Dearing, 2002)?

Definitions

1. *Dissociation* refers to a disruption or discontinuity in "the normal integration of consciousness, memory, identity, emotion, perception, body representation, motor control, and behavior," (APA, 2022).
2. *Dissociative Disorder* is considered an "interruption of identity, thought, memory, emotion, perception, and consciousness," (APA, 2013).

3. A *Rape Myth* is a specific set of attitudes and beliefs that may contribute to ongoing sexual violence by shifting blame for sexual assault from perpetrators to victims (Aosved & Long, 2006).
4. *Revictimization* refers to when a survivor has a traumatic experience again after already experiencing a traumatic experience once (Basile & Smith, 2011).
5. *Sexual Assault* is defined as any type of sexual contact or behavior that occurs without the explicit consent of the recipient, including sexual intercourse, forcible sodomy, child molestation, incest, fondling, and attempted rape (National Institute of Justice, n.d.).
6. *Shame* is a highly unpleasant, self-conscious emotion arising from the sense of there being something dishonorable, immodest, or indecorous in one's own conduct or circumstances (APA, 2018).
7. An *Unacknowledged Rape Victim* is an individual who has experienced sexual assault that would legally qualify as rape but does not conceptualize oneself as a rape victim (Koss, 2011).

Summary

SA continues to have an impact on the world today and relentlessly causes difficult, complex issues for those who experience it. While much is known about the prevalence and impact of SA, there is a critical need to understand the psychological factors that impact survivors' mental health, particularly how shame, dissociation, RMC, and revictimization contribute to these outcomes. This study consists of self-report surveys that include evidence-based inventories assessing beliefs surrounding shame, dissociation, RMC, and revictimization. Additionally, the chapter discussed the research questions associated with the study that question

the correlation of SA, shame, dissociation, RMC, and revictimization. Lastly, the chapter explored the significance the study has within the SA research world while also discussing commonly used terms that will be used within this paper. Overall, the research questions seek to explore the effects of SA regarding shame, dissociation, RMC, and victimization to determine any correlation between variables. The literature that supports this study design will be reviewed in Chapter Two.

Chapter Two: Literature Review

Overview

Extensive literature asserts that rape is one of the most traumatic experiences that can happen during an individual's life (Clum et al., 2001; Kilpatrick et al., 1989; Kilpatrick & Resnick, 1993). However, the need for further research remains critical, as it is hindered by challenges such as underreporting by survivors resulting in significant gaps in understanding (Baldwin-White & Bazemore, 2020). The aftermath of SA is detrimental and can drastically affect a survivor's life immediately, often with long-lasting effects (Vitek & Yeater, 2021). This study seeks to explore the factors associated with SA, particularly shame, dissociation, RMC, and revictimization. Utilizing trauma theory, RMC theory, dissociation theory, and shame resilience theory, the following review of the literature will explore these areas and how they impact clients and their mental health.

Problems in Literature

There is widespread agreement that SA is extremely detrimental to mental health, however, how to conceptualize that harm is often the subject of debate (Goodman et al., 1993). Differences in the definitions of SA, rape, and consent between research studies make it challenging to get clear data regarding these concepts. For example, as of March 2023, some states lacked a clear definition of consent, allowing situations that would be deemed rape to be contested without requiring proof of resistance (RAINN, 2022). Consequently, rates of reporting vary significantly across states. For example, Georgia has no clear definition of consent and has the 10th lowest rate of reporting out of all 50 states (RAINN, 2022; Murphy-Oikonen et al., 2022).

Gaps in Literature

Current literature focuses on the characteristics of SA within the country, such as blame, shame, gaslighting commentary, the violent tendencies that are occurring, and the increase in rates of SA (Ahrens & Aldana, 2012; McMahon, 2010). Additionally, the literature explores the rates of revictimization and the likelihood of someone experiencing SA more than once in their lifetime (Campbell et al., 2009). Despite advancing drastically over the decades, literature on recovering after a SA is still limited regarding the recovery of those survivors who have been revictimized (Campbell et al., 2009). A significant problem regarding SA literature is that factors that impact revictimization are not thoroughly researched. Literature shows the failure to explain the increased vulnerabilities of individuals who have already experienced SA (Kearns & Calhoun, 2010).

Protective Factors and Risk Factors

There are several factors that can contribute to both risk and protection for SA. Risk factors for individuals include a previous history of SA, lack of treatment after a previous SA or traumatic event, the use of avoidance coping or other maladaptive coping methods, lack of support or receiving negative reactions, and/or having experienced different multitudes of violence altogether such as psychological, physical, and sexual (Carter-Snell & Jakubec, 2013). There are also protective factors that insulate people from experiencing SA. Protective factors for individuals include a history of resiliency from previous SAs or traumatic events, having a support system, elements of control within daily life, and/or having a higher education (Carter-Snell & Jakubec, 2013). While the research is limited, there is significant evidence that suggests that survivors of revictimization do not seek out treatment services (Schramm, 2016). Thus, these individuals do not benefit from the protective factors gained in treatment. Due to this lack of

engagement, survivors are often victimized again (Schramm, 2016). This study seeks to explore revictimization, providing essential information to explore protective and risk factors.

Theoretical Framework

The theoretical framework for this study consists of trauma theory, RMC theory, dissociation theory, and shame resilience theory. These theories together establish the importance of the topic at hand, as well as the need for improvement in research surrounding SA and the impacts it has on the survivors. These theoretical frameworks also provide the foundation for the conceptual models and research questions explored in this study.

Trauma Theory

Researchers have established that a trauma response theoretical model is a useful conceptual framework for guiding intervention and research (Goodman, 1993; Herman, 1992). The Trauma and Recovery Model by Judith Herman asserts that survivors undergo meaninglessness, helplessness, and disconnection as a result of their traumatic experiences (Nguyen et al., 2014). Trauma deeply impacts individuals, which allows for a complex theoretical framework, as the human experience itself is complex and includes identity, morality, meaning, and spirituality (Brier & Scott, 2015).

Sexual Assault Trauma

SA is a prevailing issue that has consequential effects that impact millions of people worldwide (Benoit et al., 2015). The aftermath of a SA can be lifelong and can contribute to lower psychological functioning and lower mental health (Dworkin, 2020; Dworkin et al., 2017; Rothman et al., 2019). Studies show that the majority of individuals who experience SA develop anxiety after their incident and often turn to alcohol and other illicit substances (Frank & Anderson, 1987; Ullman, 2007; Ullman & Brecklin, 2002). In addition to increases in risky

behavior, an increase in mental health illness occurs, and survivors often experience suicidal ideation and attempts after being assaulted (Dworkin, 2020). SA is considered to be one of the strongest contributors to an individual's development of PTSD (Dworkin, 2020).

O'Byrne et al. (2006) concluded that "date rape does not routinely result from innocent misunderstandings… but rather from the witting intention to engage in coercive sexual penetration" (pp. 149-150). Additionally, there has been a correlation between these situations and women who experienced similar situations where their refusal was ignored and now feel like future refusals would be useless (O'Byrne et al., 2006). Similarly, research has identified a high rate of males reporting SA who stated that "refusing was useless" (DeSantis, 2007; Wiederman, 2005). These perceptions underscore the importance of exploring high-risk populations, particularly college students, where victimization risk is high and individuals often underreport (Canan et al., 2018; Carey et al., 2018).

Sexual Assault Among College Students. Women in their first year of college are at the highest risk for SA (Carey et al., 2018). Specifically, women and LGBT+ undergraduate students are at the highest risk while attending college (Cantor et al., 2020; Coulter et al., 2017). In comparison to the general population, college-age women are three times more likely to be sexually assaulted (Potter et al., 2018). Male students are 78% more likely to be survivors of SA than males who are not college students, and 21% of transgender, gender-nonconforming, genderqueer students have been sexually assaulted (RAINN, 2022). The high rates of SA tie into the concept of how SA is becoming desensitized. This desensitization leads to inaccurate labeling when it is experienced, implying that the statistics surrounding SA could underestimate the prevalence (Owens et al., 2021). Additionally, research has shown that women may perceive that SA is a normative male behavior (Hlayka, 2014). Unfortunately, resources on college

campuses are funded by reported SA numbers, thus, due to underreporting, campuses will go without the proper resources to address SA, subsequently continuing the cycle (Barry & Cell, 2009; Canan et al., 2018).

Problematic sexual scripts, such as RMC, are reinforced on college campuses, especially within the Greek life system of universities. Universities sanction parties at fraternities, venues that are considered high-risk for SAs, which supports a culture that is prone to SA (Canan et al., 2018; DeSantis, 2007; Foubert et al., 2006; Humphrey & White, 2000). High-risk venues are considered any place where the chances of SA are increased (Carey et al., 2015). For example, 15% of college women experience SA during their freshman year while incapacitated. Therefore, a high-risk venue would include any place, such as a fraternity party or downtown bar, that has an open tab with a large body of individuals attending (Carey et al., 2015).

While females have the highest risk for SA, males are still subject to being survivors of SA. Within Greek-life, gender roles play a large part in the "expectation" of how someone should engage during a party. Various studies concluded that male students felt pressure during these parties that they needed to engage in sexual activities as "men were more sexually aggressive and wanting sexual engagement" and did not have the "ability" to say "no" if a situation arose (DeCarlo et al., 2014; Tjaden & Thoennes, 2006; Wiederman, 2005).

Due to SA having a direct impact on the survivor's psychosocial functioning and the decreased neurocognitive functioning paired with PTSD, survivors typically experience hardship regarding their ability to learn and succeed in the educational realm (Molstad et al., 2023). Additionally, for college students, there is a decrease in academic performance (Campbell et al., 2009; Jordan et al., 2014). The trauma associated with SA has adverse physical and mental health consequences.

Sexual Assault Mental Health Consequences. SA has a variety of negative psychological and physical consequences, both short- and long-term, with some being fatal (Du Mont et al., 2021). Typical psychological symptoms that result after SA include depression, dissociation, anxiety, shame, suicidal ideation, and suicide attempts (Basile & Smith, 2011). A long-term consequence of SA is developing PTSD (Du Mont et al., 2021). Symptoms of PTSD can include hypervigilance, startled response, nightmares, detachment from others, or numbness (American Psychological Association, 2013). Lipsky et al. (2016) identified that women who experienced SA were six times more likely to suffer from PTSD than those who experienced other traumas such as accidents, military combat, or natural disasters. Women who report a history of stalking or interpersonal violence in addition to the SA have a higher chance of suffering from PTSD (Möller et al., 2014). Additionally, individuals who experience trauma after trauma who have also experienced SA have the highest chances of developing PTSD (Scott et al., 2018). Du Mont et al. (2021) identified that the highest levels of PTSD symptomatology were among individuals who knew the perpetrator of their assault rather than a stranger.

SA survivors can also experience impulsive behaviors, alcohol and drug misuse, chronic illness, risky sexual behaviors, sexually transmitted infections, infertility problems, somatic issues, and interruption in personal dynamics such as romantic or family relationships (Papalia et al., 2021; Rogers et al., 2023; Sharratt et al., 2023). Despite having information surrounding consequences, individuals still under-report their challenges due to shame, lack of awareness of assault, or fear of repercussions, indicating that research may never uncover all challenges associated with SA (Alaggia et al., 2019).

Rape Myth Culture Theory

Seminal researcher, Herman (1988) defined RMC as a theoretical construct where a set of societal ideals and beliefs normalize sexual violence and foster environments that are conducive to rape. For decades, researchers have been able to identify that rape culture exists where both men and women believe that sexual violence is an unavoidable component of life (Buchwald et al., 1993). These beliefs are identified by behaviors and attitudes that normalize, justify, and minimize SA, which increases the tolerance for the act itself (Gerger et al., 2007).

Studies show that males demonstrate higher levels of RMC, as they are more likely to find the justifications for rape and the unawareness of rape acceptable (Frese et al., 2004). Additionally, they more frequently respond in agreement that women put themselves in positions that "allow" rape to occur (Frese et al., 2004; Suarez & Gadalla, 2010; Wentz & Archbold, 2012). Additionally, RMC beliefs are stronger among populations who have less education and are younger in age (Vonderhaar & Carmody, 2015). Individuals who have not received higher levels of education are less likely to be aware of the concepts surrounding consent (Hammond et al., 2011). In addition, individuals with lower levels of education may have difficulty defining what classifies as "not appropriate" behavior, as they have not experienced situations where they would have learned this information (Aronowitz et al., 2012; Hammond et al., 2011; Vonderhaar & Carmody, 2015).

