SELF-EFFICACY AND SEXUAL ASSAULT: THE IMPACT OF VICTIM-OFFENDER RELATIONSHIP AND ALCOHOL

by

JENNA L. MCCAULEY

(Under the Direction of Karen S. Calhoun)

ABSTRACT

Using a sample of 941 college women, this study attempted to explicate the impact of contextual factors, alcohol use and victim-offender relationship, on sexual self-efficacy. Consistent with previous research, higher frequency of assault was related to lower overall sexual self-efficacy. Participants expressed significantly lower self-efficacy for contexts involving alcohol than those not involving alcohol. For victim-offender relationship, participants expressed lower efficacy in situations involving intimate partners than those with acquaintances and strangers. Finally, factors contributing to context specific self-efficacies were examined. Further research, especially longitudinal research, is needed to aid in understanding the complex relationship between victimization, self-efficacy, alcohol, and interpersonal problems.

INDEX WORDS: Rape, Sexual assault, Self-efficacy, Alcohol, Offender relationship

SELF-EFFICACY AND SEXUAL ASSAULT: THE IMPACT OF VICTIM-OFFENDER RELATIONSHIP AND ALCOHOL

by

JENNA L. MCCAULEY

B.S., The University of Georgia, 2003

A Thesis Submitted to the Graduate Faculty of The University of Georgia in Partial Fulfillment of the Requirements for the Degree

MASTER OF SCIENCE

ATHENS, GEORGIA

2006

SELF-EFFICACY AND SEXUAL ASSAULT: THE IMPACT OF VICTIM-OFFENDER RELATIONSHIP AND ALCOHOL

by

JENNA L. MCCAULEY

Major Professor:	Karen S. Calhoun
Committee:	Joan Jackson Lily D. McNair

Electronic Version Approved:

Maureen Grasso
Dean of the Graduate School
The University of Georgia
May 2006

DEDICATION

I dedicate this manuscript, and all of the time, effort, and growth that it represents, to my loving and supportive family and friends. To my parents, Ken and Annette McCauley, I give my full gratitude for their unconditional love, patience, and humor. To my brother, Josh, I say thank you for showing me what it means to follow a dream with great passion. To my friends, I say thank you for all of the life lessons, laughter and love that you have provided through the past three years. To all of you, thank you for reminding me of all that is truly important in life and for making me able to say that God has truly blessed me with it in you.

ACKNOWLEDGEMENTS

I would like to acknowledge the hard work and input of my major professor, Dr. Karen Calhoun, in the preparation of this manuscript. I would like to thank my research team for their advice, input, and support. Also, I would like to acknowledge all of the research assistants who worked countless hours entering data. Thank you.

TABLE OF CONTENTS

Page

LIST OF TABLES

Page

LIST OF FIGURES

Page

CHAPTER 1

INTRODUCTION

Definitions and Prevalence

Rape is an all too common experience among women in the United States, with effects that leave a devastating impact on psychological, interpersonal, and physical health. While the occurrence of rape is a concern of growing importance, incidence estimates often suffer from flawed measurement methods and a general underreporting, specifically of rapes perpetrated by an acquaintance (Koss, 1992). Considering the issue of underreporting, the prevalence rates for rape are notably high. Prevalence of rape within a community sample has been estimated at 14% (Kilpatrick, Edmunds, & Seymour, 1992). According to the National Violence Against Women survey (NVAWS), one in six has experienced an attempted rape or completed rape (Tjaden & Thoennes, 2000). Among college women, estimates are even higher than those within the general population (Sorrenson, Stein, Siegel, Golding, & Burnham, 1987). In a study utilizing a college sample of women, Gidycz et al. (1997) found that approximately 17% had experienced a rape, while an additional 33% had experienced some other form of sexual assault. In a sample of primarily first-year college women, approximately 27% had been sexually assaulted over the course of the 12-week semester (Greene & Navarro, 1998). The combined effects of these estimates indicate that sexual assault is a frequent occurrence, impacting thousands of women each year.

Rape is obviously a national health concern, and as such, worth further attention and research focus. In an effort to resolve the disparate and often interchangeable use of terminology in this area of research, the Centers for Disease Control (Basile & Saltzman, 2002) published a

compendium of uniform definitions and recommended data elements. Sexual violence was divided into five categories: a completed sex act without victim consent or involving a victim unable to consent or refuse, an attempted sex act without victim consent or involving a victim unable to consent or refuse, abusive sexual contact, non-contact sexual abuse (such as exhibitionism), and sexual violence unspecified. "Sex act" is uniformly defined as "contact between the penis and vulva or the penis and anus, involving penetration, however slight; contact between the mouth and penis, vulva, or anus; or penetration of the anal or genital opening of another person by hand, finger, or other object." The inability to consent may be due to age, illness, disability, being asleep, or the influence of alcohol or other drugs. The inability to refuse refers to the preclusion of disagreement due to the use of weapons, physical violence, threats of physical violence, real or perceived coercion, intimidation or pressure, or the misuse of authority.

Rape has been defined by Koss (1992) as "nonconsensual vaginal, anal, or oral penetration, obtained by force, by threat of injury or bodily harm, or when the victim is incapable of giving consent (i.e., due to impairment by drugs or other intoxicants)." Although this definition is widely used in the literature on sexual assault, it has several limitations. In addition to the exclusion of attempted rape and other forms of sexual assault, the current definition includes stranger, acquaintance, date, and marital rape and does not necessarily lend itself to distinction between these victim-offender relationships (Calhoun & Wilson, 2000). It is worth noting that "sexual coercion" is frequently used to describe methods of aggressing that do not involve force or violence, but occur more frequently in assault where the victim has some prior relationship with the offender (Koss, Dinero, Seibel, & Cox, 1988). However, it seems that often little effort is made to differentiate the spectrum of contextual variants subsumed under the frequently used definition that was proposed by Koss.

Rape is not only a concern due to its prevalence; the consequences of rape are numerous and may be enduring. The immediate effects of rape may include reactions of disorientation, numbness, feelings of vulnerability, somatic symptoms, cognitions of shame, guilt and fear (Calhoun & Wilson, 2000). For some women, these symptoms persist and may develop into long-term consequences. These include, for example, depression, fear and anxiety, sexual dysfunction, posttraumatic stress disorder, physical health issues, HIV, dissociation, lower self-esteem, lower self-efficacy, and substance use (Kimerling, Armistead, & Forehand, 1999; Kimerling & Calhoun, 1994; Koss, Woodruff, & Koss, 1991; Resick, 1993).

Revictimization

Perhaps one of the most disconcerting aspects of sexual assault is the phenomenon of revictimization. Women with a history of adolescent rape or attempted rape are almost twice as likely as non-victimized women to experience sexual assault in a given nine-week period (Gidycz, Hanson, & Layman, 1995). In addition, over the course of a nine-month follow-up, results suggested that the likelihood of victimization was directly related to the severity of victimization in the preceding time period. Koss and Dinero (1989) found within their national sample of college women that rates of rape were highest in women with a history of childhood sexual abuse. Additionally, Humphrey and White (2000) found that women in their college sample who had experienced an initial assault in early adolescence were more likely to be victimized in adulthood at rates 4.6 times those of their previously non-victimized cohorts.

Several theories have been posited to explain this phenomenon. Although many of them are either early in development or lacking in substantial support, it is beneficial to briefly highlight several of their tenets.

Finkelhor and Browne (1985) based their theory concerning the impact of childhood sexual abuse around four trauma-causing factors which they titled "traumagenic dynamics." The four dynamics include: traumatic sexualization, betrayal, powerlessness, and stigmatization. The first dynamic, traumatic sexualization, refers to the inappropriate shaping of the child's sexuality which manifests itself in several effects including repetitive sexual behaviors, promiscuous and compulsive sexual behaviors, higher risk for prostitution, confusion about sexual identity, and developing negative connotations associated with sex. The second dynamic of betrayal concerns the realization of the level of exploitation by a trusted individual and may later manifest itself in feelings of grief, depression, tendency toward abusive relationships, increased levels of hostility and anger, and difficulties in marital or intimate partnerships. Powerlessness stems from the child's inability to prevent or avoid further victimization as a child. Powerlessness may manifest itself in adulthood as a dysfunctional need to control or dominate others. Finally, stigmatization references the negative implications of the abuse experience, such as blame, shame, and guilt. In a review of the conceptual models explaining the effects of childhood sexual abuse, Freeman and Morris (2001) note that while this model was a good starting point, the theory lacks general empirical support.

Behavioral learning theories have been applied to explain the negative sequalae resulting from childhood sexual assault (CSA), including the revictimization phenomenon. Polusney and Follette (1995), based upon their review of the literature, concluded that many of the long-term negative effects of CSA may be categorized as various mechanisms of avoidance or tension-reduction strategies. As such, they applied Hayes' (1987) theory of emotional avoidance to explain many of the behavior patterns exhibited by CSA survivors. According to the theory, CSA serves as a distal factor that increases the likelihood that women would exhibit emotionally

avoidant coping strategies, and that engaging these strategies may lead to more proximal stressors which further decrease their ability to functionally cope with sexual situations. An example of this theory may include increased use of alcohol in sexually risky situations as a means of emotional avoidance. However, the use of alcohol within this situation also serves as a proximal factor in decreasing the functioning capabilities of the woman and placing her at greater risk for revictimization. Additionally, Messman and Long (1996) propose that the tenets of learning theory may operate in the context of revictimization. They propose that early experiences of abuse may lead to the development of behaviors that are adaptive in their original context, but may later increase risk for subsequent victimization. For example, behaviors associated with victimization histories, such as higher numbers of sexual partners and less assertive behavior within dating relationships have been shown to predict revictimization (Greene & Navarro, 1998). Additional support for this model was provided by Norris, Nurius, and Dimeff (1996), who found that women with a history of victimization reported engaging in more behaviors that have been identified as sexual assault risk factors. These behaviors consisted of an increased level of alcohol consumption and a greater number of sexual partners.

A third proposed theoretical mechanism for revictimization is risk recognition. That is, women with a history of sexual victimization exhibit difficulties identifying potentially risky situations (Calhoun & Wilson, 2000). Utilizing a response-latency paradigm, Wilson, Calhoun and Bernat (1999) found that women with a history of multiple victimizations took significantly longer to determine that a woman in a hypothetical date rape vignette was at risk. However, support for this mechanism remains mixed (Cloitre, 1998; Yeater & O'Donahue, 2002).

Although the aforementioned theories have garnered some support in the literature, the bulk of current research is working to elucidate potential mechanisms through which this

relationship between previous and subsequent victimization is enacted. Various proposed models accounting for revictimization were reviewed by Gold, Sinclair, and Balge (1999), who concluded that the field currently lacks a prominent theory explaining the phenomenon of revictimization. As such, they highlight the need for closer examination of risk factors, protective factors and other mechanisms that may contribute to revictimization. They hypothesized that variables such as severe psychological symptoms resulting from previous abuse, poor coping styles, insecure attachment styles, hyperfemininity, delinquent behavior, drug use, and high risk sexual behavior may play mediating roles in the pathway to revictimization. Higher levels of adjustment problems, higher levels of dissociation, and increased levels of substance use have been proposed as mechanisms linking prior and subsequent victimization (Burgess & Holstrom, 1978; Cohen & Roth, 1987; Dancu, Riggs, Hearst-Ikeda, Shoyer, & Foa, 1996; Messman-Moore & Long, 2002).

While retrospective correlative research has found a plethora of psychological variables to be associated with revictimization, the findings are inconsistent. In addition to the aforementioned effects of sexual assault, Ellis, Atkeson, and Calhoun (1982) found that in comparison to single incident victims, multiple-incident victims reported higher rates of psychological and interpersonal problems. More recently, Gidycz et al. (1993) found that women with a history of previous assault exhibited poorer adjustment following their most recent adult sexual assault than women without a history of victimization. Women with a history of previous victimization have also been shown to exhibit significantly higher rates of dissociative symptoms and interpersonal problems. Few prospective studies have been conducted to examine possible predictors of revictimization. In a prospective study by Gidycz et al. (1995), loglinear analyses indicated that the chance of victimization at one time period was significantly predicted by

victimization at the previous time periods, while potential mediating variables failed to consistently predict adult revictimization. Conclusions drawn from this study supported the previous findings of Mandoki and Burkhart (1989), that victimization is the strongest predictor of subsequent victimization.

Further prospective analysis of predictive factors contributing to revictimization was conducted by Calhoun et al. (2002). Women at two large universities, reporting a history of at least one previous sexual victimization, were recruited to participate in a risk reduction intervention. Participants were assigned to either intervention or wait-list control condition and assessed at 4, 8, 12, and 24 month follow-ups for revictimization status, psychological and behavioral variables associated with previous victimization and increased risk for subsequent victimization. Intervention participants received a program consisting of two sessions, each two hours long, aimed at reducing risk through psychoeducation, identification of personal risk, interpersonal problem solving, assertiveness training, and attention focus components based upon a social-cognitive learning model. In addition to supporting the significant success of the intervention, results indicated that rates of revictimization were still high, with one-third of the participants reporting an assault during follow-up. However, the study also found that the strongest consistent predictors of revictimization were prior victimization (as supported by previous research) and self-efficacy, specific to the domain of sexual assault prevention. Risk recognition was not predictive of subsequent victimization for this sample of women.

Self-Efficacy

An efficacy expectation has been defined as "the conviction that one can successfully execute the behavior required to produce the outcomes desired" (Bandura, 1977). Bandura later refined the definition of perceived self-efficacy to reference "one's beliefs in one's capabilities to

organize and execute the courses of action required to produce given attainments" (Bandura, 1997). Theoretically, efficacy expectations have important implications because of their power to determine how much effort people will put forth and how perseverant they will be in the face of obstacles and aversive experiences; the greater the efficacy, the more active the efforts (Bandura, 1977).