Rape Myth Culture and Sexual Assault

Social and cultural isolation are not the underlying reasons behind SA, as studies show that society is a "rape-prone culture," promoting messaging that survivors are the individuals to blame for the assault (Buchwald et al., 1993; Burt, 1998; Lonsway & Fitzgerald, 1994). Researchers identified some of the most common rape myth beliefs, which include: "rape is

simply unwanted sex," "women fantasize about being raped," "husbands cannot rape their wives," "healthy women can resist all sexual attacks," "men can be sexually provoked to a point of no return," "women who dress provocatively are asking for it," "only attractive women get raped," " women who engage in alcohol or drug-related flirting deserve to be raped," "false reports of rape are common," "women lead men on and then cry rape," and "victims are attacked by strangers" (Canan et al., 2018; Cuklanz, 2001; Johnson, Kuck & Schander, 1997; O'Neal, 2019; Payne, Lonsway & Fitzgerald, 1999). Each of these beliefs contributes to overall RMC and how society perceives SA.

RMC has placed a hierarchy on acts that occur within SA to the degree to which it affects if a survivor would report. Studies show that individuals stated that they never reported their assault because it was "not bad enough," "wasn't reportable enough," or "serious enough" and very rarely labeled the acts that occurred to them as assault (Cleere & Lynn, 2013; Dumont et al., 2003; Fisher et al., 2003; Gavey, 2005; Weiss, 2010). Additionally, RMC has assisted with contributing doubt to survivors when the perpetrator of the assault was someone that they knew, as their "friend" would not commit a crime against them intentionally (Spencer et al., 2017). Individuals consider survivors who experienced SA by a stranger to be "genuine victims," unlike those who have been assaulted by an acquaintance (Lovett & Kelly, 2009; O'Neal, 2019). Studies show how RMC has affected individuals' beliefs, and that "real rape" is an act that is physically violent, with the use of threats or a weapon, and results in injury (Littleton & Axsom, 2003; Ryan, 2011). Additionally, researchers concluded that individuals have an increased sense of survivor culpability when there are factors that could be considered inappropriate behaviors, such as accepting a ride, walking alone at night, inviting someone over or going to an individual's home, consuming alcohol/drugs, becoming drunk/incapacitated, or hanging around

in “questionable” areas (Belknap, 2007; O’Neal 2019). Goodman-Delahunty and Graham (2011) concluded that individuals believed that when a survivor partakes in any of these inappropriate behaviors, the individuals felt as if the survivor was “asking to be raped.” For example, a university in the northern United States had a public display of RMC during a survivor-focused event. Numerous individuals made comments that supported and promoted RMC, such as “Shut up, we don’t care about it. You probably lead him on anyway;” and “If her panties matched her bra… it wasn’t you who decided to have sex” (Hockett et al., 2010).

RMC has allowed individuals to become distant from the “real” characteristics of SA which often turns into the survivor downplaying the events that occurred or disengaging from what happened, as it is “normal and expected” (Machorrinho et al., 2023). As RMC allows individuals to become distant and disengaged, the risk for dissociation increases as the individual uses maladaptive coping skills to escape what has occurred to them (Holland & Cipriano, 2021).

Dissociation Theory

One of the original and main concepts centered around dissociation theory is that dissociative phenomena play a crucial role in post-traumatic stress responses. Pierre Janet (1989) based his dissociation theory on nine concepts: consciousness, psychological automatism, subconscious, dissociation, narrowed field of consciousness, amnesia, fixed idea, suggestibility, and emotion (Gentsch & Kuehn, 2022; Van der Kolk, 1989). Psychological risk factors associated with PTSD that have developed from SA include avoidance of others, lack of social support, anger, negative appraisal of symptoms, and dissociation (Damiani et al., 2023; Klump, 2006). Individuals who experience dissociation may experience detaching from reality and emotional numbing (Benzakour et al, 2021; Bryant, 2007; Cyniak-Cieciura et al., 2022). Dissociation has been linked to protecting individuals from emotional distress (Bailey & Brand,

2017). The more trauma an individual experiences, the greater the complexity of the symptoms, which includes dissociative experiences. Every individual who experiences trauma does not experience dissociation, however, it is most common in individuals who lack coping mechanisms and individuals who have previously experienced trauma (Briere et al., 2016). Betrayal Trauma Theory states that dissociation is a process an individual goes through to forget details that would interfere with the want to remain in proximity to a dangerous situation, which then serves as a protection or coping mechanism when not able to physically escape (Bailey & Brand, 2017).

Dissociation and Sexual Assault

Frazier et al. (2005) concluded that SA results in negative effects such as dissociation as a way of coping with SA. When individuals experience any degree of trauma, they implore behavioral and cognitive attempts to cope with the stress of the trauma that has occurred, but even more frequently with SA (Hamrick & Owens, 2019). Dissociation as a coping mechanism can be maladaptive, as it does not alleviate the actual cause of the stress (Carver & Conner-Smith, 2010). Leiner et al. (2012) identified that the higher the levels of stress or degrees of trauma, the greater the survivor relies on dissociation techniques for coping. Van der Kolk et al. (2001) described how SA is one of the most severe forms of trauma, and when individuals have unsuccessful attempts to cope, this translates into dissociation. Additionally, research shows that individuals who experience dissociation after their assault have higher rates of revictimization due to the individual disconnecting from what previously occurred and not being fully engaged in their surroundings (Klonsky & May 2015; Noll et al., 2003).

Survivors are often dealing with a complex situation after an SA, as they wonder who is "safe" to confide in or who may believe in these RMC messages. Survivors must consider when reporting if they will be believed, or if they will be blamed, another potentially traumatic

experience (Campbell et al., 2009). Though reporting SA to law enforcement or to universities is statistically low, studies show 65-92% of survivors report to at least one support individual, such as a family member, a friend, or a romantic partner (Ahrens et al., 2007; Ullman, 2010). While reporting to "informal" support is typically more healing when it comes to traumatic situations, it can be negative and harmful if loved ones respond with patronizing behavior, doubting, asking questions, or encouraging secrecy after a SA (Ahrens & Aldana, 2012; Sudderth, 1998; Ullman, 2010). Ullman (2000) surveyed on their experiences of disclosing their SA, and 83% of the interactions reported had at least one negative response. Chivers-Wilson (2006) determined that the stigma attached to SA by rape myths can severely impact the survivor's development of PTSD and their overall healing.

Studies show that, due to RMC, there is a decreased likelihood of bystander intervention during a potential SA scenario (Hust et al., 2013; Lonsway & Fitzgerald, 1994; Owen et al., 2021). RMC exists socially for multiple factors. Rape myths function to socially oppress women, to maintain the idea that bad things only happen to those who deserve them, and to save society from facing the true reality of SA (Hayes et al., 2013). Additionally, belief in RMC often makes individuals believe that males are less likely to be identified as survivors, especially if the perpetrator is a woman (O'Byrne et al., 2006; Owen et al., 2021).

Lastly, research shows that, as an individual's RMC belief increases, so does the likelihood of that individual committing SA (Foubert et al., 2011). Foubert et al. (2011) examined the correlation between individuals who had a higher RMC and their beliefs surrounding SA; these authors determined that the individuals with increased RMC acceptance held different interpretations of SA and reported that they saw nothing wrong with simple acts, such as "smacking an individual's ass." Holland and Cipriano (2021) further examined and

recognized that there was a high correlation between individuals who had higher levels of RMC acceptance and those who had difficulty with questions surrounding consensual actions.

Dissociation and Mental Health

The APA (2013) states that dissociative disorders (DDs) are characterized by interruptions of thought, memory, identity, perception, emotion, and consciousness. Dissociation is a defense mechanism used to cope with trauma and pain while protecting the bodily self (Costa et al., 2015; Price, 2007). Individuals who suffer from DDs are at high risk for participating in behaviors such as self-harm and suicide attempts (Nester et al. 2022). Individuals who have DDs often do not receive appropriate treatment, as providers have disbelief regarding trauma history and dissociative symptoms. Lack of specific treatment can result in severe symptoms, repeated hospitalizations, intensive outpatient treatments, and poor quality of life (Leonard et al., 2005; Nester et al., 2022). Gomez (2021) confirmed that women who are in college are more susceptible to increased risk of mental health problems during emerging adulthood and thereafter. Survivors have shown an increase in bodily dissociation and "avoidance of internal experience" (Machorrinho et al., 2023). Additionally, bodily dissociation has been directly responsible for the onset of PTSD symptoms and the restriction of treatment options due to symptomology (Machorrinho et al., 2023). Traits of bodily dissociation can include difficulty with identifying and expressing emotions and increased anxiety that is not provoked by outside factors.

DePierro et al. (2022) determined that survivors of stress and violence, especially those who have experienced it more than once, become desensitized to numbing and stress triggers, as traumatic experiences dysregulate psychophysiological and neurochemical responses to stress. Survivors of war were compared to survivors of assault in regard to their increased stress

hormones, and it was determined that the dissociation of traumatic memories allowed survivors to create "normalcy" after the war. Survivors of SA are suggested to adapt the same way (Krüger, 2020).

Shame Resilience Theory

Shame Resilience Theory asserts that shame is caused by external factors that result in individuals feeling powerless, isolated, and trapped (Brown, 2006). These feelings lead to a variety of negative consequences, and if the individual experiencing them fails to understand what is happening, the individual then becomes avoidant or silent (Brown, 2006; Hauser, 2016). If the individual experiencing these feelings understands what is happening to them and begins to understand shame, the individual will then develop shame resilience (Dayal et al., 2015; Hernandez & Mendoza, 2011).

Shame is an emotion that is an extremely painful experience. Experiencing shame includes negative self-evaluation, beliefs of being unwanted, useless, unworthy of acceptance or belonging, flawed, and insufficient (Tangney et al., 2014). Wang et al. (2020) identified that shame is a result of an adverse interpersonal event where an individual gives negative attributes to themselves.

Shame and Sexual Assault

Research shows that there are several negative components following SA, including blame, which is often correlated to shame (Breitenbecher, 2006; Weiss, 2010). Shame and self-blame among survivors are often influenced by several factors including stereotypes, false beliefs about influence such as RMC, and the reactions a survivor may receive (Campbell et al., 2009; Suarez & Gadella, 2010). Survivors who experience shame after SA have a significantly higher chance of PTSD with more variance than someone who experienced other trauma (Moor

& Farchi, 2011). This underscores the importance of exploring shame in SA survivors and how shame, dissociation, RMC, and revictimization may be related.

Related Literature

The literature regarding SA, shame, revictimization, and dissociation has indicated multiple intersections of consideration. Through the lenses of trauma theory, RMC theory, dissociation theory, and shame resilience theory, the following literature provides a foundation for this study and indicates areas of further exploration. This section will explore the literature regarding each of the variables of consideration, including shame, dissociation, SA, and revictimization.

Shame

Shame has been widely discussed and debated regarding whether shame has problematic or functional components. Researchers do agree that shame is commonly linked to eating disorders, PTSD, and depression (Cibaich et al., 2016). However, some researchers argue that shame also is functional as it helps gauge when an individual feels threatened due to a loss of social bonds or status **(**Cibaich et al., 2016). Cibaich et al. (2016) reviewed and integrated conflicting research on shame and examined how shame can be an emotional situation that evolves into a problematic situation. For example, avoidance as a response to shame can convert shame from a functional, social gauge to a motivator to repair problematic emotions. The conceptualization of this idea was reflected within this study by using the Test of Self-Conscious Affect-3 (TOSCA-3; Tangney & Dearing, 2002). Within this research study, individuals were presented with hypothetical situations that described social transgressions and asked to rate the likelihood of how those individuals would respond with four options.

Ceclan and Nechita (2021) conducted a study that examined the effects of self-compassion would have on shame proneness with individuals diagnosed with clinical depression. TOSCA-3 was used as a measure and indicated that levels of shame proneness and depression decreased from baseline to post-intervention. Wright et al. (2017) examined the relationship of self-conscious emotions, forgiveness, and parental warmth. Through the use of TOSCA-3, they were able to determine that self-forgiveness and interpersonal forgiveness were predicted by empathy, shame, and parental warmth. Alvarez (2020) conducted a study to explore how 12 sessions of therapy could address shame resilience in the treatment of depression. The use of shame resilience theory and TOSCA-3 assisted in determining that there was a statistical decline in depression symptoms.

Literature has shown significant connections between neglect, emotional abuse, and social anxiety symptoms. Shahar et al. (2015) examined how different shame states affect the mechanisms of these connections. Using the TOSCA-3, the authors identified that shame and self-criticism played a part in the development of social anxiety disorders. Social anxiety disorder and eating disorder symptoms are highly comorbid (Shahar et al., 2015; Nechita & David, 2023). Nechita and David (2023) investigated how shame was associated with both eating disorder symptoms and social anxiety disorder symptoms. TOSCA-3 identified that shame was not a significant predictor for social anxiety symptoms, but body shame was a risk factor for eating disorder symptoms.

TOSCA-3 was used in a study that examined the hypothesis that an individual's shame can lead to an individual forgiving others' transgressions (Jordan et al., 2015). Jordan et al. (2015) were able to determine that the prosocial effects of shame go much further than the boundaries of one single interpersonal interaction or relationship. Literature has explored how

shame is associated with depression, anxiety, and greater psychopathology. Proeve et al. (2018) examined the association of rumination, self-compassion, shame, and psychological distress and the effects of mindfulness-based interventions within their participants by using TOSCA-3.

Trends in the literature suggest that shame does not play as big of a part in morality as guilt does. Sirgiovanni et al. (2023) performed a study to identify the interaction between shame and guilt with the attribution of responsibility to others. By using TOSCA-3, the researchers were able to determine that shame and guilt were associated with the attribution severity and were strong within the shame-affect and guilt cases. The aversion to shame correlates with aggression against self or others. Additionally, where the aggression is aimed could depend on what the shame is attributed to (Michelle et al., 2021). Using TOSCA-3, research indicated that aversion to shame was associated positively with relational, verbal, and passive-rational aggression and non-suicidal self-injury.

Research has suggested for decades that shame is present in posttraumatic psychopathology (Ojserkis et al., 2014). Ojserkis et al. (2014) explored the relationship between shame, moral disgust, guilt, and posttraumatic stress symptoms, and assessed comprehensive distancing as a novel intervention. This study included the use of TOSCA-3 to measure the cognitive, affective, and behavioral features associated with guilt and shame in scenarios commonly experienced by individuals who are college students.

Dissociation

Extant literature discusses the importance of studying the effect of dissociation during intimate partner violence, as it is important to the risk of revictimization (Fleming & Resick, 2016). Fleming and Resick (2016) examined the different variables involved with survivors of interpersonal violence and how dissociation played a role in their experience. The DES II

(Carlson & Putnam, 1993) results stated that there were indirect effects of peritraumatic dissociation and cognitive distortions on the relationships between dissociation related to PTSD and current psychological abuse. DeCou et al. (2016) conducted a study exploring the relationship between lifetime trauma exposure, interpersonal violence, posttraumatic stress, and trait dissociation among survivors of interpersonal violence who were incarcerated. Using the DES II, the researchers identified that most participants fell above the conservative cut-off score on PTSD, trait dissociation mediated the correlation between PTSD and interpersonal violence, and trait dissociation was the strongest predictor of PTSD.

Klanecky and colleagues (2008) explored the relationship between childhood sexual trauma, dissociation, and problematic drinking while in college, including alcohol-induced blackouts. The DES II determined that drinking alcohol was a maladaptive coping mechanism used by female students with childhood sexual trauma. Katzman and Papouchis (2023) studied the relationship between dissociation, mentalization, and childhood trauma. By using the DES II, researchers identified that mentalization did not mediate between childhood trauma and dissociation. One study explored how dissociation moderated the relationships between childhood sexual abuse and sexual motivation (Gewirtz-Meydan & Lahav, 2021). Through the use of the DES II, researchers determined that individuals who report high levels of dissociation use dissociation during times of intimacy, partner approval, and coping with negative emotions.

Klanecky et al. (2016) examined the relationship between problematic drinking in college and early sexual abuse. During this study, the DES II was used to identify how often participants were dissociating, and if they were using it as a coping mechanism during times of stress. Literature has discussed dissociation as being used as a maladaptive coping mechanism (Klanecky et al., 2016). Klanecky et al. (2012) conducted a study that looked at the use of

alcohol as a replacement for times of inadequate dissociation capabilities. Researchers used the DES II to examine the mediating potential of dissociation tendencies and alcohol use among college students. The DES II has shown significant results in measuring dissociative experiences in topics related to SA, exhibiting the need for further research in SA survivors.

Rape Myth Culture

Literature in recent years has developed a theme of showing decreased rates of rape myth acceptance **(**Thelan & Meadows, 2022). However, the cause of this decrease is unknown, as it could be a genuine decline in individuals' attitudes towards RMC or because it has become socially undesirable to acknowledge acceptance **(**Thelan & Meadows, 2022). Thelan and Meadows (2022) conducted a study to look at ways to identify how psychometric measures could account for this. The IRMA was used during this study to compare results to other psychometric measures to assess degrees of decreased response to RMC. Lys et al. (2023) conducted a study comparing the results of the IRMA with other inventories completed by participants regarding right-wing authoritarianism, system justification, cultural conservatism, social dominance orientation, hostile sexism, and unjust world beliefs. The results from this study indicated that IRMA was high among all study participants. (Lys et al., 2023).

Within recent years, sexual violence prevention on college campuses has received a lot of attention (Frazier & Gonzales, 2022). Frazier and Gonzales (2022) examined the concept of re-educating college students about the ideas of consent while reducing the acceptance of rape myths. Using the IRMA allowed Frazier & Gonzales to evaluate the proposed predictors of RMC acceptance. Literature addresses how colleges have high rates of SA and are "rape-prone" cultures (Canan et al., 2018). Canan et al. (2018) conducted a study that examined rape-supportive attitudes as well as victimization in college students, specifically focused on Greek

life. Researchers used IRMA to identify trends in their research and determined that Greek life and gender have significant indicators related to RMC acceptance. Johnson et al. (2021) conducted a study to explore if a first-year college course affected attitudes, knowledge, and behavioral intentions about sexual violence, gender, and sexuality. Researchers used IRMA to analyze the results of the study and found that first-year college students had high IRMA scores and after attending the courses the participants' scores decreased (Johnson et al., 2021).

Acknowledging that the bystander approach to rape prevention has limited research but is gaining popularity on college campuses, McMahon (2010), conducted a study exploring the relationship between RMC and bystander attitudes on college campuses. McMahon used the IRMA to assess the relationship and determined that RMC acceptance was higher by males, individuals involved with Greek life, those without previous rape education, athletes, and those who did not know someone personally who was sexually assaulted. These results indicate a need for further education in bystander interventions on college campuses.

Revictimization

Research has shown that past victimization, whether in childhood or adulthood, is one of the only risk factors for future revictimization (Gidycz et al., 1995; Owens et al.,2021). Widom et al. (2008) concluded that individuals who experienced SA during their time at college have a higher risk of being sexually assaulted again later in life. Survivors frequently fear being revictimized, and many survivors feel less safe in the world altogether (Kaysen et al., 2005).

Cardeña et al (2021) reported individuals who have a history of trauma, specifically SA, have an elevated gauge of threat and heightened symptoms of arousal, which are directly linked to dissociative tendencies. While dissociation is a risk factor for revictimization, revictimization has also been shown to strengthen negative cognitions and emotions when re-experiencing

trauma, therefore increasing dissociation (McDonald et al., 2013). This underscores the need for further research in how dissociation, shame, RMC, and revictimization may be related.

Summary

SA, shame, RMC, dissociation, and revictimization have been thoroughly investigated in the literature, expressing the significance these variables have on individuals. Combining these variables into a study to explore their relationships on SA survivors is essential for further research and SA treatment and prevention. The instruments used to weigh these variables have been used in a significant number of studies, and supporting the use of these measurements for this study. In the coming chapter, the research design and measurements will be thoroughly discussed.

Chapter Three: Methods

Overview

This study aimed to investigate the relationships between shame, dissociation, rape myth culture (RMC), and revictimization among college students utilizing SA counseling services at a southern U.S. university. By comparing the impact of these factors on individuals who have experienced a single episode of SA versus those who have been revictimized, this study sought to explore how repeated victimization affects psychological and cultural responses to SA. The individuals participating in this study are among the highest risk of falling victim to SA, as participants are current college students. This chapter provides a comprehensive review of the methodology for the study, including the research design, research questions, and hypotheses. Next, a review of the study's instrumentation, the process for data collection, and the plan for data analysis will be presented. Finally, the chapter will conclude with a summary and a preview of the upcoming chapters.

Research Design

This study applied a quantitative, cross-sectional, correlational research design utilizing a moderated mediation model consisting of a single moderator and parallel mediators to determine the correlation of RMC, shame, dissociation, and revictimization among college-age survivors of SA. Quantitative research utilizes a methodological approach to examining variables, testing their associations, and examining cause-and-effect associations between variables (Bloomfield & Fisher, 2019). Quantitative research designs are best used for relationship studies, as correlation reflects the strength of the relationship (Heppner et al., 2016). As such, a correlational research design is the most appropriate for this study as it investigates relationships between multiple variables without the researcher manipulating or controlling any of the variables.

This study collected archival data from an anonymous self-report survey prior to engaging in a counseling session. After all the participants completed the survey, the researcher collected the surveys, compiled the data, and analyzed the results. Descriptive statistics, linear regression, and a moderated mediation model consisting of a single moderator and parallel mediators will be used to analyze the data and determine whether there is a relationship between the variables in the study. All data will be entered into the IBM Statistical Package for the Social Science (SPSS) Statistics version 29.0 (IBM Corp, 2022) and analyzed.

Research Questions

The research questions presented are associated with the problem under investigation in this study, which examined how repeated victimization affects psychological and cultural responses to SA among university students utilizing SA counseling services. It was expected that a greater understanding of the complex dynamics between survivors' personal experiences and cultural perceptions will contribute to a greater understanding of the phenomenon of revictimization and will support the development of protective measures in the future. As such, responses to these questions were used to assist mental health professionals and university policy-makers attain knowledge and develop evidence-based strategies to establish support systems and identify preventative measures for campuses. The research questions for this study are as follows:

RQ1: How does revictimization impact the level of shame, measured by the TOSCA-3 (Tangney & Dearing, 2002), experienced by sexual assault survivors?

RQ2: Does the acceptance of rape myths, as measured by the Illinois Rape Myth Acceptance Scale Updated (IRMA; McMahon & Farmer, 2011), mediate the relationship

between sexual assault survivors and feelings of shame, measured by the TOSCA-3 (Tangney & Dearing, 2002)?

RQ3: Does dissociation, as measured by the DES II (Carlson & Putnam, 1993), mediate the relationship between sexual assault survivors and feelings of shame, measured by the TOSCA-3 (Tangney & Dearing, 2002)?

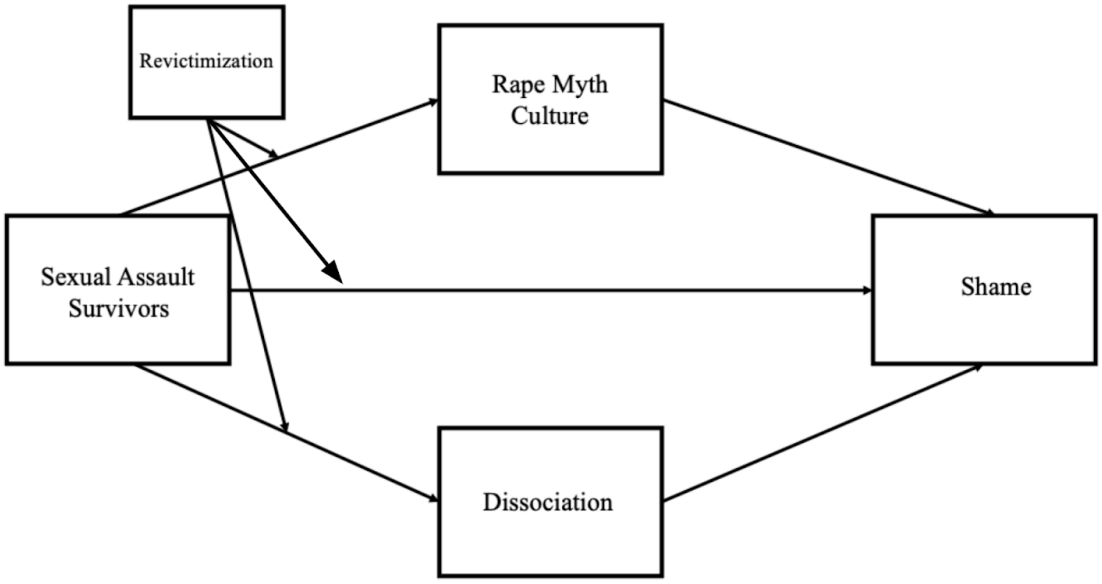
RQ4: Does revictimization moderate the mediating effect of acceptance of rape myths, measured by the IRMA, on the relationship between sexual assault survivors and feelings of shame, measured by the TOSCA-3 (Tangney & Dearing, 2002)?