The construct of self-efficacy works as a component within the larger framework of Bandura's social cognitive theory (Bandura, 1997). Social cognitive theory addresses several components necessary for the development of competencies and the regulation of action (Bandura, 1986). This multifaceted theory encompasses different classes of mechanisms and determinants of action. Bandura notes that perceived self-efficacy is an essential component within this theory in that it influences the other domains of the theory (1997). Within the social cognitive framework, efficacy is represented via propositional beliefs. These beliefs, according to theory, regulate human functioning through four main mechanisms: cognitive functioning, motivation, affective and selective processes.

Efficacy beliefs may impact cognitive processes through cognitive constructions or visualizations of future success or failure. Visualization of successful actions has been shown to improve performance, while visualization of faulty outcomes may impair them (Powell, 1973). Additionally, cognitive processes operate to enable people to make predictions about possible future outcomes of their actions (Bandura, 1997). Self-efficacy also appears to operate within the various forms of cognitive motivation. Efficacy expectations serve as main components with predictive power in attribution models, expectancy-value models, and goal theory models of motivation. The affective component subsumed under the influence of self-efficacy includes the efficacy to alter or alleviate adverse emotional states once they arise. "Selective processes" refer

to the choices that individuals make concerning their environmental surroundings and the activities in which they participate. Efficacy beliefs may lead people to choose environments or activities in which they feel competent.

There are several constructs from which it is important to distinguish self-efficacy expectations. The first of these is the concept of the omnibus locus of control measures. Bandura (1997) notes that these generalized measures fail to assess self-efficacy adequately and instead provide indefinite trait-like constructs with little predictive power. He notes that whereas domain specific measures are good predictors of behavior, the general measures of self-efficacy fall short in accounting for a large portion of variance in human motivation or performance. It is important to note that although the measure of self-efficacy implies domain specificity, it is not theoretically linked with behavioral specificity. That is, one could be efficacious about achieving specific outcomes within the same given domain through various behavioral means. While Bandura posits that perceptions of controllability are an important factor considered in efficacy beliefs, it is merely a component and not the equivalent construct.

Two additional concepts that may be confused with efficacy expectations are those of outcome expectancies and self-esteem. Outcome expectancies refer to the perceptions a person holds about the consequences of a particular action or behavior (Bandura, 1986). While the two are related, they are not the same construct and are distinguishable by the temporality of their focus. Self-efficacy focuses upon confidence of enacting a particular goal, while outcome expectancies reference the perceived outcome of a given action. Additionally, although seemingly similar, self-efficacy differs from the construct of self-esteem in several notable areas. Whereas self-esteem is a more global concept, applying to one's evaluation of the self across a wide variety of situations, self-efficacy is very task and context specific. Importantly, while self-

esteem is a stable construct, self-efficacy appears to be quite dynamic and very amenable to change (Stajkovic & Luthans, 1998).

Self-efficacy is theoretically posited to be amenable to change through four main modalities of influence (Bandura, 1997). The first of these is termed "enactive mastery experience." Enactive mastery experiences are the most influential modality of influence for efficacy information. It consists of preexisting knowledge structures and past demonstrations of personal efficacy. In the assessment of self-efficacy, enactive mastery experiences are largely influenced by contextual and diagnostic factors of the person's performance. That is, the amount of efficacy enhancement or diminishment ascribed to a given experience is partially contingent upon the particular difficulties of the given context and the amount of responsibility accredited to the self for the outcome of the experience. Self-efficacy may also be influenced through vicarious learning experiences (such as modeling), verbal persuasion, and the physiological and affective states from which people partially judge their capabilities, strengths, and vulnerabilities.

The amenability of self-efficacy to change is a promising finding in light of evidence that the construct is a valid predictor of behavior. The self-efficacy construct has been applied to a wide variety of health behaviors and to behavioral intentions (e.g Beck & Lund, 1981; Litt, 1988; Levinson, 1986; Stretcher, Devellis, Becker, and Rosenstock. 1986;). It is worth noting that self-efficacy often emerges from the social cognitive model as the dominant predictor of behavior and is thus a primary focus of research attention (Bandura, 1997). Although the construct of self-efficacy garners empirical support from a variety of health behavior domains, such as physical exercise (McAuley, 1992) and smoking cessation (Baer & Lichtenstein, 1988), there is currently much inconsistency in the literature as to whether self-efficacy is predictive of future behavior or behavioral intention.

Of particular interest, however, are the applications of the self-efficacy construct to the domains of risky sexual behavior, AIDS prevention, and sexual assault risk reduction. Much of the work within this area is influenced by conceptual models of health behavior that include some component of self-efficacy and are based upon the social cognitive model of learned behavior (Bandura, 1997). According to this model, "knowledge creates the precondition for change," but additional elements are necessary for beliefs of personal efficacy (Bandura, 1997). Other contributing factors to one's personal assessment of health-behavior efficacy include perceived threat, benefits, barriers, and cues to action.

A number of studies have assessed the role of self-efficacy in the performance of specific behaviors in the domain of sexual risk behaviors. Perceived self-efficacy has been associated with at-risk teens' effective use of contraceptives (Levinson, 1986). In studies involving homosexual men with multiple partners, self-efficacy has emerged as one of the most important predictors of safe sex practices (Kasen et al., 1992; McKusick, et al., 1990; O'Leary et al., 1992). Wulfert and Wan (1993) surveyed sexually active college students and gathered information about condom use, self-efficacy beliefs for condom use, outcome expectancies, sexual attitudes, AIDS knowledge, and perceived vulnerability. Using a LISREL model for mediation, self-efficacy beliefs were found to account for 46% of the variance in condom use.

Walsh and Foshee (1998) applied the construct of self-efficacy to the prediction of adolescent sexual victimization. Using a sample of eight and ninth graders (N = 732), they measured via self-report several attitudinal constructs hypothesized to be related to sexual victimization. These constructs included self-efficacy, self determination (extent to which one's own needs take precedence over the needs of others), and victim blaming. Participants were assessed at 6 months for victimization status. The results indicated that levels of self-efficacy,

but not self-determination or victim blaming predicted the likelihood of experiencing forced sexual activity in their adolescent sample.

In a study investigating the mechanisms governing the effects of personal empowerment over physical threats, Ozer and Bandura (1990) exposed women to a mastery modeling program in which they learned self-defense skills. While overall the mastery modeling was effective in increasing levels of perceived coping self-efficacy and cognitive control efficacy, these results were attenuated for women with a history of previous physical assault. Women who had experienced a past forced intercourse expressed a lower sense of self-efficacy to cope with interpersonal threats and to engage in activities that may involve some level of risk at pre-group assessment. This group of women also felt more vulnerable to assault and exhibited more avoidant behavior. However, in the post-treatment follow-up these differences in self-efficacy were no longer statistically significant.

Given such findings, it is important to give further consideration to the construct of self-efficacy within the domain of sexual victimization and revictimization. Self-efficacy has been shown to be predictive of behavior and amenable to change, thus it remains a viable target for intervention. However, little research has been done with the application of the self-efficacy construct within the domain of sexual victimization and to date no one has examined the construct with attention to factors relating to the context of the assault, across levels of victimization.

Context of Assault: Victim-Offender Relationship

High rates of date rape and acquaintance rape on college campuses indicate that it is important to give particular attention to the unique contributions of the victim-offender relationship. Koss et al. (1987) found that 78-89% of all rapes were perpetrated by an

acquaintance. In addition, research has shown that the victim-offender relationship may have important implications in terms of rape characteristics (Ullman & Siegel, 1993) and rape outcome variables (Culbertson & Dehle, 2001; Koss et al., 1988). Rapes by acquaintances, in comparison to those by a stranger, were more likely to be perpetrated by single offender on multiple incidents, were less likely to be labeled as rape and reported, and were labeled as "less violent" (Koss et al., 1988).

The context provided by the relationship type may also be important in terms of levels of self-efficacy. As noted by Bandura (1997), performance occurs in a context containing a constellation of factors that may include situational or personal impediments to efficacy and action. For this reason, it is suggested that measures of self-efficacy are specific not only in their behavioral actions, but also in the context in which these actions are to take place. Relationship context has been shown to be an important correlate of self-efficacy for other health-related behavior, such as condom use and sexual negotiation among a sample of HIV positive gay and bisexual men (Semple, Patterson, & Grant, 2000).

Amick and Calhoun (1987) examined potential correlates of women's ability to resist unwanted sexual contact. They found that four situational factors were predictive of resistance: the isolation of the incidence site, clarity of the victim non-consent, the previous relationship with the offender, and previous victim-offender sexual intimacy. Specifically, unsuccessful resisters were more likely to report a steady dating relationship with the offender and report higher levels of previous victim-offender sexual intimacy. Ullman (2002) also suggests that the victim-offender relationship provides an important context for specific resistance strategies. For example, self defense strategies may be more appropriate for stranger assault while interpersonal communication may be more important for acquaintance assault. It is reasonable to expect that

victim-offender relationship may impact not only one's ability to resist assault, but also one's efficacy to resist.

Context of Assault: Alcohol Use

Alcohol use prior to and during the assault situation is another factor that may contribute to one's perceived self-efficacy. In addition to the aforementioned relationship between sexual assault and alcohol use, alcohol has been found to be involved in between one-half to two-thirds of sexual assault incidents (Abbey, 1991; Pernanen, 1991). Alcohol consumption at the time of assault has been correlated with the severity of assault, the number of perpetrators, and the relationship to the perpetrator (Gidycz & Koss, 1990; Koss, Dinero, Seibel, & Cox, 1988). Although current research has not elucidated a clear model for the pathway of alcohol's role in sexual assault, researchers have found that drinking by the victim during the assault is negatively related to their ability to resist (Abbey et al., 2002). Additionally, Testa and Parks (1996) suggest in their review of the relevant literature, that higher levels of alcohol consumption may be reflective of a lifestyle that involves drinking in public places, higher numbers of sexual partners, and other risk-prone activities which all contribute to the increased risk for victimization. Support for this statement come from data that show that women's risk of victimization was predicted by a higher level of exposure to the bar environment, but not by the actual amount of alcohol consumed or whether they were intoxicated at the time of assault (Fillmore, 1985; Parks & Zetes-Zanata, 1999).

Although these studies suggest that the context of alcohol consumption may be more important than actual level of intoxication, other data show that various measures of victim's alcohol consumption discriminate between victims and non-victims (Koss & Dinero, 1988; Greene & Navarro, 1998, Testa & Livingston, 2000). While the exact relationship and

contribution of alcohol use to sexual assault is unclear, pre-assault alcohol use by both the victim and the offender are each related to more severe levels of sexual victimization (Ullman et al., 1999) and is more common in assaults occurring with less well-known offenders and in spontaneous social situations (Abbey, Ross, McDuffie, & McAuslan, 1996; Brecklin & Ullman, 2001; Ullman & Brecklin, 2000). Given the mixed findings on the role of alcohol in sexual assault scenarios, Ullman's (2003) review called for more research "on the role of alcohol in different assault contexts in order to integrate specific information about alcohol's role in sexual assault into prevention programs."

Rape Knowledge

Rape knowledge may also contribute to the overall feeling of efficacy in that it would increase the activation of personal coping abilities, as suggested by the theoretical model (Bandura, 1997). However, there is evidence to suggest that knowledge of rape risk and prevention may vary greatly. Yeater and O'Donahue (2002) evaluated women's response to a psychoeducational sexual assault prevention program using a training-to-criterion approach. The program focused on dispelling rape myths, providing facts about rape prevalence and incidence, addressing risk factors and risk perception, and providing possible response strategies. The results indicated that all women who completed the program (regardless of victimization history) demonstrated higher levels of rape prevention knowledge than the controls. These findings indicate that the women surveyed may have been unfamiliar with the information targeted by the intervention.

Purpose of Study

The aim of this study was to more closely examine the role of sexual self-efficacy in the victimization of college women. Specifically, this study examined the impact of a history of

victimization, victim-offender relationship, and alcohol use on perceived sexual self-efficacy. Three main hypotheses were tested:

Hypothesis One: Given that previous research supports an inverse relationship between frequency of victimization and sexual self-efficacy (Calhoun & Gidycz, 2002), it was hypothesized that this relationship would be replicated with this sample: frequency of victimization would be inversely related to overall sexual self-efficacy. Further, it was hypothesized that revictimized women would report significantly lower levels of overall sexual self-efficacy, followed by single assault victims. Women without a history of completed rape would report the highest overall sexual self-efficacy.

Hypothesis Two: Given that previous research suggests that alcohol use decreases ability to resist assault (Abbey et al., 2002) and could be viewed as a "barrier to action" within the social cognitive theoretical framework, it was hypothesized that all women, regardless of victimization history, would report decreased self-efficacy for situations in which they were drinking alcohol in comparison to those in which they were not drinking.

Hypothesis Three: Given that previous research suggests the importance of the victim-offender relationship in rape resistance and also suggests that relationship status may be an important factor impacting self-efficacy for situations demanding similar interpersonal effectiveness (Amick & Calhoun, 1987; Semple, Patterson, & Grant, 2000), victim-offender relationship was predicted to have an impact on sexual self-efficacy in this study. Specifically, it was predicted that there would be a significant interaction of previous assault and relationship to offender in association with lower self-efficacy scores. That is, victims (both single incident and revictims) would report their lowest self-efficacy in dating and acquaintance situations, whereas non-victims would their report lowest self-efficacy in the context of stranger rape.

CHAPTER 2

METHOD

Participants

Participants were 941 female undergraduates recruited from a research pool at a large southeastern university. The average age of the participants was 19.19 years (*SD = 1.72*), ranging from 18 to 48 years. The sample of women were predominantly Caucasian (86.7%), with African American being the next most represented population (5.4%), followed by Asian American (3.9%), and Hispanic (1.8%). The majority of participants reported being single at the time of assessment (59.4%), while approximately 40% of the sample reported being in committed dating relationship.