RQ5: Does revictimization moderate the mediating effect of dissociation, measured by the DES-II, on the relationship between sexual assault survivors and feelings of shame, measured by the TOSCA-3 (Tangney & Dearing, 2002)?

The conceptual model shown in Figure 3.1 visually depicts the relationships examined for this study.

Figure 3.1

Study Conceptual Model



Hypotheses

The hypotheses for this study are as follows:

***H_a1*:** SA survivors who have been revictimized will report lower levels of shame compared to those who have experienced a single SA.

***H_a2*:** The relationship between SA survivors and their feelings of shame will be mediated by their acceptance of RMC, such that higher acceptance of rape myths will increase the level of shame experienced by SA survivors.

***H_a3*:** There is an inverse relationship between SA survivors and their feelings of shame when mediated by their levels of dissociation, such that higher levels of dissociation will decrease the level of shame experienced by SA survivors.

***H_a4*:** The mediating effect of rape myth acceptance on the relationship between SA survivors and their feelings of shame will be stronger for survivors who reported revictimization compared to those who have experienced a single incident of SA.

***H_a5*:** The mediating effect of dissociation on the relationship between SA survivors and their feelings of shame will be stronger for survivors who reported revictimization compared to those who have experienced a single incident of SA.

Participants and Setting

The data for this study was obtained from students recruited from a university health center located in the southern United States. The university is categorized as a large university that serves roughly 40,118 students and among those students, 57 different countries are represented. The SA counseling department currently offers services to students enrolled in courses ranging from undergraduate studies to graduate/doctoral courses, resulting in a variety of individuals 18 or older receiving services. The department does not discriminate and provides services to both male and female students of varying ethnicities and cultural backgrounds.

The targeted participants for this study are college students who are receiving counseling services for SA. All recipients of services at the SA counseling department are given the opportunity to participate in the study, and those who provided consent will be included in the sample. Specific details and demographics of participants for this survey were not obtained, as the SA department operates on an anonymous basis and does not collect this data. As such, the survey followed this established protocol.

To determine the sample size appropriate for this study, the researcher utilized specialized software, G*Power 3.1 (Faul et al., 2009). According to Cohen (1988), f^2 is the ratio of the explained variance to the error variance and serves as a measure of effect size. Cohen (1988) purported f^2 values of .02, .15, and .35, which indicate small, medium, and large effects. For this study, an effect size of .15 was chosen to evaluate for a medium effect due to sample size restrictions. The following parameters were entered into G*Power 3.1: F test family; linear

multiple regression: fixed model, R-squared deviation from zero; a priori; effect size .15; alpha value was set at .05; power test was set at .80; and the total number of predictors proposed for the study was 5. After calculation, the total sample size necessary for this study is 92 participants (see Appendix E).

Instrumentation

Using a cross-sectional design, this study sought to gain insight into the phenomenon of SA on campuses by assessing the relationship between shame, dissociation, RMC, and revictimization among college students. A survey was created that included four initial questions in a self-report format followed by questions from three psychological measures. The study uses the Test of Self-Conscious Affect-3 (TOSCA 3), the Dissociative Experiences Scale II (DES II), and the Illinois Rape Myth Acceptance Scale Updated (IRMA) to measure shame, dissociation, and RMC respectively, reflecting the study's theoretical framework. Each instrument will be reviewed in greater detail in the upcoming sections.

Self-Report Survey

The beginning of the survey includes a self-report survey designed to measure participants' history of SA and revictimization. As the individual is receiving services, it is implied that they have experienced SA. Therefore, the first question addressed age by asking, "Age of first incident?" The second survey question inquired about revictimization by asking, "Have you experienced more than one incident?" Lastly, participants were asked, "Age of additional incident(s)." These questions were used to assess the occurrence or recurrence of their experiences. Eligible participants have indicated a previous incident of SA, as they are obtaining services but are not required to indicate revictimization.

Test of Self-Conscious Affect – 3

The study assessed for shame with the use of the Test of Self-Conscious Affect – 3 (TOSCA-3; Tangney & Dearing, 2002). This psychological measure evaluates the participant's tendency towards feelings of guilt and shame through scenarios with associated questions that describe a social situation. The TOSCA-3 measures participants' responses to hypothetical situations by asking the individual to rate their response from four different options. Additionally, TOSCA-3 has overall good psychometric properties and a shame subscale which has demonstrated high internal consistency (Proeve et al., 2018; Tangney & Dearing, 2002). For this reason, the present study used those same TOSCA-3 instruments, which include the shame subscale.

In the present study, participants were provided the TOSCA-3 questionnaire with clear directions to respond to each scenario on a Likert-type scale of 1 (not likely) to 5 (likely). Following completion, each participant's 11 responses were summed with scores ranging from 11-55. Higher scores reflected a higher possibility of experiencing feelings of shame. Participants with a score greater than 35 were coded positively for shame, as recommended within the scoring section of the TOSCA-3 (Tangney & Dearing, 2002).

Dissociative Experiences Scale II

The study assessed for dissociation through the use of the Dissociative Experiences Scale II (DES II; Carlson & Putnam, 1993). The DES II evaluates dissociative experiences that occur within an individual's daily life such as depersonalization, absorption, derealization, and amnesia. The DES II has overall good psychometric properties (Carlson & Putnam, 1993). The DES II has been shown to be valid and reliable both in clinical and non-clinical settings (Wright

& Loftus, 1999). Additionally, it has shown to be a success within the college population (Klanecky et al., 2008; Rodriguez-Srednicki, 2001).

For this present study, DES II was used to assess how frequently study participants experienced symptoms of dissociation. The 28 items were summed with scores ranging from 0% (never) to 100% (always), measured in 10% increments, and then averaged to yield an overall score. Higher resulting scores indicated a higher level of dissociative symptoms. According to the creators of the assessment, an appropriate cutoff score indicating severe levels of dissociation is 30 (Carlson & Putnam, 1993). Additionally, a previous study of college-aged participants, agreed that 30 was an appropriate cutoff score indicating severe levels of dissociation (Klanecky et al., 2012). Given these recommendations, this study's participants with a score greater than 30 were coded positively for dissociative experiences.

Illinois Rape Myth Acceptance Scale

The study assessed RMC using the Illinois Rape Myth Acceptance Scale Updated (IRMA; McMahon & Farmer, 2011). The IRMA is an assessment that asks participants to rate their level of agreement with statements surrounding the topic of SA and women. The IRMA is among the most reliable and sound psychometric measures in use today to measure rape myth acceptance (McMahon & Farmer, 2011). Previous research has confirmed adequate to excellent internal consistency and construct validity (Newins et al., 2018; Payne et al., 1999).

For this present study, IRMA was used to measure the frequency of participants' symptoms/ beliefs of RMC. Participants were asked to respond to prompts using a Likert-type scale with their responses varying from strongly agree (1) to strongly disagree (5). Participants with lower scores reflected a participant's weaker rejection of rape myths, therefore, having a strong endorsement of RMC.

Selection of Participants

After receiving Institutional Review Board (IRB) approval at the southern university providing the data for this study, the collection of surveys began. Participants were prompted prior to their scheduled counseling sessions to invite them to participate in the study. Each participant was advised of the purpose of the study and notified of their anonymity prior to participating. Once participants agreed to take part in the study and consent was signed, the participant was given a self-report survey to complete before their pre-scheduled counseling session. Precautions were taken to ensure the participant's responses remained anonymous, as no identifying information was collected. After completing the survey, the participant was provided instructions to return the anonymous survey, at which time the survey was placed in a manilla envelope in a locked drawer. Upon approval from the IRB at Liberty University, the researcher gained access to the protected and secured surveys, compiled the data into an online format, and analyzed the results utilizing IBM SPSS. The next section will review the process for data analysis.

Data Analysis and Statistical Procedures

As conceptualized in Figure 3.1, this study sought to analyze relationships between the constructs shame, dissociation, RMC, and revictimization among college students seeking counseling services for SA. It is anticipated that the use of descriptive statistics and a moderated mediation model with a single moderator and parallel mediators will provide an in-depth understanding of the relationships in question. To begin data analysis, the data was collected from the surveys and was input into IBM SPSS to create a codebook. Any items that required reverse coding were entered appropriately within that system and were double-checked prior to

data analysis to ensure accuracy. The following sections will provide additional details on the statistical procedures that were used to analyze the data.

Descriptive Statistics

Descriptive statistics are various methods used to calculate, describe, and summarize collected research data in a logical, meaningful, and efficient manner (Vetter, 2017). Descriptive statistics were used in this study to identify the characteristics of the sample and verify that there are no variables that violate the assumptions underlying the statistical techniques for the research questions (Pallant, 2020). This was completed by an initial scan of the surveys to verify that all participants indicated an experience of SA and met the study's requirements. This preliminary data review provides a foundation for additional complex analysis.

Moderation Model

In a simple moderation model, it is assumed that the effect of X on Y is moderated by W if its size, sign, or strength depends on or can be predicted by W (Hayes, 2018). After gaining an understanding of the feelings of shame (Y) experienced by SA survivors (X), the study used a moderation model to test for any moderating effects on the relationship from the moderator, revictimization (W). By using a simple moderation model to test our hypothesis, this study aimed to align with current research and further solidify the reliability of the results.

This method of analysis will assess the following alternate hypothesis:

***H_a*1:** Sexual assault survivors who have been revictimized will report lower levels of shame compared to those who have experienced a single sexual assault.

Parallel Mediation Model

Complex models, such as parallel mediation models, include the analysis of more than one mediator and are often proposed to analyze multiple mediations concurrently and their influence on the relationship between X and Y (Hayes, 2018). These mediators are allowed to correlate with one another but cannot influence each other in causality, as they are placed in different paths with no measurement between them (Kane & Ashbaugh, 2017). By isolating the mediator's dissociation and RMC from each other and reducing the risk of their influence on each other, this model will allow for a more complex assessment of the processes through which SA survivors experience shame.

This method of analysis will assess the following alternate hypotheses:

***H_a*2:** The relationship between SA survivors and their feelings of shame will be mediated by their acceptance of RMC, such that higher acceptance of rape myths will increase the level of shame experienced by SA survivors.

***H_a*3:** There is an inverse relationship between SA survivors and their feelings of shame when mediated by their levels of dissociation, such that higher levels of dissociation will decrease the level of shame experienced by SA survivors.

Moderated Mediation Model

Moderated mediation model analyses, also known as conditional process models, are used when the relationship between X to Y can be considered conditional given the indirect effect of X and Y through M is contingent on a moderator W (Hayes, 2018). Two different PROCESS Model 7 (Hayes, 2018) analyses were conducted to test for the indirect effect of SA

experiences (X) on shame (Y) through the proposed mediators RMC (M) and dissociation (M), with the indirect effect being moderated by revictimization (W).

This method of analysis will assess the following alternate hypotheses:

***H_a*4:** The mediating effect of rape myth acceptance on the relationship between SA survivors and their feelings of shame will be stronger for survivors who reported revictimization compared to those who have experienced a single incident of SA.

***H_a*5:** The mediating effect of dissociation on the relationship between SA survivors and their feelings of shame will be stronger for survivors who reported revictimization compared to those who have experienced a single incident of SA.

Summary

This chapter provided a detailed overview of the research methodology for this study. This study applied a quantitative, cross-sectional, correlational research design utilizing a moderated mediation model consisting of a single moderator and parallel mediators to determine the correlation of RMC, shame, dissociation, and revictimization among college-age survivors of SA. The research design consisted of a self-report survey taken by SA survivors before engaging in therapeutic services. Participation in the study was anonymous and optional. Data was collected and entered into IBM SPSS Statistics. The next chapter will provide a comprehensive overview of the results gathered from the analyses, and the subsequent chapter will explore the study's limitations and further implications.