Measures

Sexual Experiences Survey (SES): The Sexual Experiences Survey is a self-report behavioral measure created to assess levels of sexual victimization. The items have been worded to assess a range of unwanted sexual contact (Koss & Gidycz, 1985; Koss & Oros, 1982) and their frequency of occurrence at and above age 14. The measure has good test-retest reliability, with 93% agreement rates between two administrations (Koss & Gidycz, 1985). Additionally, the measure has sufficient internal consistency and reliability for female college students (α = .74). The female version of the SES will be used in this study.

Victimization was defined as completed assault. *Single incident victimization* was defined as the experience of only one event meeting criteria for victimization. Seventy women (7.4%) met criteria for single incident victimization. *Revictimization,* or multiple incident victims, were

defined as women endorsing more than one victimization experience. One-hundred and fifty-three (16.3%) women met criteria for revictimization.

Additionally, the SES was modified to include an assessment of the age at which the reported victimization(s) occurred.

Sexual Self-Efficacy Rating (SER): The Sexual Self-Efficacy Rating (Calhoun & Gidycz, 2002) is a 6-item self-report measure of the participants' level of confidence that they can resist and avoid sexually risky situations. The scale is a representation of Bandura's concept of self-efficacy covering the domain of sexual behavior. Statements are assessed with a seven point Likert scale of responses that range from "not at all confident" to "very confident." The items are summed to attain a sum-total self-efficacy level. The measure was found to have good test-retest reliability, with a coefficient of .86. Levels of sexual self-efficacy have been found to be associated with revictimization at subsequent follow-up assessments. The scale was administered six times, with each administration beginning with varying directions to "answer these questions for a situation involving . . ." either a stranger, an acquaintance, or an intimate partner, and either involving or not involving alcohol use. Each scale may be individually summed to produce six contextual self-efficacy ratings, or may be collapsed across contextual categories to produce an average score for that given context (e.g., perpetrator type or alcohol use). *Overall sexual self-efficacy* was measured by the average of all six contextual measures of sexual self-efficacy.

Cahalan Drinking Habits Questionnaire (DHQ): The Drinking Habits Questionnaire (DHQ) (Cahalan, 1969), is a 13-item self-report questionnaire assessing level of drinking via multiple choice questions concerning the quantity and frequency of alcohol consumption. The DHQ asks the individual to estimate the frequency of their consumption of wine, beer, and liquor over a specified period of time, as well as the quantity of drinks they typically consume during a

drinking episode. Using this information, an estimate of the total volume of alcohol consumed on an average drinking occasion may be calculated, volume-variability index (VV; Cahalan & Cisin, 1968). This index acknowledges that their may be differences in the characteristics of one's drinking patterns based upon their spacing or bunching of drinks. The index has been shown to be sensitive to differences in the middle range of drinking (Khavari & Farber, 1978).

For the purposes of this study, participants were grouped by drinking category, based upon their volume-variability index, as follows: *Heavy Drinkers* reported drinking levels consistent with problem drinking behavior (> appx. 15 drinks per week; volume-variability index of 9-11); *Non-heavy Drinkers* reported drinking levels ranging from moderate alcohol consumption to abstinence (< appx. 15 drinks per week; volume-variability under 9). Three-hundred and seventy-seven (40%) participants were classified as heavy drinkers.

Child Experiences Questionnaire (CEQ): The Child Experiences Questionnaire is a self-report behavioral measure, based upon the Finklehor scale for childhood sexual experiences (1979), which assesses levels of severity of sexual victimization that occurred prior to age 14. The scale allows for a continuous measurement of abuse severity as outlined by Mayall and Gold (1995), and in conjunction with the SES, allows for a continuous assessment of victimization from childhood through adulthood.

Inventory of Interpersonal Problems-Circumplex (IIP-C): The Inventory of Interpersonal Problems (Horowitz, Rosenberg, Baer, Ureno & Villasenor, 1988) was developed as a self-report measure containing 127 items that assess a variety of interpersonal problems. Alden, Wiggins, and Pincus (1990) divided the scale into eight subscales, creating octants that can be defined in terms of different combinations of the two dimensions of the original scale (affiliation and dominance). Octants include Vindictive, Cold, Socially Avoidant, Nonassertive, Exploitable,

Overly Nurturant, Intrusive, and Domineering. With eight items representing each octant, the complete IIP-C contains a total of 64 items. The raw score for each octant is the mean value of the eight items. The measure has demonstrated high test-retest reliability coefficients for a non-clinical community sample, over a median retest interval of 7 days, ranging from .58 (Domineering) to .84 (Socially Avoidant) (Horowitz, Alden, Wiggins, & Pincus, 2000). Additionally, the internal consistencies of the octants are high, ranging from .76 (Domineering and Intrusive) to .88 (Nonassertive). The measure has also demonstrated utility with a population of sexually revictimized women, with victims scoring significantly higher than non-revictimized women (N=52) on the octants of Socially Avoidant, Nonassertive and Overly Nurturant (Classen et al., 2001).

Rape Knowledge Questionnaire (RKQ): The Rape Knowledge Questionnaire is a 20 item, true-false inventory that assesses women's knowledge and assessment of risky sexual situations. Examples of items include "Heavy alcohol use is associated with acquaintance rape" and "If you are attacked by your date it is safer to just go along with it." Items are scored for the number of correct responses and this score is totaled for the measure. Higher scores indicate a greater degree of knowledge of risky sexual situations.

Procedures

Participants gave their informed consent and completed the aforementioned questionnaires in a group testing environment where they were given ample space and time to allow for privacy and accuracy. Upon completion of the questionnaires, the participants were debriefed concerning the purpose of the study and given course credit for their participation.

CHAPTER 3

RESULTS

Missing Data

The original sample consisted of 994 participants. Because the main analyses involved measures of adult/adolescent victimization, self-efficacy, and alcohol, participants missing any of the measures included in the subsequent analyses (SES, all versions of the SER, and DHQ) were removed. Thirty-nine data points were removed from the non-victim group, two from the single incident victim group, and twelve data points were removed from the revictim group based on the aforementioned criteria. These participants did not differ significantly from the sample on any of their extant measures.

Initial Analysis

Prior to specific hypothesis tests, the relationship among all six assault contexts (stranger, acquaintance, intimate partner; with and without alcohol) was examined using a mixed design ANOVA. The within subjects factor consisted of the six contexts. The between subjects factor was women's victimization category. The dependent variable was a sum self-efficacy score on each independent measure of contextual self-efficacy.

There was a significant main effect for victimization category, $F(2, 3691.57) = 12.47$, $p<.001$, $\acute{\eta}_p^2 = .026$. Post-hoc comparisons revealed that across all six categories, revictims were significantly lower on reported self-efficacy than non-victims (see means and standard deviations in Table 1). There was also a significant main effect for context of assault, $f(2.87, 21{,}237.29) = 313.11$, $p<.001$, $\acute{\eta}_p^2 = .250$. Overall, women were least efficacious in situations involving intimate

partners and alcohol and most efficacious in situations involving strangers and no alcohol. There was no significant interaction between victimization category and context.

Hypothesis One

Hypothesis One stated that the frequency of victimization would be inversely related to overall sexual self-efficacy and that revictims in particular would have significantly lower overall self-efficacy. Overall, the results supported Hypothesis One. A bivariate correlation was used to assess the general relationship between overall sexual self-efficacy and frequency of victimization. Overall sexual self-efficacy had a significant inverse relationship to frequency of completed rape ($r=-.196$, $p<.001$). This relationship was also consistent across all measures of sexual self-efficacy (see Table 2).

A univariate analysis of variance (ANOVA) was performed to examine the specific relationship of category of victimization (i.e., non-victim, single incident victim, and revictim) on overall sexual self-efficacy (see Figure 1). Means and standard deviations are presented in Table 3.The omnibus test resulted in a significant overall effect for victimization catergory, $F(2, 615.26)=12.47$, $p<.001$, $\acute{\eta}_p^2=.026$. Planned comparisons, using Bonferroni corrections against type I error, revealed a significant difference between levels of self-efficacy in non-victims and revictims, $t(2)=4.92$, $p<.001$. No other group comparisons revealed significant differences.

Hypothesis Two

A mixed design ANOVA was used to test Hypothesis Two, which predicted that all women would report lower levels of self-efficacy in contexts in which they had consumed alcohol as opposed to those in which no alcohol was involved. Given that the same participants completed measures of self-efficacy in contexts with alcohol use and without alcohol use,

alcohol was the within-subjects factor. Women were compared by the between group factor of victimization level (see Figure 2). Means and standard deviations are presented in Table 3.

As indicated by the insignificant Mauchley's W, the sphericity assumption was met. There was a significant main effect for alcohol, $F(1, 17166)=545.69$, $p<.001$, $\acute{\eta}_p^2= .368$. All women, regardless of victimization level reported significantly lower sexual self-efficacy for situations in which they had been consuming alcohol than in situations without alcohol consumption.

Additionally, there was a significant main effect for victimization level, $F(2, 1230.52)=12.47$, $p<.001$, $\acute{\eta}_p^2 = .026$. Post hoc pairwise comparisons, using the Bonferroni correction for reduction of type I error, indicated a significant difference between non-victims and re-victims, $t(2)=4.18$, $p<.001$, with revictims having significantly lower sexual self-efficacy. No other comparisons reflected significant differences. In sum, the results of this analysis supported Hypothesis Two.

Hypothesis Three

To investigate the impact of victim-offender relationship and victimization history on sexual self-efficacy ratings, a mixed design ANOVA was used, with victim-offender relationship (stranger, date, intimate partner) being a repeated measure factor and victimization level (non-victim, victim, and revictim) being the between group factor (see Figure 3). Means and standard deviations are presented in Table 3.

As indicated by the significant Mauchley's W, the sphericity assumption for the repeated measures factor was not met, therefore results reported have been corrected by the Greenhouse-Geisser correction. There was a significant main effect for victim-offender relationship, $F(1.37, 3490.26)=131.39$, $p<.001$, $\acute{\eta}_p^2= .123$. Post hoc contrasts revealed a significant difference between

stranger and intimate partner contexts, $F(1, 8644.5)=152.79$, $p<.001$, and between acquaintance/date and intimate partner contexts, $F(1, 5252.9)=136.63$, $p<.001$. Women reported being most efficacious in handling encounters with strangers and least efficacious in contexts involving intimate partners.

Results also indicate a main effect for level of victimization, $F(2, 615.26)=12.47$, $p<.001$, $\acute{\eta}_p^2=.026$. As with previous analyses, the higher degree of previous victimization related to women's lower self-efficacy ratings. Although the interaction term did not retain significance following the Greenhouse-Geisser correction ($p<.05$ to $p=.07$), it is still beneficial to examine the post hoc effects of victimization level in terms of simple effects for pairwise comparison. Within the context of stranger relationship and intimate partner relationship, non-victims and revictims displayed the only significant difference in efficacy, $t(2)=4.12$, $p<.001$. However, for contexts involving acquaintance/dating relationships, significant differences were noted between non-victims and revictims, $t(2)=4.40$, $p<.001$, and between single incident victims and revictims, $t(2)=2.13$, $p<.05$.

Exploratory Analyses

The overall support for the main hypotheses encouraged further investigation of factors that may contribute to women's sexual self-efficacy in various contexts. As such, regression analyses were performed for each main context of sexual self-efficacy (overall, alcohol consumption, no alcohol consumption, stranger, acquaintance, and intimate partner). Frequency of completed adult/adolescent rape, frequency of child sexual abuse, interpersonal problems, alcohol volume, and rape knowledge were investigated as potential contributors to sexual self-efficacy. For the purposes of these exploratory analyses, interpersonal problems were indicated by participants' total raw score on the Inventory of Interpersonal Problems.

Across all measures of self-efficacy, frequency of completed rape in adulthood/ adolescence and interpersonal problems were significant contributors to the variance in self-efficacy. Child sexual abuse and rape knowledge did not significantly contribute to any measures of self-efficacy. Interestingly, alcohol volume consumption was a significant contributor to women's overall sexual self-efficacy and their self-efficacy in situations in which they were consuming alcohol, with a trend toward significance for situations involving acquaintances and intimate partners. It is worth noting that the relationship between alcohol consumption and self-efficacy is positive in direction; greater consumption of alcohol is related to higher levels of self-efficacy in situations in which women are drinking alcohol (see Table 4).

CHAPTER 4

DISCUSSION

This was the first study to investigate the impact of contextual factors, specifically alcohol consumption and victim-offender relationship, on women's self-efficacy to resist sexual assault. Research with the construct of sexual self-efficacy is currently in its infancy, but is supported by many extant literatures pertaining to self-efficacy expectancies in varying domains such as substance use, health behaviors, and condom negotiation, that highlight the importance of self-efficacy in predicting and altering behavioral outcomes. Overall, the results of this study provide encouragement for further research on this construct within populations of female sexual assault victims.

In general, sexual self-efficacy was negatively correlated with frequency of completed assault experienced by the women. This finding is consistent with earlier work by Calhoun and Gidycz (2002), and is also consistent with social cognitive theory in that experience of rape may be framed as the exact opposite of a "mastery experience" of resisting sexual assault. Further, while the only significant difference in overall sexual self-efficacy was between non-victims and revictims, it is worth noting that self-efficacy ratings followed a linear pattern, with non-victims feeling the most efficacious, followed by single incident victims, and finally, revictims.

One potential explanation for the general lack of significant differences in self-efficacy between single incident victims and other groups may be the relatively low number of participants fitting this description (only 7.4% of the sample). As such, power to investigate this group in relation to others was substantially lower. This may also be seen as a reflection of the

importance of work with women experiencing multiple victimizations, as this was much more common in the current sample (approximately 16%).

The results also lent continuing support to consideration of the role of alcohol in the assault scenario. Hypothesis Two was supported in that all women, regardless of previous victimization history, felt significantly less efficacious in resisting sexual assault when they had been consuming alcohol. This finding is consistent with previous qualitative findings indicating that women viewed outward signs of intoxication (e.g., motor impairment, slurred speech, etc.) as placing them at higher risk for victimization in bar settings (Parks, et al., 1998). However, the current findings seem to contradict the latter portion of findings from the Parks' study, in that even while women noted the greater risk for victimization, they still perceived themselves as capable of "controlling or minimizing the aggression through their own behavior." Clearly, the current results indicate that women view themselves as significantly less capable of resisting assault while consuming alcohol. One potential explanation for this discrepancy may be found in the specificity of behaviors measured by sexual self-efficacy in this study compared with the broad measurement of "being in control of the situation" discussed in the Parks' study.

There was also a significant effect for victimization level such that revictims had significantly lower self-efficacy than non-victims. This again highlights the importance of targeting previously victimized women for further research and intervention purposes.

Additionally of interest, exploratory analyses revealed that current levels of drinking were significantly related to women's sexual self-efficacy in situations involving alcohol, but not in those in which alcohol was not a factor. While this is consistent with logic, what is somewhat inconsistent is that the relationship is in a direction one may not suspect; the greater the volume of alcohol consumed by women, the more confident they felt that they could resist sexual assault.

Although the relationship is relatively small in strength, it may pinpoint a potential fallacy in women's risk perception. One could hypothesize that this slight overconfidence may be a result of, or related to positive alcohol expectancies.

Corbin et al. (2001) found that college women with a history of severe victimization (attempted or completed rape) consumed significantly more alcohol on a weekly basis, reported significantly more sexual activity following consumption of alcohol, and reported less likelihood of refusing future unwanted sexual behavior. Each may increase risk for future revictimization. Interestingly, women in the severe victimization group, when compared to non-victims, held greater positive outcome expectancies for alcohol consumption in the domains of Tension Reduction, Global Positive Change, and Sexual Enhancement. In predicting sexual behavior following consumption of alcohol, both alcohol consumption and social expectancies for alcohol made significant independent contributions and when combined, accounted for approximately 43% of the variance. This study highlights the important role of alcohol expectancies in predicting not only drinking behavior, but also in contributing to engagement in sexual activity subsequent to drinking. It is possible that alcohol expectancies may also contribute to women's sexual self-efficacy in situations involving alcohol. Future research should examine this potential relationship.

Victim-offender relationship was the final contextual factor examined in the current study. Women across all victimization categories were significantly less efficacious in situations involving intimate partners, followed by situations involving acquaintances, and finally those involving strangers. One potential explanation for this finding could be that women may know that their odds of being assaulted by someone they know are far greater than those of being assaulted by a stranger (Koss et al., 1987). However, an alternate explanation may be that

women recognize that potential assault contexts involving intimate partners require a higher degree of interpersonal negotiation skills. As there are often competing demands (e.g., maintain relationship vs. asserting oneself) in these situations, it is plausible that women view this context as more demanding, and thus view themselves as less efficacious at successfully resisting assault in this context.

A recent study by VanZile-Tamsen, Testa, and Livingston (2005) lends support to this hypothesis. Women varying in victimization were given analog rape situations varied by level of intimacy with the offender. The women were then asked to appraise the man's actions as either sexual interest or assault, as well as reporting their response intentions, either resistance or non-resistance behavior. While there were only small effects for previous victimization level, a notable effect was found for level of intimacy with the offender such that the largest contributor to both appraisal and response intentions was perpetrator intimacy. More intimate relationships were associated with less threatening appraisals and less intention of resistance. Additional research supports the notion that women may be more aware of risk and more willing to enact resistance strategies in contexts with strangers than in situations with dates or intimate partners (Gidycz, et al., in press; Messman-Moore & Brown, in press).

Partial and tentative support for this hypothesis may be found in the exploratory analyses which revealed that interpersonal problems were significantly related to sexual self-efficacy ratings in all contexts. Further, interpersonal problems were more strongly related to self-efficacy than any of the other domains assessed. Whether interpersonal problems are mediating the relationship between intimate partner contexts and lower self-efficacy is currently unclear, but it is clear that interpersonal problems may play an important role in women's sexual self-efficacy.

As with Hypothesis Two, there was also a main effect for victimization level, such that revictims were consistently lower in their self-efficacy than single incident victims and non-victims. Again, this finding is consistent with previous research associating lower sexual self-efficacy with a higher frequency of previous victimization (Calhoun & Giidycz, 2002). This finding may also be interpreted in light of previous research highlighting the poorer general adjustment of women with multiple victimizations in their history (Ellis, Atkeson, & Calhoun, 1982; Gidycz, et al., 1993).

It is important to note that the current study failed to find a significant interaction between level of victimization and victim-offender relationship after applying a statistical correction for the failure to meet the sphericity assumption of ANOVA. Given that a trend toward significance was still present, it may still be of benefit to discuss significant simple effects. While the main effect for victimization highlights that revictims were significantly lower than others in self efficacy, the simple effects indicate that revictims were significantly lower than *non-victims* for all offender relationships, but were significantly lower than both non-victims and single incident victims in the case of acquaintance/date relationships. This finding may be interesting to investigate in further detail given that the majority of assault on college campuses is perpetrated by acquaintances and intimate partners.

In general, the current study supports the importance of previous victimization, involvement of alcohol, and victim-offender relationship in determining women's self-efficacy to resist sexual assault. These findings may be particularly applicable to the design and/or modification of sexual assault intervention programming. Previous research (Calhoun & Gidycz, 2002) supports the amenability to change and the importance of sexual self-efficacy in preventing revictimization. This study highlights the potential importance of including

information pertaining alcohol consumption, as well as touching on the importance of interpersonal factors in contexts involving intimate partners or dates, in risk-reduction programming.

Potential caveats to such conclusions involve the preliminary nature of these findings. Due to the homogenous nature of the sample, generalizability of these findings is limited to female college populations. Additionally, the retrospective data limit conclusions of causation or temporality of the findings. That is, while theoretical frameworks assist in determining the order of these relationships, it is not statistically possible to draw inferences about the temporal onset of various issues experienced by the participants.

Future research should seek to further elucidate additional factors, such as alcohol expectancies, that may impact women's efficacy in the various contexts. Additionally, further investigation of the impact of interpersonal problems is warranted given its significant relationship to sexual self-efficacy across all contexts. Finally, specific attention should continue to be given to revictimization and efforts toward its prevention.

REFERENCES

Abbey, A. (1991). Acquaintance rape and alcohol consumption on college campuses: How are they linked? *Journal of American College Health,* 39(4), 165-169.

Abbey, A., Clinton, A.N., McAuslan, P., Zawacki, T. & Buck, P.O. (2002). Alcohol-involved rapes: Are they more violent? *Psychology of Women Quarterly,* 26(2), 99-109.

Abbey, A., Ross, L.T., McDuffie, D., & McAuslan, P. (1996). Alcohol and dating risk factors for sexual assault among college women. *Psychology of Women Quarterly,* 20(1), 147-169.

Alden, L.E., Wiggins, J.S., & Pincus, A.L. (1990). Construction of the circumplex scales for the Inventory of Interpersonal Problems. *Journal of Personality Assessment*, 55, 521-536.

Amick, A.E. & Calhoun, K.S. (1987). Resistance to sexual aggression: Personality, attitudinal, and situational factors. *Archives of Sexual Behavior,* 16(2), 153-163.

Baer, J.S. & Lichtenstein, E. (1988). Classification and prediction of smoking relapse episodes: An exploration of individual differences. *Journal of Consulting and Clinical Psychology,* 56(1), 104-110.

Bandura, A. (1977). Self-efficacy: Toward a unifying theory of behavioral change. *Psychological Review,* 84(2), 191-215.

Bandura, A.(1986). *Social foundations of thought and action: A social cognitive theory.* Rockville, MD: National Institute of Mental Health (NIMH).

Bandura, A. (1997). *Self-Efficacy: The Exercise of Control.* New York: W.H. Freeman & Company.

Basile, K.C. & Saltzman, L.E. (2002). *Sexual violence surveillance: Uniform definitions and recommended data elements*. Atlanta, GA: Centers for Disease Control and Prevention.

Beck, K.H. & Lund, A.K. (1981). The effects of health threat seriousness and personal efficacy upon intentions and behavior. *Journal of Applied Social Psychology,* 11, 401-415.

Brecklin, L.R. & Ullman, S.E. (2001). The role of offender alcohol use in rape attacks: An analysis of national crime victimization survey data. *Journal of Interpersonal Violence,* 16(1), 3-21.

Buchner, A., Erdfelder, E., & Faul, F. (1997). How to Use G*Power [WWW document]. URL http://www.psycho.uni-duesseldorf.de/aap/projects/gpower/how_to_use_gpower.html

Burgess, A.W. & Holstrom, L.L. (1978). Recovery from rape and prior life stress. *Research in Nursing & Health,* 1, 165-174.

Calhoun, K.S. & Gidycz, C.A. (2002, November). *Self-efficacy as a predictor of revictimization*. Poster session presented at the annual meeting of the Association for the Advancement of Behavior Therapy, Reno, NV.

Classen, C., Field, N.P., Koopman, C., Nevill-Manning, K. & Spiegel, D. (2001). Interpersonal problems and their relationship to sexual revictimization among women sexually abused in childhood. *Journal of Interpersonal Violence,*16(6), 495-509.

Cloitre, M. (1998). Sexual revictimization: Risk factors and prevention. In V.M. Follette & J.I. Ruzek (Eds.), *Cognitive-behavioral therapies for trauma* (pp.278-304). New York: Guilford Press.

Cohen, L.J. & Roth, S. (1987). The psychological aftermath of rape: Long term effects and individual differences in recovery. *Journal of Social & Clinical Psychology,* 5, 525-534.

Corbin, W. R., Bernat, J. A., Calhoun, K. S., McNair, L. D., & Seals, K. L. (2001). The role of alcohol expectancies and alcohol consumption among sexually victimized and nonvictimized college women. *Journal of Interpersonal Violence,* 16(4), 297-311.

Culbertson, K.A. & Dehle, C. (2001). Impact of sexual assault as a function of perpetrator type. *Journal of Interpersonal Violence,* 16(10), 992-1007.

Dancu, C.V., Riggs, D.S., Hearst-Ikeda, D., Shoyer, B. & Foa, E. (1996). Dissociative experiences and posttraumatic stress disorder among female victims of criminal assault and rape. *Journal of Traumatic Stress,* 9(2), 253-267.

Ellis, E.M., Atkeson, B.M., & Calhoun, K.S. (1982). An examination of differences between multiple- and single-incident victims of sexual assault. *Journal of Abnormal Psychology,* 91(3), 221-224.

Erdfelder, E., Faul, F., & Buchner, A. (1996). GPOWER: A general power analysis program. *Behavior Research Methods, Instruments, & Computers*, 28, 1-11.

Finkelhor, D. (1979).What's wrong with sex between adults and children? Ethics and the problem of sexual abuse. *American Journal of Orthopsychiatry,* 49(4), 692-697.

Finkelhor, D. & Browne, A. (1985). The traumatic impact of child sexual abuse: A conceptualization. *American Journal of Orthopsychiatry,* 55(40, 530-541.

Freeman, K.A. & Morris, T.L. (2001). A review of the conceptual models explaining the effects of child sexual abuse. *Aggression & Violent Behavior,* 6(4), 357-373.

Gidycz, C.A., Coble, C. Lathatm, L. & Layman, M. (1993). Sexual assault experience in adulthood and prior victimization experiences. *Psychology of Women Quarterly,* 17, 151-168.

Gidycz, C.A., Hanson, K., & Layman, M. (1995). A prospective analysis of the relationships among sexual assault experiences: An extension of previous findings. *Psychology of Women Quarterly,* 19, 5-29.

Gidycz, C.A., Layman, M.J., Crothers, M. Gylys, J., Matorin, A. & Dowdall, C. (1997*). An*

evaluation of an acquaintance rape prevention program: Impact on attitudes and behavior. Paper presented at the meeting of the Midwestern Psychological Association, Chicago, IL.

Gidycz, C.A. & Koss, M.P. (1990). A comparison of group and individual sexual assault victims. *Psychology of Women Quarterly,* 14(3), 325-342.

Gidycz, C.A., McNamara, J.R., & Edwards, K.M. (in press). Women's risk perception and sexual victimization: A review of the literature. *Aggression and Violent Behavior.*

Gold, S.R., Sinclair, B.B., & Balge, K.A. (1999). Risk of sexual revictimization: A theoretical model. *Aggression & Violent Behavior,* 4(4), 457-470.

Greene, D.M. & Navarro, R.L. (1998). Situation-specific assertiveness in the epidemiology of sexual victimization among university women. *Psychology of Women Quarterly,* 22, 589-604.

Fillmore, K.M. (1985). The social victims of drinking. *British Journal of Addiction,* 80(3), 307-314.

Hayes, S.C. (1987). A contextual approach to therapeutic change. In N.S. Jacobsen (Ed.), *Psychotherapists in Clinical Practice: Cognitive Behavioral Perspectives* (pp.327-387). New York: Guilford Press.

Horowitz, L., Alden, L.E., Wiggins, J.S., & Pincus, A.L. (2000). *Inventory of Interpersonal Problems Manual*. The Psychological Corporation.

Horowitz, L., Rosenberg, S., Baer, B., Ureno, G. & Villasenor, V. (1988). Inventory of Interpersonal Problems: Psychometric properties and clinical applications. *Journal of Consulting and Clinical Psychology,* 56, 885-892.

Humphrey, J.A. & White, J.W. (2000). Women's vulnerability to sexual assault from

adolescence to young adulthood. *Journal of Adolescent Health,* 27, 419-424.

Kasen, S. Vaughn, R.D., & Walter, H.J. (1992). Self-efficacy for AIDS preventive behaviors among tenth grade students. *Health Education Quarterly,* 19, 187-202.