Chapter Four: Findings

Overview

Surveys were collected over three semesters to obtain participants for this quantitative, cross-sectional, correlational design. This study explored the relationship between shame, dissociation, RMC, and revictimization among college survivors of SA. At the beginning of this study, with an initial approval from the southern university's IRB, participants were provided the survey, and their data was securely stored. Upon final approval of the study by the Liberty University IRB, these completed surveys and associated data were retrieved and analyzed. This chapter reports the data collected and the findings of the study as determined utilizing IBM SPSS and PROCESS Models 4 and 7 (Hayes, 2018).

Data Screening & Filtering

The survey was collected for individuals participating in counseling services for three semesters at a southern university. The data collected included 113 total responses. Surveys were manually scored and transferred into an online, secure, Google Sheet database. For the purposes of this study, data from the TOSCA-3 survey on guilt and blaming others was not included as they were not predictors under analysis, leaving only the data on shame in the database. Additionally, the data from the IRMA was totaled and individual subscales were deleted. For the number of SA column, the number of SAs an individual reported was entered. If the participant reported "no" for revictimization, it was assumed one SA occurred. If "yes" was reported but ages were not, it was assumed two SAs occurred. After reviewing these responses, illogical answers within the fill-in-the-blank portions of the survey were excluded from the data sample. Next, this data was uploaded into the IBM SPSS program. The data was labeled, and the codebook was reviewed for accuracy. Scores from the DES II, TOSCA-3, and IRMA were

mean-centered, and missing variables were replaced to reduce the impact to the analysis. Additionally, incomplete screenings were removed from the data, resulting in 108 remaining responses.

Descriptive Statistics

An essential component of this study is assessing demographic data to explore descriptive statistics within the study's measurements. This section first addresses the data obtained from the demographic questions administered at the beginning of the survey. Next, the data obtained from the questions in each of the assessments will be reviewed. Finally, descriptive statistics about the variables and measures from the scales are addressed.

Demographics

To protect the safety and security of the participants of this study, demographic information regarding their age, gender, ethnicity, age, or educational level was not requested. However, the demographic information provided for this study, while limited, was significant, as each participant provided information about their age of first SA, the age of any additional SAs, and if they had experienced revictimization. The average number of SAs among the participants in this study was reported to be 2.19, with the highest number of SAs reported as 11. The earliest reported age of SA among participants was 3**.** Of all of the participants in this study, 82 out of 108, or 75.93%, reported experiencing revictimization.

Research Questions and Hypotheses

After collecting demographic information, participants answered questions regarding the four conceptual lenses of this study: shame, dissociation, RMC, and revictimization. Statistical tests, including Pearson correlation, Spearman correlation, and linear regression, were performed on this study's data to answer the following research questions and hypotheses:

RQ1: How does revictimization impact the level of shame, measured by the TOSCA-3 (Tangney & Dearing, 2002), experienced by SA survivors?

***H_a1*:** SA survivors who have been revictimized will report lower levels of shame compared to those who have experienced a single SA.

RQ2: Does the acceptance of rape myths, as measured by the Illinois Rape Myth Acceptance Scale Updated (IRMA; McMahon & Farmer, 2011), mediate the relationship between SA survivors and feelings of shame, measured by the TOSCA-3 (Tangney & Dearing, 2002)?

***H_a2*:** The relationship between SA survivors and their feelings of shame will be mediated by their acceptance of RMC, such that higher acceptance of rape myths will increase the level of shame experienced by SA survivors.

RQ3: Does dissociation, as measured by the Dissociative Experiences Scale II (DES II; Carlson & Putnam, 1993), mediate the relationship between SA survivors and feelings of shame, measured by the TOSCA-3 (Tangney & Dearing, 2002)?

***H_a3*:** There is an inverse relationship between SA survivors and their feelings of shame when mediated by their levels of dissociation, such that higher levels of dissociation will decrease the level of shame experienced by SA survivors.

RQ4: Does revictimization moderate the mediating effect of acceptance of rape myths, measured by the IRMA, on the relationship between SA survivors and feelings of shame, measured by the TOSCA-3 (Tangney & Dearing, 2002)?

***H_a4*:** The mediating effect of rape myth acceptance on the relationship between SA survivors and their feelings of shame will be stronger for survivors who reported revictimization compared to those who have experienced a single incident of SA.

RQ5: Does revictimization moderate the mediating effect of dissociation, measured by the DES-II, on the relationship between SA survivors and feelings of shame, measured by the TOSCA-3 (Tangney & Dearing, 2002)?

***H_a5*:** The mediating effect of dissociation on the relationship between SA survivors and their feelings of shame will be stronger for survivors who reported revictimization compared to those who have experienced a single incident of SA.

Measures and Variables

This section discusses the data obtained from the survey and reports the descriptive statistics of the scales for each variable, including the independent variable (number of SAs = X), dependent variable (shame = Y), two mediators (dissociation and RMC = M) and the moderator (revictimization = W). This section will explore each variable separately, reporting their results within the surveyed population.

Reliability

The acceptance of RMC, as measured by the IRMA total score, has a mean of 101.556, a standard deviation of 8.7283, skewness of -1.540, and the kurtosis of 2.866. The IRMA results are highly negatively skewed, indicating that there are lower RMC scores. The IRMA's kurtosis level indicates the tails are heavier with sharper peaks than normal distribution.

The feelings of shame, as measured by the TOSCA-3, has a mean of 39.679, a standard deviation of 6.3622, skewness of -0.201, and a kurtosis of -0.431. The TOSCA-3 is slightly

negatively skewed, indicating lower shame scores. The TOSCA-3 has a kurtosis level that indicates the tails are lighter with less peaks than normal distribution. Additionally, it represents a departure from normality.

Dissociation, as measured by the DES II Total Score, has a mean of 23.93592, a standard deviation of 16.333409, skewness of 1.004, and the kurtosis of 0. 683.The DES II is highly positively skewed, indicating higher dissociation scores. The DES II has a kurtosis level that indicates the tails are heavier with higher peaks than normal distribution.

Statistical Results

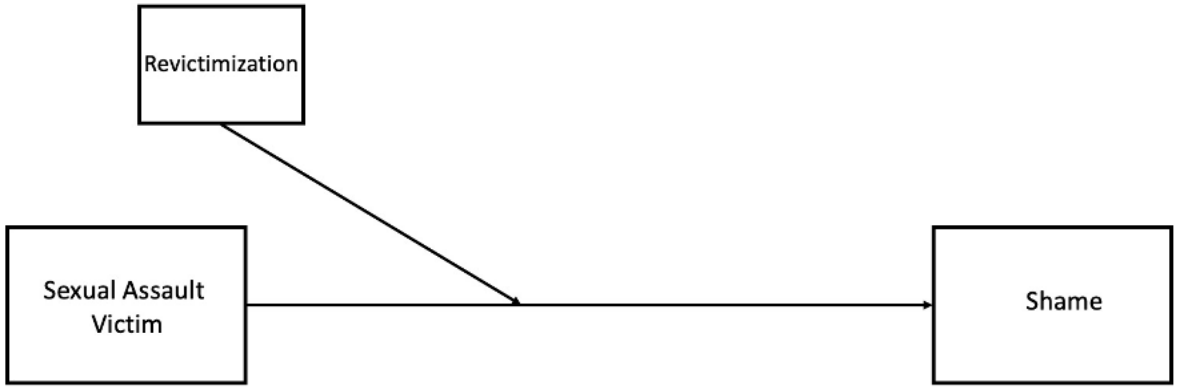
Data analysis was conducted using IBM SPSS Version 2. The PROCESS macro extension (Version 4.0; Hayes, 2018) was installed in SPSS to assess moderation and mediation in the models presented. In this section, moderation analysis and moderated mediation analysis will be reported and interpreted. Each statistical test, correlation, and hypothesis will now be presented in the analysis sequence and separated by the research question. This section discusses the interactions between the predictor variables (number of SAs, RMC, dissociation, and revictimization) and the dependent variable (shame). The aim is to follow the analytical process systematically. This study demonstrated statistical robustness and rigor by using advanced statistical techniques such as the PROCESS macro and moderated mediation analysis. This robustness and rigor enhances the reliability and credibility of the study's findings.

Moderation Analysis

The first hypothesis stated: "SA survivors who have been revictimized will report higher levels of shame compared to those who have experienced a single SA." See Figure 4.1.

Figure 4.1

Hypothesized Theoretical Model 1



A regression analysis was performed, and the results showed that revictimization does not significantly predict shame ($R^2 = 0.000$; $p = 0.921$). Therefore, the relationship between revictimization and shame has almost no linear correlation. See Table 4.1 for further details.

Table 4.1

Linear Regression Results: Revictimization (X) on Shame (Y)

				95% CI	
Source	*B*	*SE*	*p*	*LL*	*UL*
Constant	39.62	.87	<0.001	37.89	41.34
Revictimization	.12	1.23	.92	-2.32	2.56

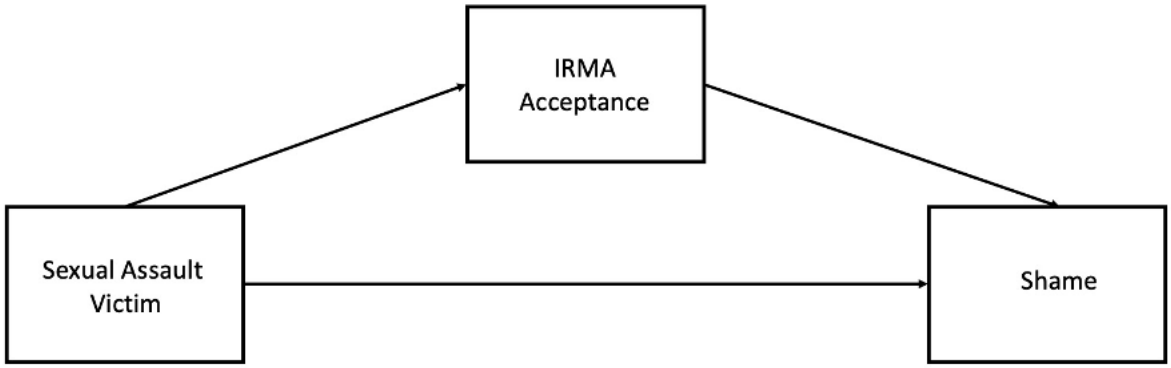
Note. CI = confidence interval; *LL* = lower limit; *UL* = upper limit.

Parallel Mediation Analysis

The second hypothesis stated the following: "The relationship between SA survivors and their feelings of shame will be mediated by their acceptance of RMC, such that higher acceptance of rape myths will increase the level of shame experienced by SA survivors." See Figure 4.2.

Figure 4.2

Hypothesized Theoretical Model 2



A mediation analysis was performed, and the results showed that the relationship between the levels of shame and number of SAs an individual experiences is not significantly mediated by the acceptance of RMC (SANum, $p = 0.80$; IRMA, $p = 0.86$). Therefore, these results indicate that neither the direct relationship between shame and SAs or the indirect relationship through RMC is statistically significant. See Table 4.2 for further information.

Table 4.2

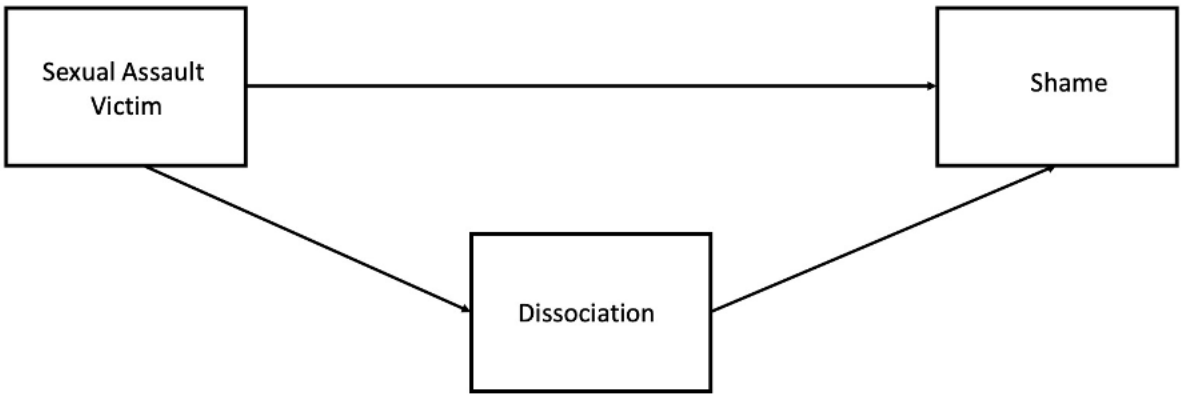
PROCESS Model 4 Results: Number of SAs (X) on Shame (Y) through IRMA (M)

				95% CI	
Source	*B*	*SE*	*p*	*LL*	*UL*
Constant	40.74	7.25	0.00	26.37	55.12
SANum	.09	.36	.80	-.62	.80
RMC	-0.01	.07	.86	-0.15	.13

The third hypothesis stated: “There is an inverse relationship between SA survivors and their feelings of shame when mediated by their levels of dissociation, such that higher levels of dissociation will decrease the level of shame experienced by SA survivors.” See Figure 4.3.