Kilpatrick, D.G., Edmunds, C.N., & Seymour, A.K. (1992). *Rape in America: A Report to the Nation.* Arlington, VA: National Victim Center.

Kimerling, R., Armistead, L.P., & Forehand, R. (1999). Victimization experience and HIV infection in women: Associations with serostatus, psychological symptoms and health status. *Journal of Traumatic Stress*, 12, 41-58.

Kimerling, R. & Calhoun, K.S. (1994). Somatic symptoms, social support and treatment seeking among sexual assault victims. *Journal of Consulting and Clinical Psychology*, 62, 333-340.

Koss, M.P. (1992). The underdetection of rape: Methodological choices influence incidence estimates. *Journal of Social Issues,* 48, 61-75.

Koss, M.P. & Dinero, T.E. (1989). Discriminant analysis of risk factors for sexual victimization among a national sample of college women. *Journal of Consulting and Clinical Psychology,* 57, 242-252.

Koss, M.P., Dinero, T.E., Seibel, C., & Cox, S. (1988). Stranger and acquaintance rape: Are there differences in the victim's experience? *Psychology of Women Quarterly, 12,* 1-24.

Koss, M.P. & Gidycz, C.A. (1985). Sexual experiences survey: Reliability and validity. *Journal of Consulting and Clinical Psychology,* 53, 422-423.

Koss, M.P., Gidycz, C.A., & Wisniewski, N. (1987). The scope of rape: Incidence and prevalence of sexual aggression and victimization in a national sample of higher education students. *Journal of Consulting and Clinical Psychology,* 55(2), 162-170.

Koss, M.P. & Oros, C. (1982). Sexual experiences survey: A research instrument investigating sexual aggression and victimization. *Journal of Consulting and Clinical Psychology,* 50, 455-457.

Koss, M.P., Woodruff, W.J., & Koss, P.G. (1991). Criminal victimization among primary care medical patients: Prevalence, incidence, and physician usage. *Behavioral Sciences and the Law,* 9, 85-96.

Levinson, R.A. (1986). Contraceptive self-efficacy: A perspective on teenage girls' contraceptive behavior. *Journal of Sex Research,* 22, 347-369.

Litt, M.D. (1988). Self-efficacy and perceived control: Cognitive mediators of pain tolerance. *Journal of Personality and Social Psychology,* 54, 149-160.

Mandoki, C.A. & Burkhart, B.R. (1989). Sexual victimization: Is there a vicious cycle? *Violence & Victims,* 4(3), 179-190.

Mayall, A. & Gold, S.R. (1995). Definitional issues and mediating variables in the sexual revictimization of women sexually abused as children. *Journal of Interpersonal Violence,* 10(1), 26-42.

McAuley, E. (1992). Understanding exercise behavior: A self-efficacy perspective. In G.C. Roberts (Ed.), *Motivation in Sport and Exercise* (pp.107-127). Chapaign, IL: Human Kinetics.

McKusick, L.(1990). Changing sexual behavior. In B.R. Voeller & J.M. Reinisch (Eds.), *AIDS and sex: An integrated biomedical and biobehavioral approach* (pp.155-167). London: Oxford University Press.

Messman-Moore, T.L. & Brown, A.L. (in press). Risk perception, rape, and sexual revictimization: Aprospective study of college women. *Psychology of Women Quarterly.*

Messman, T.L. & Long, P.J. (1996). Child sexual abuse and its relationship to revictimization in adult women: A review. *Clinical Psychology Review,* 16(5), 397-420.

Messman-Moore, T.L. & Long, P.J. (2002).Alcohol and substance use disorders as predictors of child to adult sexual revictimization in a sample of community women. *Violence & Victims,* 17(3), 319-340.

Norris, J., Nurius, P., & Dimeff, L. (1996). Through her eyes: Factors affecting women's perception of resistance to acquaintance sexual aggression threat. *Psychology of Women Quarterly,* 20, 123-145.

O'Leary, A., Goodheart, F. Jemmott, L.S., & Boccer-Lattimore, D. (1992). Predictors of safer sexual behavior on the college campus: A social cognitive theory analysis. *Journal of American College Health*, 40, 254-263.

Ozer, E.M. & Bandura, A. (1990). Mechanisms governing empowerment effects: A self-efficacy analysis. *Journal of Personality and Social Psychology,* 58(3), 472-486.

Parks, K.A., Miller, B.A., Collins, R.L., & Zetes-Zanata, L.M. (1998). Women's description of drinking in bars: Reasons and risks. *Sex Roles,* 38, 701-771.

Parks, K.A. & Zetes-Zanata, L.M. (1999). Women's bar-related victimization: Refining and testing a conceptual model. *Aggressive Behavior,* 25(5), 349-364.

Pernanen, K. (1991). *Alcohol in Human Violence.* New York: Guilford Press.

Polusney, M.A. & Follette, V.M. (1995). Long-term correlates of child sexual abuse: Theory and review of the empirical literature. *Applied & Preventive Psychology,* 4(3), 143-166.

Powell, G.E. (1973). Negative and positive mental practice in motor skill acquisition. *Perceptual & Motor Skills,* 37, 312.

Resick, P. (1993). The psychological impact of rape. *Journal of Interpersonal Violence,* 8, 223-

255.

Semple, S.J., Patterson, T.L., Grant, I. (2000). Psychosocial predictors of unprotected anal intercourse in a sample of HIV positive gay men who volunteer for sexual risk reduction intervention. *AIDS Education & Prevention,* 12(5), 416-430.

Sorrenson, S.B., Stein, J.A., Siegel, J.M., & Burnham, M.A. (1987). The prevalence of sexual assault. *American Journal of Epidemiology,* 126, 1154-1164.

Stajkovic, A.D. & Luthans, F. (1998). Social cognitive theory and self-efficacy: Going beyond traditional motivational and behavioral approaches. *Organizational Dynamics,* 26(4), 62-74.

Strecher, V.J, Devellis, B.M., Becker, M.H., & Rosenstock, I.M. (1986). The role of self-efficacy in achieving health behavior change. *Health Education Quarterly,* 13(1), 73-92.

Testa, M. & Livingston, J.A. (2000). Alcohol and sexual aggression: Reciprocal relationships over time in a sample of high-risk women. *Journal of Interpersonal Violence,* 15(4), 413-427.

Testa, M. & Parks, K.A. (1996). The role of women's alcohol consumption in sexual victimization. *Aggression & Violent Behavior,* 1(3), 217-234.

Tjaden, P. & Thoennes, N. (2000). Prevalence and consequences of male-to-female and female-to-male intimate partner violence as measured by the National Violence Against Women Survey. *Violence Against Women,* 6(2), 142-161.

Ullman, S.E. (2002). Rape avoidance: Self-protection strategies for women. In P.A. Schewe (Ed.), *Preventing Violence in Relationships: Interventions Across a Lifespan* (pp. 137-162). Washington D.C.: American Psychological Association.

Ullman, S.E. (2003). A critical review of field studies on the link of alcohol and adult sexual

assault in women. *Aggression & Violent Behavior,* 8(5), 471-486.

Ullman, S.E. & Brecklin, L.R. (2000). Alcohol and adult sexual assault in a national sample of women. *Journal of Substance Abuse,* 11(4), 405-420.

Ullman, S.E., Karabatsos, J. & Koss, M.P. (1999). Alcohol and sexual assault in a national sample of college women. *Journal of Interpersonal Violence,* 14(6), 603-625.

Ullman, S.E. & Sieglel, J.M. (1993). Victim-offender relationship and sexual assault. *Violence & Victims,* 8(2), 121-134.

VanZile-Tasmen, C., Testa, M., & Livingston, J.A. (2005). The impact of sexual assault history and relationship context on appraisal of and responses to acquaintance sexual assault risk. *Journal of Interpersonal Violence*, 20, 813-832.

Walsh, J.F. & Foshee, V. (1998). Self-efficacy, self-determination and victim blaming as predictors of adolescent sexual victimization. *Health Education Research,* 13(1), 139-144.

Wilson, A.E., Calhoun, K.S., & Bernat, J. (1999). Risk recognition and trauma related symptoms among sexually revictimized women. *Journal of Consulting and Clinical Psychology,* 67, 705-710.

Wulfert, E. & Wan, C.K. (1993). Condom use: A self-efficacy model. *Health Psychology,* 12, 346-389.

Yeater, E.A. & O'Donahue, W. (2002). Sexual revictimization: The relationship among knowledge, risk perception, and ability to respond to high risk situations. *Journal of Interpersonal Violence,* 17(11). 1135-1144.

Table 1. Means and standard deviations for self-efficacy scores.

	Non-Victims		Single Incident Victims		Revictims	
Context	M	SD	M	SD	M	SD
Stranger	38.06	6.41	37.26	6.34	36.16	6.63
Date	37.18	6.96	36.74	6.79	34.76	7.98
Intimate	34.66	8.83	32.21	9.79	31.00	10.14
Stranger-alcohol	29.47	10.00	28.67	9.60	26.10	10.40
Date-alcohol	28.38	9.81	27.56	9.40	25.00	10.05
Intimate-alcohol	25.41	11.00	23.06	9.98	21.67	10.94

Table 2. Correlations between measures of frequency of victimization, overall self-efficacy (OSE), each self-efficacy (SE) context, and alcohol volume

Scale	1	2	3	4	5	6	7	8
					N=941			
1.Rape Frequency	--	-.196**	-.162**	-.193**	-.193**	-.171**	-.163**	.112**
2.OSE		--	.926**	.835**	.871**	.951**	.889**	.042
3.SE-alcohol			--	.564**	.792**	.882**	.838**	.091**
4.SE-no alcohol				--	.748**	.790**	.720**	-.041
5.SE-intimate					--	.726**	.583**	.037
6.SE-acquaintance						--	.872**	.039
7.SE-stranger							--	.037
8.Alcohol								--

** indicates p<.01

Table 3. Means and standard deviations for hypothesis one measuring overall self-efficacy (SE), hypothesis two measuring alcohol and non-alcohol contexts, and hypothesis three measuring victim-offender relationship.

Measures	Non-Victims		Single Incident Victims		Revictims		Overall	
	M	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*
Overall SE	32.19	7.01	30.92	6.51	29.12	7.28	31.60	7.11
Alcohol Context SE	27.75	9.50	26.43	8.72	24.29	9.26	27.09	9.49
No Alcohol Context SE	36.63	6.36	35.40	6.18	33.98	6.94	36.11	6.52
Stranger Context SE	33.77	7.13	32.96	6.96	31.13	7.58	33.28	7.25
Dating Context SE	32.78	7.33	32.15	6.88	29.88	7.96	32.26	7.48
Intimate Context SE	30.03	8.74	27.64	8.63	26.34	9.29	29.25	8.93

Table 4. Summary of regression analyses investigating significant contributors to sexual self-efficacy in various contexts.

	Dependent Variables					
	Overall	Alcohol	No Alcohol	Stranger	Acquaintance	Intimate
	β	β	β	β	β	β
Frequency of Adult/Adolescent Rape	-.208***	-.168**	-.213***	-.160**	-.134*	-.251***
Child Sexual Abuse	-.028	.009	.048	.047	.015	.015
Interpersonal Problems	-.370***	-.296***	-.384***	-.341***	-.367***	-.295***
Alcohol Volume	.082	.130*	-.009	.096	.043	.082
Rape Knowledge	-.041	-.060	-.002	-.071	-.034	-.010

$p < .05$ indicated by *, $p < .01$ indicated by **, $p < .001$ indicated by ***

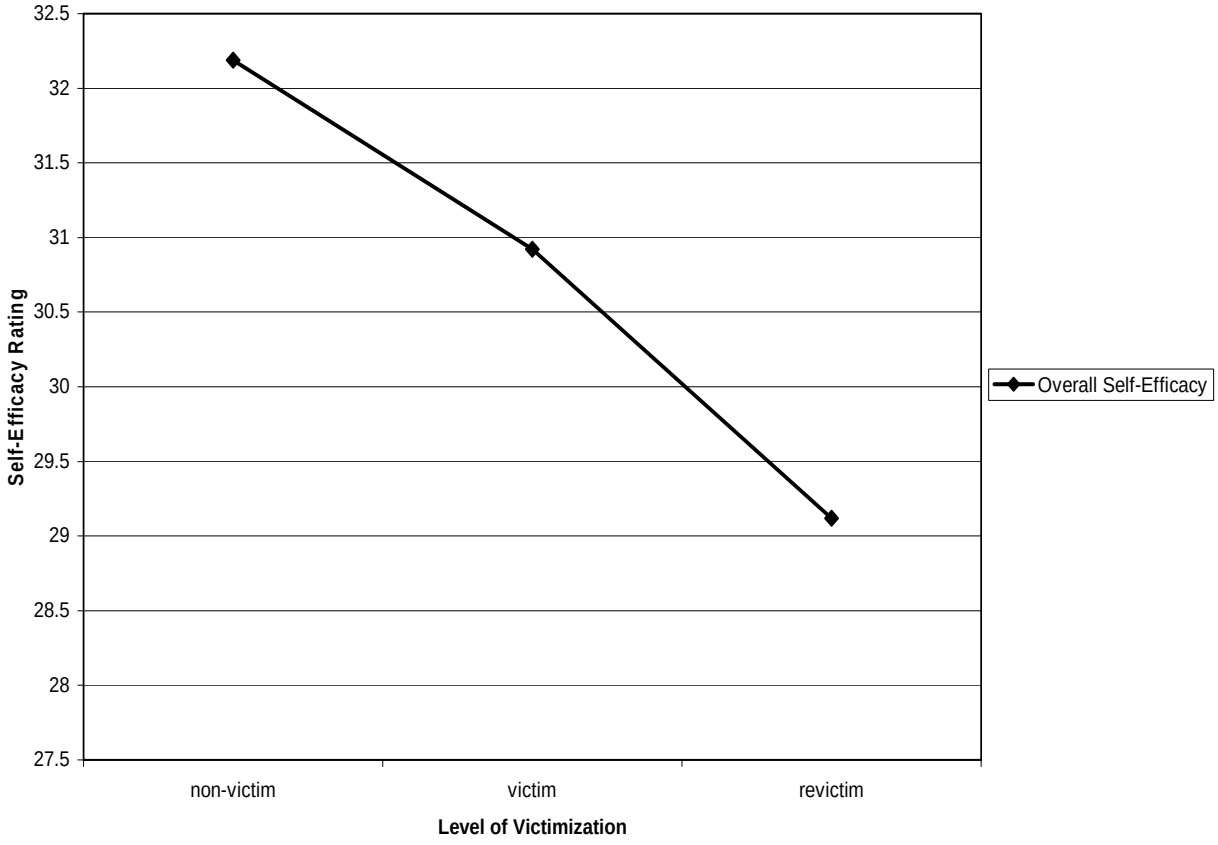

Figure 1. Impact of level of victimization on overall sexual self-efficacy.