Figure 4.3

Hypothesized Theoretical Model 3



A mediation analysis was performed, and the results indicated that the number of SAs an individual has experienced does not significantly predict dissociation ($p = 0.14$). However, dissociation does significantly predict the feelings of shame an individual experiences. The analysis concluded that the number of SAs an individual experiences does not have a significant indirect or direct effect of feelings of shame through dissociation ($p = 0.72$). Therefore, the results show that the number of SAs experienced by an individual does not have a significant relationship on feelings of shame through dissociation, but dissociation is a significant predictor of shame ($p = 0.81$). See Table 4.3 for further details of the results.

Table 4.3

PROCESS Model 4 Results: Number of SAs (X) on Shame (Y) through Dissociation (M)

				95% CI	
Source	*B*	*SE*	*p*	*LL*	*UL*
Constant	36.29	1.18	0.00	33.95	38.64

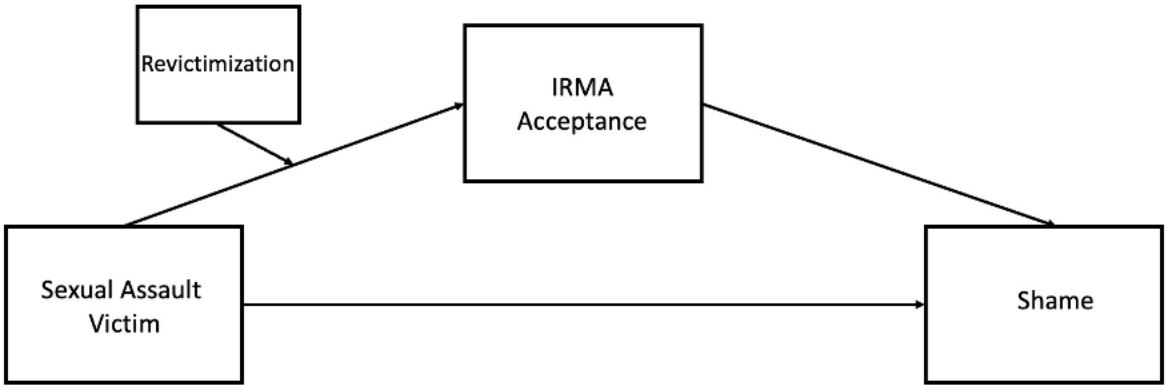
SANum	-.12	.33	.72	-.78	.54
Dissociation	.15	.04	.000	.08	.22

Moderated Mediation Analysis

The fourth hypothesis stated the following: "The mediating effect of rape myth acceptance on the relationship between SA survivors and their feelings of shame will be stronger for survivors who reported revictimization compared to those who have experienced a single incident of SA." See Figure 4.4.

Figure 4.4

Hypothesized Theoretical Model 4



A moderated mediation analysis was performed, indicating that the relationship between the number of SAs an individual experienced and revictimization significantly predicted RMC. In participants who reported that they have not experienced victimization, the number of SAs experienced negatively predicted RMC. In participants who reported that they have experienced revictimization (REVICT = 1), the number of SAs experienced positively predicted RMC (p =

0.02). Lastly, neither the indirect nor the direct effects of the number of SAs an individual have experienced on shame are significant. See Table 4.4.

Table 4.4

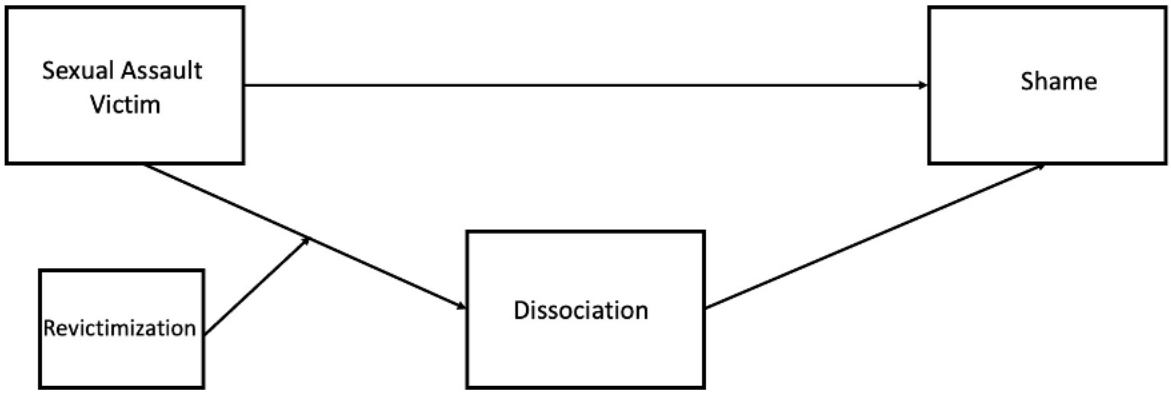
PROCESS Model 7 Results: Number of SAs (X) on Shame through IRMA (M) Conditioned by Revictimization (W)

				95% CI	
Source	*B*	*SE*	*p*	*LL*	*UL*
Constant	40.74	7.25	0.00	26.37	55.12
SANum	.09	.36	.80	-.62	.80
RMC	-0.01	.07	.86	-0.15	.13
Revictimization	1.00	.64	.02	.28	2.81

The fifth hypothesis stated: "The mediating effect of dissociation on the relationship between SA survivors and their feelings of shame will be stronger for survivors who reported revictimization compared to those who have experienced a single incident of SA." See Figure 4.5.

Figure 4.5

Hypothesized Theoretical Model 5



Moderated mediation analysis indicated that dissociation significantly predicts feelings of shame. However, the number of SAs an individual has experienced does not significantly predict dissociation ($p = 0.28$). Additionally, the mediation effect of dissociation on the relationship between the feelings of shame and the number of SAs an individual has experienced is significantly moderated by revictimization. Lastly, the mediation effect is stronger for those who have not been revictimized compared to those who have experienced revictimization. See Table 4.5.

Table 4.5

PROCESS Model 7 Results: Number of Sexual Assaults (X) on Shame (Y) through Dissociation (M) Conditioned by Revictimization (W)

				95% CI	
Source	*B*	*SE*	*p*	*LL*	*UL*
Constant	36.29	1.18	0.00	33.95	38.64
SANum	-.12	.33	.72	-.78	.54
Dissociation	.15	.04	.00	.08	.22
Revictimization	1.00	.64	.02	.28	2.81

Summary

This study collected data from 113 SA survivors through random sampling. Incomplete or illegible answers from the self-report survey were excluded from the data sample through the screening process prior to data analysis, leaving 108 surveys collected. The final sample resulted in relevant statistics regarding the participants, shame, RMC, dissociation, and revictimization. The results provided that revictimization does not significantly predict levels of shame. Acceptance of rape myths does not mediate the relationship between the feelings of shame and the number of SAs experienced. Dissociation significantly predicts the feelings of shame, but the number of SAs does not significantly affect shame through dissociation or dissociation. The mediation effect of RMC on the relationship between the feelings of shame and the number of SAs is not significantly moderated by revictimization. The mediation effect of dissociation on the relationship between the feelings of shame and the number of SAs experienced by an individual is significantly moderated by revictimization. Lastly, the mediation effect is stronger for individuals who have not been revictimized compared to those who have been revictimized.

Chapter Five: Conclusions

Overview

Within this final chapter, discussion surrounding the results from the study will be explored, including the relationships between variables, consideration from findings, and how these results can futuristically impact the counselor and counselor educator fields. Additionally, the proposed research questions will be answered and implications from these results will be discussed. Lastly, limitations of this study and recommendations for future research will be addressed.

Discussion

The only way to end the SA epidemic happening on college campuses is to change cultural norms surrounding RMC so survivors can be empowered and supported (Potter et al., 2018). The goal of this study is to help counselors and counselor educators become more aware of the cultural norms that impact survivors and give more insight into how to engage with this population. The results of this study revealed many aspects of SA and what effects dissociation, shame, and RMC have on each other.

One analysis showed that dissociation significantly mediates the relationship between shame and the number of SAs an individual experiences. This relationship indicates that dissociation plays a significant role in how survivors of SA experience shame. This result is an important insight for understanding the psychological impact of SA.

The moderated mediation analysis concluded that the mediation effect of dissociation on the relationship between shame and the number of SAs experienced by an individual is significantly moderated by revictimization. The mediation effect is stronger for individuals who have never experienced victimization. This result is crucial, as it highlights how psychological

processes after trauma can differ depending on the individual's experience and if they have experienced revictimization. This finding is echoed in the literature, as studies have shown that individuals who have never experienced a traumatic situation such as SA often have stronger traumatic responses due to their body's attempting to find a way to protect them and keep them safe (Boyer et al., 2022).

RQ1

The first research question asked, "How does revictimization impact the level of shame, measured by the TOSCA-3, experienced by sexual assault survivors?" The regression analysis performed indicated that experiencing revictimization does not significantly predict shame. There is currently no current literature that looks at the relationship between shame and revictimization of SA, indicating an area of further investigation.

RQ2 & RQ3

The second research question asked, "Does the acceptance of rape myths, as measured by the Illinois Rape Myth Acceptance Scale (IRMA; McMahon & Farmer, 2011), mediate the relationship between sexual assault survivors and feelings of shame, measured by the TOSCA-3?" The mediation analysis indicated that the number of SAs an individual has experienced does not significantly predict the acceptance of RMC. Neither the acceptance of RMC or the number of SAs an individual experiences significantly predicts shame. The mediation of RMC on the relationship between shame and the number of SAs an individual experiences and shame is not statistically significant. There is currently no literature that looks at the complex interactions and relationships between RMC, SA, and shame, therefore, there are no studies for comparative analysis. This underscores the need for future research to explore these relationships.

The third research question asked, “Does dissociation, as measured by the Dissociative Experiences Scale II (DES II; Carlson & Putnam, 1993), mediate the relationship between sexual assault survivors and feelings of shame, measured by the TOSCA-3?” The mediation analysis indicated that the number of SAs experienced by an individual does not significantly predict dissociation. Dissociation, however, significantly predicts shame. The number of SAs an individual has experienced does not have a significant direct or indirect effect on shame through dissociation. There is currently no literature that looks at the mediation between SA, shame, and dissociation, highlighting the need for additional investigation.

RQ4 & RQ5

The fourth research question asked, “Does revictimization moderate the mediating effect of acceptance of rape myths, measured by the IRMA, on the relationship between sexual assault survivors and feelings of shame, measured by the TOSCA-3?”. The moderated mediation analysis by using the PROCESS Model 7 indicated that the acceptance of RMC does not mediate the relationship between shame and the number of SAs an individual has experienced. The mediation effect of RMC is not significantly moderated by revictimization. Neither the direct nor indirect effects of shame and the number of SAs an individual has experienced are significant. There is currently no literature that examines the mediating effects of RMC, SA, and shame, therefore, there is no other research to compare results to.

The fifth research question asked, “Does revictimization moderate the mediating effect of dissociation, measured by the DES-II, on the relationship between sexual assault survivors and feelings of shame, measured by the TOSCA-3?” The moderated mediation analysis by using the PROCESS Model 7 indicated that dissociation significantly predicts shame. The number of SAs an individual experiences does not significantly predict dissociation. The mediation effect of

dissociation on the relationship between shame and the number of SAs an individual experiences is significantly moderated by if the individual has experienced victimization. The mediation effect is stronger for those individuals who have not experienced revictimization compared to those who have experienced revictimization. There is currently no literature that looks at the mediation effect between dissociation, SA, and shame, therefore, there is no research to compare the results to.