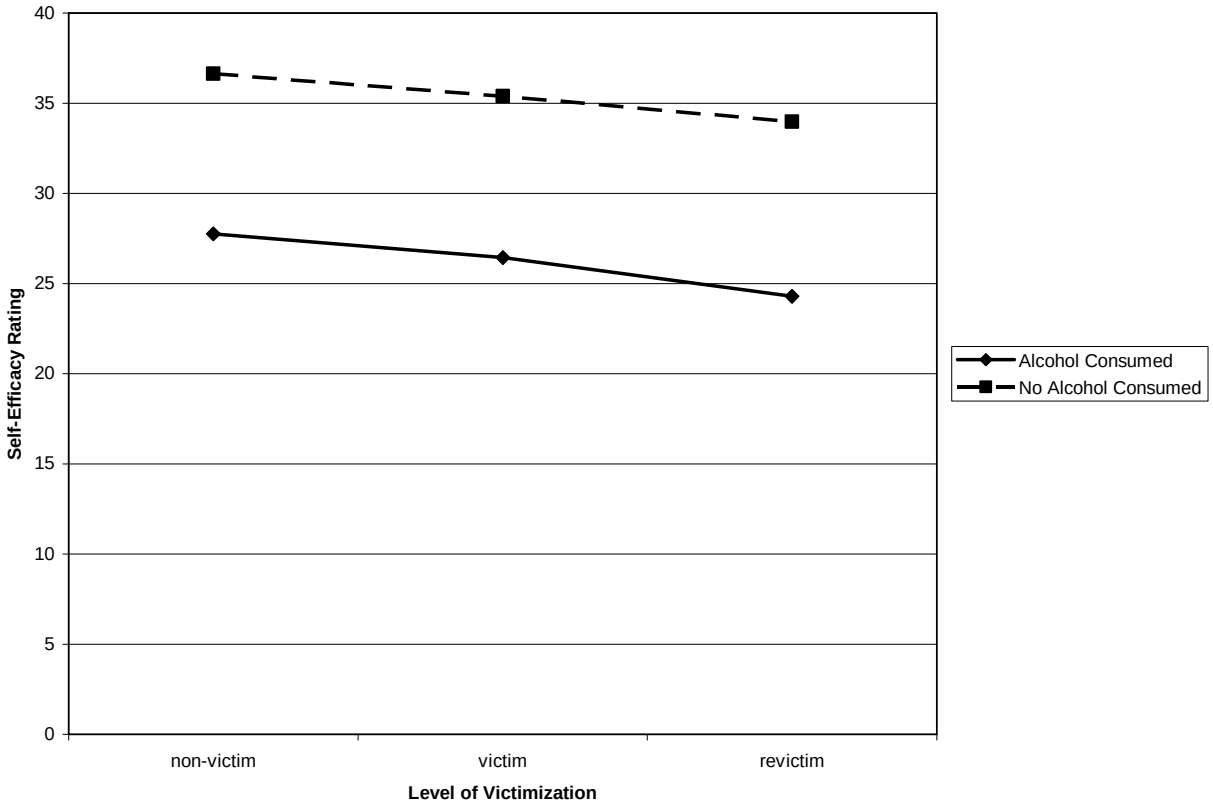

Figure 2. Impact of context (alcohol vs. no alcohol) on sexual self-efficacy.

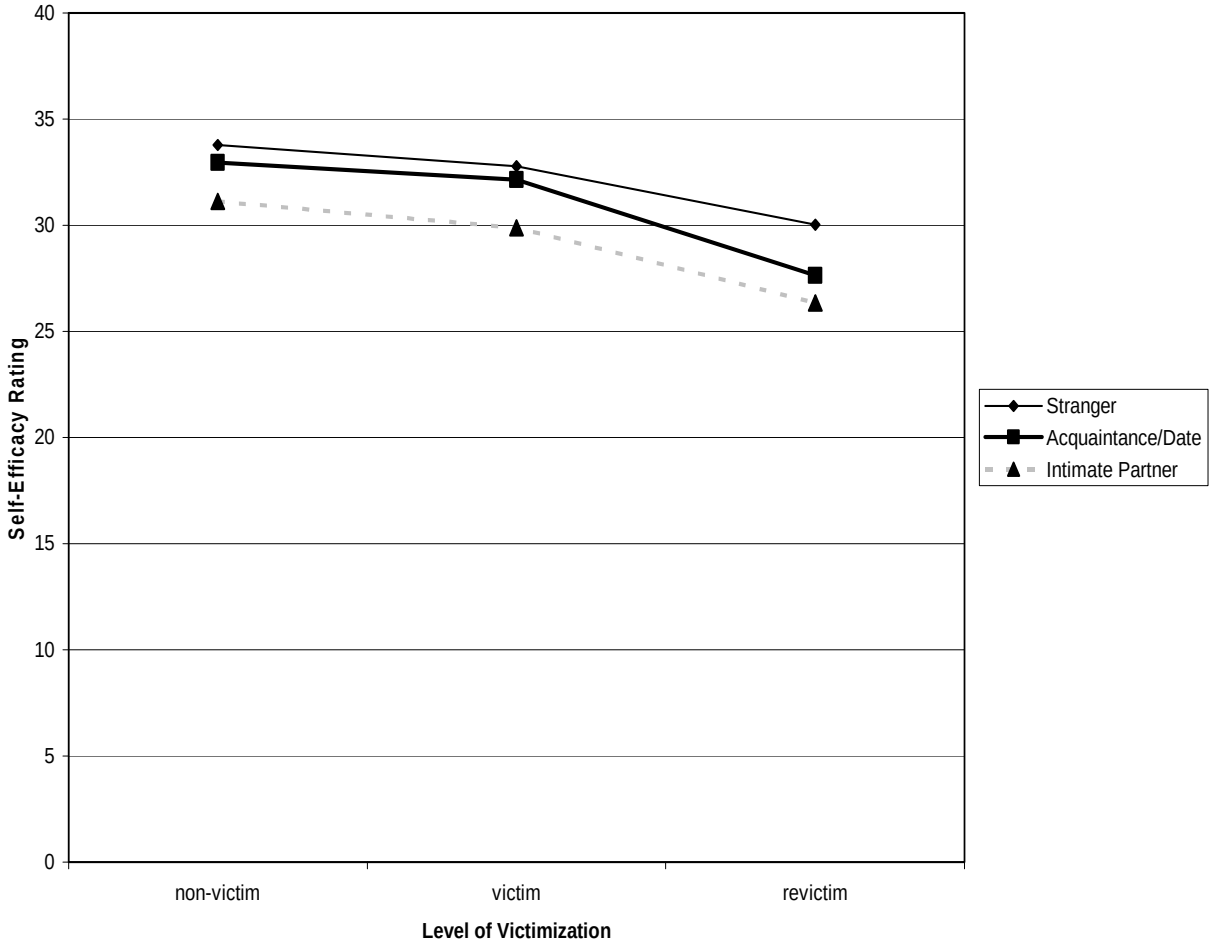

Figure 3. Impact of context (victim-offender relationship) on sexual self-efficacy.

APPENDIX A

CONSENT FORM

Consent Form

I agree to participate in the research study titled "Self-Efficacy and Dating," which is being conducted by Jenna McCauley under the supervision of Dr. K. Calhoun, Department of Psychology at University of Georgia, phone number; (706) 542-1173. I understand that this participation is entirely voluntary; I can withdraw my consent at any time without penalty and have the results of the participation, to the extent that it can be identified as mine, returned to me, removed from the research records, or destroyed.
The following points have been explained to me:

1) The reason for the research is:
To find out how efficacious women perceive themselves to be at preventing a sexual assault given various contextual variables.

The benefits that I may expect from it are:
I will receive 1 hour research credit. Although there will be no additional direct benefit to me in participating in this study, the knowledge that we gain from studying the construct of self-efficacy will help inform the design of future sexual assault prevention programs. **Participation in this study is voluntary, and I can refuse to be in the study, or stop at any time. If applicable, my research credits for my class will not be affected if I decide to decline from participating at any point**.

2) The procedures are as follows:
I will be asked to complete a packet of questionnaires that will take approximately 30 to 45 minutes. The questionnaires will be labeled with a participant number that will not, in any way, be linked with information that may identify me personally. Following completion of the questionnaires, I will be debriefed and will have completed my participation.

3) The discomforts or stresses that may be faced during this research are:
No discomforts or stresses are foreseen. However, I may experience temporary discomfort because I will be asked some personal questions. There is always the option of skipping any of these questions if I feel it is absolutely necessary. If I feel any discomfort as a result of participating in this study, I will either use the contact information provided below or contact the investigator for further consultation.

(1) Athens Rape Crisis Center: Phone: 706.353.1912
(2) University of Georgia Psychology Clinic: Phone: 706.542.1173
The clinic is located on the first floor of the psychology building.
(3) Project Supervisor: Karen S. Calhoun, Ph.D.
Department of Psychology
706.542.1173

4) Participation entails the following risks:
There are no anticipated risks in participating in this study.

5) The results of this participation will be confidential, and will not be released in any individually identifiable form without my prior consent, unless otherwise required by law.
All information obtained during this study is strictly confidential. Data may be reported in scientific journals, but will not include any information, which identifies me as a subject in this study. All of my data will be associated with a number and data will be recorded based on that number. There will be no list matching personal identification to participation numbers.

6) My signature below indicates that the researchers have answered all of my questions to my satisfaction and that I consent to volunteer for this study. I have been given a copy of this form.

_____ _____
Signature of Researcher Date Signature of Participant Date

Please sign both copies of this form. Keep one and return the other to the investigator.

Additional questions or problems regarding your rights as a research participant should be addressed to Chris A. Joseph, Ph.D. Human Subjects Office, University of Georgia, 606A Boyd Graduate Studies Research Center, Athens, Georgia 30602-7411; Telephone (706) 542-3199; E-Mail Address IRB@uga.edu

APPENDIX B

MEASURES

Demographics

Please take a few moments to answer the following questions:

1. Age: _____

2. Year in school: Freshman ___ Sophomore ___ Junior ___ Senior ___ Other ___

3. Race (please check one):

   White/Caucasian ___
   Black/African American ___
   Hispanic ___
   Asian/Pacific Islander ___
   Other ___

4. Relationship status (please check one that most applies):
   Married ___
   Committed Dating Relationship/Engaged ___
   Single ___

5. Are you a member of a sorority? Yes ___ No ___

6. Religious Affiliation:
   Catholic ___
   Episcopal ___
   Methodist ___
   Presbyterian ___
   Baptist ___
   Jewish ___
   Other (please specify) _____

SES

Please answer the following questions about your previous sexual experiences FROM AGE 14 TO THE PRESENT. Indicate age at which experience occurred in the space provided.

1. **Have you ever given in to sex play (fondling, kissing, or petting, but <u>not</u> intercourse) when you didn't want to because you were overwhelmed by a man's continual arguments and pressure?**

   A. No (go to question 3)
   B. Yes (answer question 2)

2. **About how many times has it happened?**
   1 2 3 4 5 or more

   At what age(s) _____

3. **Have you ever had sex play (fondling, kissing or petting, but <u>not</u> intercourse) when you didn't want to because a man used his authority (boss, teacher, camp counselor, supervisor) to make you?**

   A. No (go to question 5)
   B. Yes (answer question 4)

4. **About how many times has it happened?**
   1 2 3 4 5 or more

   At what age(s) _____

5. **Have you ever had sex play (fondling, kissing, petting, but <u>not</u> intercourse) when you didn't want to because a man threatened or used some degree of physical force (twisting your arm, holding you down, etc.) to make you?**

   A. No (go to question 7)
   B. Yes (answer question 6)

6. **About how many times has it happened?**
   1 2 3 4 5 or more

   At what age(s) _____

The following are questions about sexual intercourse. By sexual intercourse, we mean the penetration of the woman's vagina, no matter how slight, by a man's penis. Ejaculation is not required. When you see the words "sexual intercourse," please use this definition.

7. Have you had a man attempt sexual intercourse (get on top of you, attempt to insert his penis) when you didn't want by threatening or using some degree of force (twisting your arm, holding you down, etc.) but intercourse did <u>not</u> occur?

A. No (go to question 10)
B. Yes (answer questions 8 & 9)

8. About how many times has it happened?
1 2 3 4 5 or more

At what age(s) _____

9. What is the primary reason why intercourse did not occur? (if you had this experience more than once refer to the most significant time the experience occurred).

A. I did something to stop it from happening (e.g., screamed, yelled, fought, pushed, kicked, etc.)
B. I did not do anything to stop it from happening, but it did not occur for other reasons (e.g., the man stopped on his own, someone walked in, etc.)

10. Have you had a man attempt sexual intercourse (get on top of you, attempt to insert his penis) when you didn't want to by giving you alcohol or drugs to prevent you from resisting, but intercourse did <u>not</u> occur?