Implications

This study looked at the differing interactions and relationships between SA survivors, shame, RMC, dissociation, and revictimization. From the results of the study, it could be deduced that there were some significant direct and indirect effects between the variables of the study. These direct and indirect effects can provide information for counselors and counselor educators in regard to engaging with survivors of SA.

The relationship between shame and dissociation was statistically significant, therefore it reinforces the importance of addressing dissociation in counseling settings for survivors of SA. This relationship provides a clear direction for interventions within the clinical setting aimed at targeting dissociation in order to reduce shame. Counselors who are working with survivors of SA will be able to focus on using interventions that are designed for dissociation, such as Cognitive Behavioral Therapy or Dialectical Behavioral Therapy, as the results of this study revealed that dissociation and shame are significant.

While the analysis of the number of SAs experienced by an individual on shame was not significant, the indirect effect through dissociation was significant for individuals who have not experienced revictimization. This finding demonstrates the complexity of the relationship of the variables and the importance when considering pathways in psychological practice and research.

Previous research parallels these findings as individuals who have experienced a significant traumatic experience for the first time can have an increased dissociation responses due to the body's attempt to provide escape (Boyer et al., 2022). Survivors have displayed behaviors associated with dissociation in situations where they feel shame surrounding what has happened, especially in situations surrounding disclosure of the incident (Bhuptani & Messman-Moore, 2019).

The results from the moderation analysis were significant and indicated that the experience of an individual experiencing revictimization changes how dissociation mediates the relationship between shame and survivors of SA. Understanding this nuanced information can assist counselors and counselor educators in developing a more tailored therapeutic approach when taking in the individual's experience of revictimization. The current treatments for revictimization are intertwined within the therapeutic space. Aakvaag et al. (2019) explained that shame may be the causal link between revictimization and mental health. Often, it is the SA survivors' guilt and shame that lead to revictimization. Therefore, it is important for counselors to hold space for these individuals while actively challenging maladaptive thoughts tied to their experience (Jaffe et al., 2019). If the perpetrator is an individual that was in close proximity, such as a family member, the survivor is left with even more to work through in a therapeutic space, such as abandonment, loneliness, betrayal and other complicated emotions that come with nonconsensual acts against a person (Jaffe et al., 2019). Currently, the best practice for preventing revictimization is for the survivor to engage in trauma-focused counseling and work on the heavy feelings the individual may be experiencing, such as shame, guilt, blame, dissociation, and other mental health illnesses (Briere, 2019). This study informs and supports

the previous literature, as the results of this study specifically discuss the risks associated with revictimization and how dissociation and shame play a role in it.

The results of this study can have a significant impact on five core competencies within counselor education and supervision: supervision, teaching, research and scholarship, counseling, and leadership and advocacy. These impacts can help both current and future counselors and counselor educators through each individual competency lens, as discussed further below.

Supervision

Including the results of this study within the supervision realm could enhance the future counselors and counselor educators. Discussing the results of this study within the supervision space can help grow new counselors and counselor educators. Allowing more individuals to understand the ways these variables affect survivors of SA can evolve the way we approach SA survivors and grow the field overall. Additionally, this knowledge can create a space for discussion on how to support counselors and help them understand how revictimization can affect the therapeutic process while causing vicarious trauma.

Teaching

Teaching has been known as one of the best ways to reach others and impact their future. Combining teaching with the results of this study, individuals teaching can educate others on SA and revictimization and how this can significantly impact individuals' futures. Using this information within the classroom setting could meaningfully change the way new counselors interact with survivors of SA, as they will have a better understanding of their behaviors, reactions, and beliefs. This impact can look like spreading knowledge surrounding shame, RMC, dissociation, and revictimization and expanding the concepts discovered by this study. Educating

others would allow the overall expansion and knowledge of a very important subject that is often disregarded due to the discomfort associated with SA. Additionally, it can allow for teaching trauma-informed practices and put extra focus on teaching evidence-based interventions, such as Cognitive Processing Therapy or Dialectical Behavioral Therapy, as this study explored and supported the importance of these items. Teaching these trauma-informed practices will allow survivors to have a reduction in symptomology with the potential to process the trauma they have experienced faster, allowing them to live much fuller lives.

Research and Scholarship

The results of this study allow future researchers to continue to explore the dynamics involved with SA survivors. Counselor educators can expand the field by developing literature involving SA and filling the current gaps surrounding revictimization. As of right now, there is very limited research on SA, especially studies that include revictimization, dissociation, shame, or RMC. During this study, it was difficult to make comparisons and parallels, as no research has looked at these variables before. Through additional research on the subject matter, the current gaps within the literature would minimize and allow others within the field to gain this information and continue to expand the wealth of knowledge surrounding SA survivors. Growth within research will allow researchers, counselors, and counselor educators to have a better understanding of the complexities of working with SA survivors and how to best navigate their experiences.

Counseling

Within the counseling space, the results of this study can provide current counselors with knowledge of how SA survivors respond after an incident. Providing counselors with increased information surrounding how survivors engage can assist counselors with knowing which

treatment modalities and techniques would work best with the individual they are providing services. Allowing counselors this insight into information could significantly decrease the length of time an individual may need treatment and increase the success in reducing the symptomology of a survivor.

Leadership and Advocacy

Leadership and advocacy are an important competency within the counselor education and supervision space as they help the field grow and support counselor educators. Counselor educators who understand the complexities surrounding the results of this study can work to advocate for survivors of SA in hopes of systematic change or improved knowledge surrounding the impacts of revictimization on SA survivors. Leadership and advocacy are important factors in counselor education and supervision as they help the field grow, educate, and gain support.

Overall, this study contributed to the field of SA and trauma research by addressing the complex interplays between a variety of psychological constructs. Additionally, this study allows for counselor educators and counselors to have a better understanding of the interactions of different dynamics that occur with survivors of SA. Acknowledging these significant interactions will allow for counselors to be able to provide more specific care for their clientele. Additionally, counselor educators will be able to better teach and instruct the counselors they are developing. Lastly, these analyses add depth to the extant literature, such as Martha Burt in 1980, as she established the first definition of Rape Myth, or Mary Koss, who published the first national SA study among college students in 1987 and allow for new paths to explore.

Limitations

There are multiple limitations in this study that should be considered. The limitations of this study are that the surveys were only presented to individuals who were already receiving

therapeutic services or who had reached out to engage in services. Due to the fact that these individuals were already engaged in services, there was not a way to collect data from individuals who did not have any therapeutic intervention surrounding the incident that occurred. Additionally, there was no way to capture individuals who had not already recognized that something "bad" had happened to them. The demographic information was anonymous, therefore further research and correlation could not be done regarding how these variables interact with demographic components.

Additional limitations surrounding the study is the dilemma previously discussed about individuals not recognizing what has happened to them identified as SA, therefore, data could be skewed or misreported. Another component to be considered is the #MeToo movement and the "cancel culture," which supports punishing and public shaming those who express notions of harassing and discriminatory beliefs, as this movement may have resulted in fewer individuals willing to endorse RMC beliefs (Aggarwal & Brenner, 2020; Carr, 2020).

The #MeToo movement happened after sexual misconduct allegations arouse regarding Harvey Weinstein were brought to light (Levy et al., 2023). After these allegations were brought to light, Alyssa Milano tweeted an encouraging post to all survivors of SA to write "Me too" on their social media platforms (Levy et al., 2023). The #MeToo movement was extremely successful in increasing awareness surrounding the issues surrounding SA and sexual misconduct. Within the year that the movement began, the average Google search interest in SA and sexual misconduct rose by 85% and spread quickly across several countries (Battaglini et al., 2020; Levy et al., 2023). While the #MeToo movement received a lot of positive attention, the movement also received a lot of skepticism due to the focus on prominent figures and that it was only changing things for famous people (Cheng & Hsiaw, 2022). In addition to skepticism, there

were a lot of discussions that occurred surrounding survivors making false reports due to anger and revenge. The #MeToo movement gave voice to survivors but also gave a platform for RMC to run wild and work against those attempting to bring awareness (Batut et al., 2021). Overall, the #MeToo movement allowed survivors to express their SA in ways that they had never had a chance to before, whether it be publicly, privately, or anonymously. It gave space for validation, justice, and those who had been silenced a chance to be heard. However, it also gave space for more doubt, more shame, and more voice to RMC (Alaggia & Wang, 2020; Association of American Universities, 2020).

Recommendations for Future Research

This study laid solid groundwork for future researchers to explore the different dynamics between moderators and mediators. Future researchers should try to collect a sample of students who have not had any therapeutic experience, as this would most likely reflect the most accurate and raw data regarding RMC, shame, and dissociation. Individuals who have already experienced a therapeutic setting, will have better insight into maladaptive thoughts, especially depending on how long they have participated in counseling. Additionally, individuals will already have an understanding that the SA was not their fault or something they caused. Lastly, individuals that have a good therapeutic experience will have experienced psychoeducation surrounding the neurobiology of trauma, trauma responses, the interpersonal violence cycle and other lessons that could be beneficial to the individuals healing (Lewis et al., 2020). Future researchers could expand this study even further by conducting a pre-test prior to the survivor's first counseling session and a post-test after the survivor has completed counseling, as this could display the effectiveness of therapeutic intervention. Additionally, continuing to further this

study could provide insight for counselor educators, which can in turn directly impact new counselors coming into the field, allowing for more experienced trauma counselors.

Future researchers should attempt to repeat or conduct a similar study including demographic information to allow for a better understanding of demographic interactions with the variables of the study. Literature reflects that SA happens to all demographics and that some individuals are at greater risk due to their ethnicity and race. For instance, multiracial women have reported higher rates of SA than white women (Breiding, 2014). Individuals who have more than one marginalized identity have higher risks of SA (Staples & Fuller, 2021). Therefore, if this study could be repeated but include demographic information, it could unveil a lot of insight into the behaviors of those who experience SA and illuminate the differences between the different ethnicities.

Lastly, future researchers should consider conducting qualitative studies, as there seems to be a disconnect between the "real" feelings survivors are experiencing rather than what is being portrayed via the testing instruments. Conducting a qualitative study with survivors would allow researchers to gain insight into how individuals perceive different beliefs, as there may be discrepancies when answering quantitative scales, especially if there is not an appropriate response that reflects the survivor's perspective. Overall, a qualitative study will allow researchers to thoroughly investigate a survivor's reactions and responses more conclusively, which will provide additional insight into how counselors and counselor educators should provide treatment for their clients.

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Appendix A: University of Georgia IRB Approval Letter

Tucker Hall, Room 212
310 E. Campus Rd.
Athens, Georgia 30602
TEL 706-542-3199 | FAX 706-542-5638
IRB@uga.edu
http://research.uga.edu/hso/irb/

Human Research Protection Program

NOT HUMAN RESEARCH DETERMINATION

March 6, 2023

Dear Jessica Wiggs:

On 3/6/2023, the Human Subjects Office reviewed the following submission:

Title of Study:	Sexual Assault Impressions, Beliefs and Trends
Investigator:	Jessica Wiggs
Co-Investigator:	Larisa Wallace
IRB ID:	PROJECT00006821
Funding:	None

We have determined that the proposed activity is not research involving human subjects as defined by DHHS and FDA regulations. The activity is designed to contribute data in the development of better services/programs for University of Georgia (UGA) students.

UGA IRB review and approval is not required. This determination applies only to the activities described in the IRB submission and does not apply should any changes be made. If changes are made and there are questions about whether these activities are research involving human subjects, please submit a new request to the IRB for a determination.

Sincerely,

Jessica Lasebikan, HRPP Assistant Director
Human Subjects Office, University of Georgia

Appendix B: Liberty University IRB Approval Letter

LIBERTY UNIVERSITY.
INSTITUTIONAL REVIEW BOARD

June 6, 2024

Joy Mwendwa Joy Mwendwa

Re: IRB Application - IRB-FY23-24-2104 Revictimization of Sexual Assault Survivors: Correlation Between Shame, Dissociation, Rape Myth Culture and Revictimization

Dear Joy Mwendwa and Joy Mwendwa,

The Liberty University Institutional Review Board (IRB) has reviewed your application in accordance with the Office for Human Research Protections (OHRP) and Food and Drug Administration (FDA) regulations and finds that your study does not meet the definition of human subjects research. This means you may begin your project with the data safeguarding methods mentioned in your IRB application.