A. No (go to question 13)
B. Yes (answer questions 11 & 12)

11. About how many times has it happened?
1 2 3 4 5 or more

At what age(s) _____

12. What is the primary reason why intercourse did not occur? (if you had this experience more than once refer to the most significant time the experience occurred).

A. I did something to stop it from happening (e.g., screamed, yelled, fought, pushed, kicked, etc.)
B. I did not do anything to stop it from happening, but it did not occur for other reasons (e.g., the man stopped on his own, someone walked in, etc.)

13. Have you given in to sexual intercourse when you didn't want to because you were overwhelmed by a man's continual arguments and pressure?

A. No (go to question 15)
B. Yes (answer question 14)

14. About how many times has it happened?
1 2 3 4 5 or more

At what age(s) _____

15. Have you had sexual intercourse when you didn't want to because a man used his position of authority (boss, teacher, camp counselor, supervisor) to make you?

A. No (go to question 17)
B. Yes (answer question 16)

16. About how many times has it happened?
1 2 3 4 5 or more

At what age(s) _____

17. Have you had sexual intercourse when you didn't want to because a man gave you alcohol or drugs to prevent you from resisting?

A. No (go to question 19)
B. Yes (answer question 18)

18. About how many times has it happened?
1 2 3 4 5 or more

At what age(s) _____

19. Have you had sexual intercourse when you didn't want to because a man threatened or used some degree of physical force (twisting your arm, holding you down, etc.) to make you?

A. No (go to question 21)
B. Yes (answer question 20)

20. About how many times has it happened?
1 2 3 4 5 or more

At what age(s) _____

21. Have you had sexual acts (intercourse or penetration by objects other than the penis) when you didn't want to because a man threatened or used some degree of physical force (twisting your arm, holding you down, etc.) to make you?

A. No (go to question 23)
B. Yes (answer question 22)

22. About how many times has it happened?
1 2 3 4 5 or more

At what age(s) _____

For the following questions, refer to the highest number to which you answered "YES" in items 1-22. If you have had this experience with more than one person on different occasions, refer to the most significant time this occurred. If you did not answer "YES" to any of the items in questions 1-22, please respond "no experience" to the following questions.

---

23. What was your relationship to the man/men at that time?

A. Stranger
B. Non-romantic acquaintance (e.g., friend, neighbor, etc.)
C. Casual/first date or romantic acquaintance
D. Relative (father, stepfather, uncle, brother, etc.)
E. No experience

24. Was the man/men using any intoxicants on this occasion?

A. Alcohol
B. Drugs
C. Both
D. None
E. No experience

25. Were you using intoxicants on this occasion?

A. Alcohol
B. Drugs
C. Both
D. None
E. No experience

26. Did you discuss the experience with anyone?

A. Yes
B. No
C. No experience

27. Did you press charges?

A. Yes
B. No
C. No experience

28. How aggressive was the man?

A. Not at all or a little
B. Somewhat
C. Quite a bit
D. Very Much
E. No experience

29. How clear did you make it to the man/men that you didn't want sex?

A. Not at all or a little
B. Somewhat
C. Quite a bit
D. Very Much
E. No experience

30. How much do you feel responsible for what happened?

A. Not at all or a little
B. Somewhat
C. Quite a bit
D. Very Much
E. No experience

31. How much did you resist?

A. Not at all or a little
B. Somewhat
C. Quite a bit
D. Very Much
E. No experience

32. How responsible is he/are they for what happened?

A. Not at all or a little
B. Somewhat
C. Quite a bit
D. Very Much
E. No experience

33. Have you willingly had intercourse with the man/men involved in this experience since this happened?

A. Yes
B. No
C. No experience

34. At what age did the first experience you've reported occur? _____

SER

Directions: Please rate the following statements using the scale below. **Imagine that the following questions relate to a situation involving someone with whom you are acquainted, but are not in an intimate relationship with (e.g., a friend, an acquaintance, a first/second date).**

A. Not at all confident
B. Little confident
C. Moderately confident
D. Confident
E. Fairly Confident
F. Mostly Confident
G. Very Confident

____ 1. If an **acquaintance/first date** was attempting to get you to have sex with him and you were not interested, how confident are you that you could successfully resist his advances?

____ 2. If an **acquaintance/first date** was attempting to pay for your meal when you did not want him to, how confident are you that you could be assertive enough to tell him that you would pay your own way?

____ 3. If an **acquaintance/first date** was attempting to get you to consume alcohol despite your wishes not to do so, how confident are you that you could successfully resist his pressuring?

____ 4. How confident are you that you could successfully avoid a situation in which you could be sexually assaulted?

____ 5. If a situation develops in which you feel you could be in danger of sexual assault, how confident are you that you could successfully think up ways to get out of that situation and then execute your plan?

____ 6. How confident are you that you could successfully recognize the signs that you might be in danger of being sexually assaulted?

____ 7. How confident are you that if you recognized the danger signs of sexual assault you could avoid/prevent it from happening.

SER

Directions: Please rate the following statements using the scale below. **Imagine that the following questions relate to a situation involving someone with whom you are acquainted, but are not in an intimate relationship with (e.g., a friend, an acquaintance, a first/second date). ALSO IMAGINE THAT YOU HAVE BEEN DRINKING ALCOHOL.**

A. Not at all confident
B. Little confident
C. Moderately confident
D. Confident
E. Fairly Confident
F. Mostly Confident
G. Very Confident

____ 1. If an **acquaintance/first date** was attempting to get you to have sex with him and you were not interested, how confident are you that you could successfully resist his advances?

____ 2. If an **acquaintance/first date** was attempting to pay for your meal when you did not want him to, how confident are you that you could be assertive enough to tell him that you would pay your own way?

____ 3. If an **acquaintance/first date** was attempting to get you to consume alcohol despite your wishes not to do so, how confident are you that you could successfully resist his pressuring?

____ 4. How confident are you that you could successfully avoid a situation in which you could be sexually assaulted?

____ 5. If a situation develops in which you feel you could be in danger of sexual assault, how confident are you that you could successfully think up ways to get out of that situation and then execute your plan?

____ 6. How confident are you that you could successfully recognize the signs that you might be in danger of being sexually assaulted?

____ 7. How confident are you that if you recognized the danger signs of sexual assault you could avoid/prevent it from happening?

SER

Directions: Please rate the following statements using the scale below. **Imagine that the following questions relate to a situation involving a man with whom you are in a relationship (i.e., boyfriend, partner, fiancée, husband).**

A. Not at all confident

B. A little confident

C. Moderately confident

D. Confident
E. Fairly Confident
F. Mostly Confident
G. Very Confident

____ 1. If your **romantic partner** was attempting to get you to have sex with him and you were not interested, how confident are you that you could successfully resist his advances?

____ 2. If your **romantic partner** was attempting to pay for your meal when you did not want him to, how confident are you that you could be assertive enough to tell him that you would pay your own way?

____ 3. If your **romantic partner** was attempting to get you to consume alcohol despite your wishes not to do so, how confident are you that you could successfully resist his pressuring?

____ 4. How confident are you that you could successfully avoid a situation in which you could be sexually assaulted?

____ 5. If a situation develops in which you feel you could be in danger of sexual assault, how confident are you that you could successfully think up ways to get out of that situation and then execute your plan?

____ 6. How confident are you that you could successfully recognize the signs that you might be in danger of being sexually assaulted?

____ 7. How confident are you that if you recognized the danger signs of sexual assault you could avoid/prevent it from happening?

SER

Directions: Please rate the following statements using the scale below. **Imagine that the following questions relate to a situation involving a man with whom you are in a relationship (i.e., boyfriend, partner, fiancée, husband). ALSO IMAGINE THAT YOU HAVE BEEN DRINKING ALCOHOL.**

A. Not at all confident
B. A little confident
C. Moderately confident
D. Confident
E. Fairly Confident
F. Mostly Confident
G. Very Confident

____ 1. If your **romantic partner** was attempting to get you to have sex with him and you were not interested, how confident are you that you could successfully resist his advances?

____ 2. If your **romantic partner** was attempting to pay for your meal when you did not want him to, how confident are you that you could be assertive enough to tell him that you would pay your own way?

____ 3. If your **romantic partner** was attempting to get you to consume alcohol despite your wishes not to do so, how confident are you that you could successfully resist his pressuring?

____ 4. How confident are you that you could successfully avoid a situation in which you could be sexually assaulted?

____ 5. If a situation develops in which you feel you could be in danger of sexual assault, how confident are you that you could successfully think up ways to get out of that situation and then execute your plan?

____ 6. How confident are you that you could successfully recognize the signs that you might be in danger of being sexually assaulted?

____ 7. How confident are you that if you recognized the danger signs of sexual assault you could avoid/prevent it from happening?

SER

Directions: Please rate the following statements using the scale below. **Imagine that the following questions relate to a situation involving someone with whom you have no prior relationship (i.e., a stranger). PAY CAREFUL ATTENTION TO THE WORDS IN BOLD.**

A. Not at all confident
B. A little confident
C. Moderately confident
D. Confident
E. Fairly Confident
F. Mostly Confident
G. Very Confident

____ 1. If a **stranger** was attempting to get you to have sex with him and you were not interested, how confident are you that you could successfully resist his advances?

____ 2. If a **stranger** was attempting to pay for your meal when you did not want him to, how confident are you that you could be assertive enough to tell him that you would pay your own way?

____ 3. If a **stranger** was attempting to get you to consume alcohol despite your wishes not to do so, how confident are you that you could successfully resist his pressuring?

____ 4. How confident are you that you could successfully avoid a situation in which you could be sexually assaulted?

____ 5. If a situation develops in which you feel you could be in danger of sexual assault, how confident are you that you could successfully think up ways to get out of that situation and then execute your plan?

____ 6. How confident are you that you could successfully recognize the signs that you might be in danger of being sexually assaulted?

____ 7. How confident are you that if you recognized the danger signs of sexual assault you could avoid/prevent it from happening?

SER

Directions: Please rate the following statements using the scale below. **Imagine that the following questions relate to a situation involving someone with whom you have no prior relationship (i.e., a stranger). ALSO IMAGINE THAT YOU HAVE BEEN DRINKING ALCOHOL.**

A. Not at all confident
B. A little confident
C. Moderately confident
D. Confident
E. Fairly Confident
F. Mostly Confident
G. Very Confident

____ 1. If a **stranger** was attempting to get you to have sex with him and you were not interested, how confident are you that you could successfully resist his advances?

____ 2. If a **stranger** was attempting to pay for your meal when you did not want him to, how confident are you that you could be assertive enough to tell him that you would pay your own way?

____ 3. If a **stranger** was attempting to get you to consume alcohol despite your wishes not to do so, how confident are you that you could successfully resist his pressuring?

____ 4. How confident are you that you could successfully avoid a situation in which you could be sexually assaulted?

____ 5. If a situation develops in which you feel you could be in danger of sexual assault, how confident are you that you could successfully think up ways to get out of that situation and then execute your plan?

____ 6. How confident are you that you could successfully recognize the signs that you might be in danger of being sexually assaulted?

____ 7. How confident are you that if you recognized the danger signs of sexual assault you could avoid/prevent it from happening?

DHQ

INSTRUCTIONS: For each of the following questions, please state which alternative is most accurate for you. Select only one alternative per question please.

(NOTE: A "time" refers to a discrete drinking occasion in which you have 1-10 or more drinks. For example, 2 beers at lunch, 3 beers before supper, and a beer for a nightcap would be 3 "times" a day. Six beers during an evening would be one "time".)

1. I usually have wine or drinks contained wine (e.g., wine cooler):
    a. Three or more times a day
    b. Two times a day
    c. Once a day
    d. Nearly every day
    e. Three or four times a week
    f. Once or twice a week
    g. Two or three times a month
    h. About once a month
    i. Less than once a month, but at least once a year (DO NOT COMPLETE QUESTIONS 5-7)
    j. Less than once a year OR I never had wine or punch containing wine (DO NOT COMPLETE QUESTIONS 5-7)

2. I usually have beer:
    a. Three or more times a day
    b. Two times a day
    c. Once a day
    d. Nearly every day
    e. Three or four times a week
    f. Once or twice a week
    g. Two or three times a month
    h. About once a month
    i. Less than once a month, but at least once a year (DO NOT COMPLETE QUESTIONS 8-10)
    j. Less than once a year OR I never had wine or punch containing wine (DO NOT COMPLETE QUESTIONS 8-10)

3. I usually have whisky or liquor (such as martinis, manhattans, highballs, or straight drinks including scotch, bourbon, gin, vodka, rum, etc.)
    a. Three or more times a day
    b. Two times a day
    c. Once a day
    d. Nearly every day
    e. Three or four times a week
    f. Once or twice a week
    g. Two or three times a month

h. About once a month
i. Less than once a month, but at least once a year (DO NOT COMPLETE QUESTIONS 11-13)
j. Less than once a year OR I never had wine or punch containing wine (DO NOT COMPLETE QUESTIONS 11-13)

4. How often do you have any drink containing alcohol, whether it is wine, beer, whisky, or any other drink. (Make sure that your answer is not less frequent than the frequency reported on any of the preceding three questions).

a. Three or more times a day
b. Two times a day
c. Once a day
d. Nearly every day
e. Three or four times a week
f. Once or twice a week
g. Two or three times a month
h. About once a month
i. Less than once a month, but at least once a year (DO NOT COMPLETE THE REST OF THE SECTION)
k. Less than once a year OR I never had wine or punch containing wine (DO NOT COMPLETE THE REST OF THE SECTION)

5. Think about all the times you have had wine recently. When you drink wine, how often do you drink as many as five or six glasses?

a. Nearly every time (GO TO QUESTION 8)
b. More than half the time (GO TO QUESTION 8)
c. Less than half the time
d. Once in a while
e. Never

6. When you drink wine, how often do you have three or four glasses?

a. Nearly every time (GO TO QUESTION 8)
b. More than half the time (GO TO QUESTION 8)
c. Less than half the time
d. Once in a while
e. Never

7. When you drink wine, how often do you have one or two glasses?

a. Nearly every time
b. More than half the time
c. Less than half the time
d. Once in a while
e. Never

8. Think about all the times you have had beer recently. When you drink beer, how often do you drink as many as five or six glasses or cans?

a. Nearly every time (GO TO QUESTION 11)
b. More than half the time (GO TO QUESTION 11)
c. Less than half the time
d. Once in a while
e. Never

9. When you drink beer, how often do you have three or four glasses or cans?
    a. Nearly every time (GO TO QUESTION 11)
    b. More than half the time (GO TO QUESTION 11)
    c. Less than half the time
    d. Once in a while
    e. Never

10. When you drink beer, how often do you have one or two glasses or cans?
    a. Nearly every time
    b. More than half the time
    c. Less than half the time
    d. Once in a while
    e. Never

11. Think about all the times you have had a drink containing whisky or liquor recently. When you drink beer, how often do you drink as many as five or six drinks?
    a. Nearly every time (GO TO QUESTION 12-13)
    b. More than half the time (GO TO QUESTION 12-13)
    c. Less than half the time
    d. Once in a while
    e. Never

12. When you have drinks containing whisky or other liquor, how often do you have three or four drinks?
    a. Nearly every time (GO TO QUESTION 13)
    b. More than half the time (GO TO QUESTION 13)
    c. Less than half the time
    d. Once in a while
    e. Never

13. When you have drinks containing whisky or other liquor, how often do you have one or two drinks?
    a. Nearly every time
    b. More than half the time
    c. Less than half the time
    d. Once in a while
    e. Never

Child Experiences Questionnaire

Directions: Many people have sexual experiences as children, either with friends or with people older than themselves. The following questions refer to experiences you may have had <u>before the age of 14.</u>

Did you have any of these experiences <u>before age 14</u>?

1. Another person showed you his/her sex organs to you?
   a. Yes b. No

   IF YES:
   How old were you when this occurred? ____
   How old was the other person? _____
   What was this person's relationship to you?
   a. Stranger
   b. Acquaintance/friend
   c. Relative
   d. Father/stepfather

   How much force was used?
   a. No force
   b. Verbal threats
   c. Physical threats
   d. Weapon use or physical sequela

   How long did this experience last?
   a. Once
   b. Less than one month
   c. One month to one year
   d. More than one year

2. A request by someone older than you to do something sexual.
   a. Yes b. No

   IF YES:
   How old were you when this occurred? _____
   How old was the other person? _____
   What was this person's relationship to you?
   a. Stranger
   b. Acquaintance/friend
   b. Relative
   c. Father/stepfather

   How much force was used?
   a. No force
   b. Verbal threats
   c. Physical threats
   d. Weapon use or physical sequela

   How long did this experience last?
   a. Once
   b. Less than one month
   c. One month to one year
   d. More than one year

3. You showed your sex organs to another person at his/her request
   a. Yes b. No

   IF YES:
   How old were you when this occurred? ____

   How old was the other person? _____

   What was this person's relationship to you?
   a. Stranger
   b. Acquaintance/friend
   c. Relative
   d. Father/stepfather

   How much force was used?
   a. No force
   b. Verbal threats
   c. Physical threats
   d. Weapon use or physical sequela

   How long did this experience last?
   a. Once
   b. Less than one month
   c. One month to one year
   d. More than one year

4. Another person fondled you in a sexual way
   a. Yes b. No

   IF YES:
   How old were you when this occurred? _____

   How old was the other person? _____

   What was this person's relationship to you?
   a. Stranger
   b. Acquaintance/friend
   c. Relative
   d. Father/stepfather

   How much force was used?
   a. No force
   b. Verbal threats
   c. Physical threats
   d. Weapon use or physical sequela

   How long did this experience last?
   a. Once
   b. Less than one month
   c. One month to one year
   d. More than one year

5. Another person touched or stroked your sex organs
   a. Yes b. No

   IF YES:
   How old were you when this occurred? _____

   How old was the other person? _____

   What was this person's relationship to you?
   a. Stranger
   b. Acquaintance/friend
   c. Relative
   d. Father/stepfather

   How much force was used?
   a. No force
   b. Verbal threats
   c. Physical threats
   d. Weapon use or physical sequela

   How long did this experience last?
   a. Once
   b. Less than one month
   c. One month to one year
   d. More than one year

6. You touched or stroked another person's sex organs at his/her request
   a. Yes b. No

   IF YES:
   How old were you when this occurred? _____

   How old was the other person? _____

   What was this person's relationship to you?
   a. Stranger
   b. Acquaintance/friend
   c. Relative
   d. Father/stepfather

   How much force was used?
   a. No force
   b. Verbal threats
   c. Physical threats
   d. Weapon use or physical sequela

   How long did this experience last?
   a. Once
   b. Less than one month
   c. One month to one year
   d. More than one year

7. Attempted intercourse (got on top of you, attempted to insert penis, but penetration did not occur)
   a. Yes b. No

   IF YES:
   How old were you when this occurred? _____

   How old was the other person? _____

   What was this person's relationship to you?
   a. Stranger
   b. Acquaintance/friend
   c. Relative
   d. Father/stepfather

   How much force was used?
   a. No force
   b. Verbal threats
   c. Physical threats
   d. Weapon use or physical sequela

   How long did this experience last?
   a. Once
   b. Less than one month
   c. One month to one year
   d. More than one year

8. Intercourse (oral, anal, vaginal) with any amount of penetration (ejaculation not necessary)
   a. Yes b. No
   IF YES:
   How old were you when this occurred? _____

   How old was the other person? _____

   What was this person's relationship to you?
   a. Stranger
   b. Acquaintance/friend
   c. Relative
   d. Father/stepfather

   How much force was used?
   a. No force
   b. Verbal threats
   c. Physical threats
   d. Weapon use or physical sequela

   How long did this experience last?
   a. Once
   b. Less than one month
   c. One month to one year
   d. More than one year

IIP

INSTRUCTIONS: People have reported the following problems in relating to other people. Please read the list below, and for each item, consider whether it has been a problem for you with respect to <u>any</u> significant person in your life. Then fill in the numbered circle that describes how distressing that problem has been.

The following are things you find hard to do with other people.

It is hard for me to:	**Not at all**	**A little bit**	**Moderately**	**Quite a bit**	**Extremely**
1. Trust other people	0	1	2	3	4
2. Say “no” to other people	0	1	2	3	4
3. Join in on groups	0	1	2	3	4
4. Keep things private from other people	0	1	2	3	4
5. Let other people know what I want	0	1	2	3	4
6. Tell a person to stop bothering you	0	1	2	3	4
7. Introduce myself to new people	0	1	2	3	4
8. Confront people with problems that come up	0	1	2	3	4
9. Be assertive with another person	0	1	2	3	4
10. Let other people know when I am angry	0	1	2	3	4
11. Make a long-term commitment to another person.	0	1	2	3	4
12. Be another person’s boss	0	1	2	3	4
13. Be aggressive toward other people when the situation calls for it.	0	1	2	3	4
14. Socialize with other people.	0	1	2	3	4
15. Show affection to people.	0	1	2	3	4
16. Get along with people.	0	1	2	3	4
17. Understand another person’s point of view.	0	1	2	3	4
18. Express my feelings to other people directly.	0	1	2	3	4

	Not at all	A little bit	Moderately	Quite a bit	Extremely
19. Be firm when I need to be	0	1	2	3	4
20. Experience a feeling of love for another person.	0	1	2	3	4
21. Set limits on other people.	0	1	2	3	4
22. Be supportive of another person's goals in life.	0	1	2	3	4
23. Feel close to other people.	0	1	2	3	4
24. Really care about other people's problems	0	1	2	3	4
25. Argue with another person	0	1	2	3	4
26. Spend time alone.	0	1	2	3	4
27. Give a gift to another person.	0	1	2	3	4
28. Let myself feel angry at somebody I like	0	1	2	3	4
29. Put somebody else's needs before my own	0	1	2	3	4
30. Stay out of other people's business	0	1	2	3	4
31. Take instructions from people who have authority over me.	0	1	2	3	4
32. Feel good about another person's happiness	0	1	2	3	4
33. Ask other people to get together socially with me.	0	1	2	3	4
34. Feel angry at other people.	0	1	2	3	4
35. Open up and tell my feelings to another person.	0	1	2	3	4
36. Forgive another person after I've been angry	0	1	2	3	4
37. Attend to my own welfare when somebody else is needy.	0	1	2	3	4

	Not at all	A little bit	Moderately	Quite a bit	Extremely
38. Be assertive without worrying about hurting the other person's feelings	0	1	2	3	4
39. Be self-confident when I am with other people	0	1	2	3	4

The following are things that you do too much.

	Not at all	A little bit	Moderately	Quite a bit	Extremely
40. I fight with other people too much.	0	1	2	3	4
41. I feel too responsible for solving other people's problems.	0	1	2	3	4
42. I am too easily persuaded by other people.	0	1	2	3	4
43. I open up to people too much.	0	1	2	3	4
44. I am too independent.	0	1	2	3	4
45. I am too aggressive toward other people.	0	1	2	3	4
46. I try to please other people too much.	0	1	2	3	4
47. I clown around too much.	0	1	2	3	4
48. I want to be noticed too much.	0	1	2	3	4
49. I trust other people too much.	0	1	2	3	4
50. I try to control other people too much.	0	1	2	3	4
51. I put other people's needs before my own too much.	0	1	2	3	4
52. I try to change other people too much.	0	1	2	3	4
53. I am too gullible.	0	1	2	3	4
54. I am overly generous to other people.	0	1	2	3	4
55. I am too afraid of other people.	0	1	2	3	4
56. I am too suspicious of other people.	0	1	2	3	4

57. I manipulate other people too much to get what I want.	0	1	2	3	4
	Not at all	**A little bit**	**Moderately**	**Quite a bit**	**Extremely**
58. I tell personal things to other people too much	0	1	2	3	4
59. I argue with other people too much.	0	1	2	3	4
60. I keep other people at a distance too much.	0	1	2	3	4
61. I let other people take advantage of me too much.	0	1	2	3	4
62. I feel embarrassed in front of other people too much.	0	1	2	3	4
63. I am affected by another person's misery too much.	0	1	2	3	4
64. I want to get revenge against people too much.	0	1	2	3	4

RKQ

Please indicate whether you believe the following statements are true or false. Circle the response that you feel is most appropriate.

1. Heavy alcohol use is associated with acquaintance rape.

   TRUE FALSE

2. One of every four college women are victims of rape or attempted rape.

   TRUE FALSE

3. Women are more likely to be assaulted by a stranger than by someone they know.

   TRUE FALSE

4. Trying to talk the man out of it is a good strategy for resisting acquaintance rape.

   TRUE FALSE

5. You can tell that a man is a rapist the first time you meet him.

   TRUE FALSE

6. If a woman does not actively resist, then it is not rape.

   TRUE FALSE

7. As long as a guy's friends think he is okay, he is safe.

   TRUE FALSE

8. It is unhealthy for a man not to have sex once he gets turned on.

   TRUE FALSE

9. If you get bad vibes on a date, you're just being paranoid.

   TRUE FALSE

10. Women who dress "suggestively" are at a greater risk for rape than women who dress conservatively.

    TRUE FALSE

11. If you are attacked by your date, it is safer to just go along with it.

    TRUE FALSE

12. Women who "sleep around" are more likely to be raped.

    TRUE FALSE

13. Women always know when they have been raped.

    TRUE FALSE

14. The man paying all expenses on a date is associated with date rape.

    TRUE FALSE

15. Rapes are likely to occur in isolated places.

    TRUE FALSE

16. When a man is very possessive, it shows how much he cares about his girlfriend.

    TRUE FALSE

17. Liberal men are more likely to be rapists than traditional, conservative men.

    TRUE FALSE

18. It is not considered rape if a woman is unconscious.

    TRUE FALSE

19. Men tend to think that a woman wants sex if she has been drinking.

    TRUE FALSE

20. A woman can be assaulted or raped by her husband.

    TRUE FALSE

APPENDIX C

DEBRIEFING FORM

Coercive sexual behavior in dating relationships among college students is a serious problem. A national survey of college students indicated that 54 percent of college women report having experienced some form of sexual victimization. Additionally, an estimated 15 percent of women reported experiences that meet the legal definition of rape (Koss, Gidycz, & Wisniewski, 1987).

Research has found that the effects of rape experiences may include long-term increases in general levels of anxiety, levels of dissociation, and an increased use of avoidance coping strategies. Some of these reactions may contribute to adjustment problems within the contexts of many areas of the victim's life, as well as an increased risk for revictimization. Additionally, research suggests that women who report lower levels of sexual self-efficacy may be at greater risk for victimization. However, no research to date has considered the possible impact that contextual variables may have on assessments of self-efficacy.

As a result of the high numbers of women who experience unwanted sexual experiences, researchers have tried to develop programs for preventing such experiences. Past results show that these programs are effective for some women, but not for others. Further research is needed to more clearly delineate the variance in self-efficacy levels when victim-offender relationship and alcohol use are considered.

The purpose of this project is to examine the impact of sexual victimization on levels of self-efficacy in varying contexts. Specifically, this study hopes to learn more about the role of victim-offender relationship and alcohol use in the assessment of women's sexual self-efficacy. The results of this study will provide more detailed information to aid in the development of future prevention/intervention programs.

If you feel any discomfort or concern, you are encouraged to contact the following resources:

1) Athens Rape Crisis Center: Phone: 706.353.1912
2) University of Georgia Psychology Clinic: Phone: 706.542.1173
   The clinic is located on the first floor of the psychology building.
3) Project Supervisor: Karen S. Calhoun, Ph.D.
   Department of Psychology
   706.542.1173