Decision: No Human Subjects Research
Explanation: Your study/project is not considered human subjects research because

(1) it will not involve the collection of identifiable, private information from or about living individuals (45 CFR 46.102).

Please note that this decision only applies to your current application. Any modifications to your protocol must be reported to the Liberty University IRB for verification of continued non-human subjects research status. You may report these changes by completing a modification submission through your Cayuse IRB account.

For a PDF of your IRB letter, click on your study number in the My Studies card on your Cayuse dashboard. Next, click the Submissions bar beside the Study Details bar on the Study Details page. Finally, click Initial under Submission Type and choose the Letters tab toward the bottom of the Submission Details page.

Also, although you are welcome to use our recruitment and consent templates, you are not required to do so. If you choose to use our documents, please replace the word research with the word project throughout both documents.

If you have any questions about this determination or need assistance in determining whether possible modifications to your protocol would change your application's status, please email us at irb@liberty.edu.

Sincerely,

G. Michele Baker, PhD, CIP

Administrative Chair

Research Ethics Office

Appendix C: Informed Consent Document

[redacted] CONSENT FORM

Sexual Assault Impressions, Beliefs and Trends

You are being asked to take part in a research study. The information in this form will help you decide if you want to be in the study. Please ask the researcher(s) below if there is anything that is not clear or if you need more information.

Principal Investigator: Jessica Wiggs

Health Promotion

JWiggs@uhs.uga.edu

We are doing this research study to learn more about what knowledge students have regarding sexual assault and how that contributes to the decisions, beliefs and feelings they may have towards sexual assault. The research study itself is looking at the correlation between sexual assault survivors, Rape Myth Culture and Revictimization. Additionally, it will look at how Rape Myth Culture interacts with Shame and Dissociation through the revictimization process. This study is being conducted to better understand where students are coming from which would allow us to develop better prevention programs and treatment options for future students who are survivors of sexual assault.

You are being invited to be in this research study because you are currently receiving therapeutic services through Relationship and Sexual Violence Prevention (RSVP) at [redacted].

If you agree to participate in this study:

- We will collect information about how students interpret sexual assault and what they have previously learned regarding sexual assault.
- We will ask you to complete a short self-reported survey. It will take about roughly about 5-10 minutes. This survey will be completed prior to your already scheduled therapy

appointment and will be completed in the waiting room prior to the start of the therapy session.

Participation is voluntary. You can refuse to take part or stop at any time without penalty. Your decision to participate will have no impact in your participation in RSVP services.

There may be questions that may make you uncomfortable. If discomfort occurs, please bring this up to your therapist when you are brought into your session after completing the survey. We by no means want to cause any discomfort and want to provide support through this process.

Your responses may help us understand how we can better serve our students regarding prevention education and treatment options in the future.

We will take steps to protect your privacy, but there is a small risk that your information could be accidentally disclosed to people not connected to the research. To reduce this risk, we will keep the survey itself anonymous and once completed it will be located in a sealed file, locked away until the data collection period is completed. Once the data has been gathered and translated, the surveys will be shredded. There will be no identifying information kept for this study.

No identifying information will be shared during this research period or any future research that may use the data collected.

Appendix D: Survey Items

Dissociative Experiences Scale - II

Instructions: This questionnaire asks about experiences that you may have in your daily life. We are interested in how often you have these experiences. It is important, however, that your answers show how often these experiences happen to you when you **are not** under the influence of alcohol or drugs. To answer the questions, please determine to what degree each experience described in the question applies to you, and circle the number to show what percentage of the time you have the experience.

For example: 0% (Never) 10 20 30 40 50 60 70 80 90 100% (Always)

There are 28 questions. These questions have been designed for adults. Adolescents should use a different version.

Disclaimer: This self-assessment tool is not a substitute for clinical diagnosis or advice.

1. Some people have the experience of driving or riding in a car or bus or subway and suddenly realizing that they don't remember what has happened during all or part of the trip. Circle the number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%

2. Some people find that sometimes they are listening to someone talk and they suddenly realize that they did not hear part or all of what was said. Circle the number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%

3. Some people have the experience of finding themselves in a place and have no idea how they got there. Circle the number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%

4. Some people have the experience of finding themselves dressed in clothes that they don't remember putting on. Circle the number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%

5. Some people have the experience of finding new things among their belongings that they do not remember buying. Circle the number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%

6. Some people sometimes find that they are approached by people that they do not know, who call them by another name or insist that they have met them before. Circle the number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%

7. Some people sometimes have the experience of feeling as though they are standing next to themselves or watching themselves do something and they actually see themselves as if they were looking at another person. Circle the number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%

8. Some people are told that they sometimes do not recognize friends of family members. Circle the number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%

9. Some people find that they have no memory for some important events in their lives (for example, a wedding or graduation). Circle the number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%

10. Some people have the experience of being accused of lying when they do not think that they have lied. Circle the number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%

11. Some people have the experience of looking in a mirror and not recognizing themselves. Circle the number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%

12. Some people have the experience of feeling that other people, objects, and the world around them are not real. Circle the number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%

13. Some people have the experience of feeling that their body does not seem to belong to them. Circle the number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%

14. Some people have the experience of sometimes remembering a past event so vividly that they feel as if they were reliving that event. Circle the number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%

15. Some people have the experience of not being sure whether things that they remember happening really did happen or whether they just dreamed them. Circle the number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%

16. Some people have the experience of being in a familiar place but finding it strange and unfamiliar. Circle the number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%

17. Some people find that when they are watching television or a movie they become so absorbed in the story that they are unaware of other events happening around them. Circle the number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%

18. Some people find that they become so involved in a fantasy or daydream that it feels as though it were really happening to them. Circle the number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%

19. Some people find that they sometimes are able to ignore pain. Circle the number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%

20. Some people find that they sometimes sit staring off into space, thinking of nothing, and are not aware of the passage of time. Circle the number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%

21. Some people sometimes find that when they are alone they talk out loud to themselves. Circle the number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%

22. Some people find that in one situation they may act so differently compared with another situation that they feel almost as if they were two different people. Circle the number to show what percentage of the time this happens to you. 0% 10 20 30 40 50 60 70 80 90 100%

23. Some people sometimes find that in certain situations they are able to do things with amazing ease and spontaneity that would usually be difficult for them (for example, sports, work, social situations, etc.). Circle the number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%

24. Some people sometimes find that they cannot remember whether they have done something or have just thought about doing that thing (for example, not knowing whether they have just mailed a letter or have just thought about mailing it). Circle the number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%

25. Some people find evidence that they have done things that they do not remember doing. Circle the number to show what percentage of the time this happens to you. 0% 10 20 30 40 50 60 70 80 90 100%

26. Some people sometimes find writings, drawings, or notes among their belongings that they must have done but cannot remember doing. Circle the number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%

27. Some people sometimes find that they hear voices inside their head that tell them to do things or comment on things that they are doing. Circle the number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%

28. Some people sometimes feel as if they are looking at the world through a fog, so that people and objects appear far away or unclear. Circle the number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%

Total:

DES Score: ____
(Total divided by 28)

Updated Illinois Rape Myth Acceptance Scale (IRMA)

	Strongly agree 1	2	3	4	Strongly disagree 5
Subscale 1: She asked for it					
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.					
Subscale 2: He didn't mean to					
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.					
Subscale 3: It wasn't really 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.					
Subscale 4: She lied					
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.					

TOSCA-3

Below are situations that people are likely to encounter in day-to-day life, followed by several common reactions to those situations.

As you read each scenario, try to imagine yourself in that situation. Then indicate how likely you would be to react in each of the ways described. We ask you to rate *all* responses because people may feel or react more than one way to the same situation, or they may react different ways at different times.

For example:

A. You wake up early one Saturday morning. It is cold and rainy outside.

	not likely very likely
a. You would telephone a friend to catch up on news.	(1) 2 3 4 5
b. You would take the extra time to read the paper.	1 2 3 4 (5)
c. You would feel disappointed that it's raining.	1 2 (3) 4 5
d. You would wonder why you woke up so early.	1 2 3 (4) 5

In the above example, I've rated *all* of the answers by circling a number. I circled "1" for answer (a) because I wouldn't want to wake up a friend very early on a Saturday morning—so it's not at all likely that I would do that. I circled a "5" for answer (b) because I almost always read the paper if I have time in the morning (very likely). I circled a "3" for answer (c) because for me it's about half and half. Sometimes I would be disappointed about the rain and sometimes I wouldn't—it would depend on what I had planned. And I circled a "4" for answer (d) because I would probably wonder why I had awakened so early.

Please do not skip any items—rate all responses.

1. You make plans to meet a friend for lunch. At five o'clock, you realize you have stood your friend up.

	not likely very likely
a. You would think, "I'm inconsiderate."	1 2 3 4 5
b. You'd think you should make it up to your friend as soon as possible.	1 2 3 4 5
c. You would think, "My boss distracted me just before lunch."	1 2 3 4 5

* Developed by June Price Tangney and others, *The Test of Self-Conscious Affect* (TOSCA-3S) (Fairfax, VA: George Mason University, 2000).

2. You break something at work and then hide it.

	not likely very likely
a. You would think, "This is making me anxious. I need to either fix it or get someone else to."	1···2···3···4···5
b. You would think about quitting.	1···2···3···4···5
c. You would think, "A lot of things aren't made very well these days."	1···2···3···4···5

3. At work, you wait until the last minute to plan a project, and it turns out badly.

	not likely very likely
a. You would feel incompetent.	1···2···3···4···5
b. You would think, "There are never enough hours in the day."	1···2···3···4···5
c. You would feel, "I deserve to be reprimanded for mismanaging the project."	1···2···3···4···5

4. You make a mistake at work and find out a co-worker is blamed for the error.

	not likely very likely
a. You would think the company did not like the co-worker.	1···2···3···4···5
b. You would keep quiet and avoid the co-worker.	1···2···3···4···5
c. You would feel unhappy and eager to correct the situation.	1···2···3···4···5

5. While playing around, you throw a ball, and it hits your friend in the face.

	not likely very likely
a. You would feel inadequate that you can't even throw a ball.	1···2···3···4···5
b. You would think maybe your friend needs more practice at catching.	1···2···3···4···5
c. You would apologize and make sure your friend feels better.	1···2···3···4···5

6. You are driving down the road, and you hit a small animal.

	not likely very likely
a. You would think the animal shouldn't have been on the road.	1···2···3···4···5
b. You would think, "I'm terrible."	1···2···3···4···5
c. You'd feel bad you hadn't been more alert [while] driving down the road.	1···2···3···4···5

7. You walk out of an exam thinking you did extremely well; then you find out you did poorly.

	not likely very likely
a. You would think, "The instructor doesn't like me."	1···2···3···4···5
b. You would think, "I should have studied harder."	1···2···3···4···5
c. You would feel stupid.	1···2···3···4···5

8. While out with a group of friends, you make fun of a friend who's not there.

	not likely very likely
a. You would feel small . . . like a rat.	1···2···3···4···5
b. You would think that perhaps that friend should have been there to defend himself/herself.	1···2···3···4···5
c. You would apologize and talk about that person's good points.	1···2···3···4···5

9. You make a big mistake on an important project at work. People were depending on you, and your boss criticizes you.

	not likely very likely
a. You would think your boss should have been more clear about what was expected of you.	1···2···3···4···5
b. You would feel as though you want to hide.	1···2···3···4···5
c. You would think, "I should have recognized the problem and done a better job."	1···2···3···4···5

10. You are taking care of your friend's dog while she is on vacation and the dog runs away.

	not likely very likely
a. You would think, "I am irresponsible and incompetent."	1···2···3···4···5
b. You would think your friend must not take very good care of her dog or it wouldn't have run away.	1···2···3···4···5
c. You would vow to be more careful next time.	1···2···3···4···5

11. You attend your co-worker's housewarming party, and you spill red wine on a new cream-colored carpet, but you think no one notices.

	not likely very likely
a. You would stay late to help clean up the stain after the party.	1···2···3···4···5
b. You would wish you were anywhere but at the party.	1···2···3···4···5
c. You would wonder why your co-worker chose to serve red wine with the new light carpet.	1···2···3···4···5

Age of first incident: _____

Have you experienced more than one incident? YES NO

Age of additional incident(s): _____

Appendix E: G Power Analysis