2017

The Effects of Rape Myth Acceptance, Benevolent Sexism, Characterological Self-Blame, and Behavioral Self-blame on Posttraumatic Stress Disorder Symptom Severity

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THE EFFECTS OF RAPE MYTH ACCEPTANCE, BENEVOLENT SEXISM, CHARACTEROLOGICAL SELF-BLAME, AND BEHAVIORAL SELF-BLAME ON POSTTRAUMATIC STRESS DISORDER SYMPTOM SEVERITY

A thesis submitted to
the Graduate College of
Marshall University
In partial fulfillment of
the requirements for the degree of
Master of Arts
In
Psychology
by
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Approved by
Dr. Brittany Canady, Committee Chairperson
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Marshall University
August 2017

APPROVAL OF THESIS

We, the faculty supervising the work of Jacob Whitaker Camp, affirm that the thesis, *The Effects of Rape Myth Acceptance, Benevolent Sexism, Characterological Self-Blame, and Behavioral Self-Blame on Posttraumatic Stress Disorder Symptom Severity*, meets the high academic standards for original scholarship and creative work established by the General Masters in Psychology program and Marshall University. This work also conforms to the editorial standards of our discipline and the Graduate College of Marshall University. With our signatures, we approve the manuscript for publication.

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ABSTRACT

Roughly 35 to 50 percent of victims of sexual assault begin to suffer from posttraumatic stress disorder (PTSD) relatively early after the assault (Elklit, Due, & Christiansen, 2009). Many victims of sexual assault who are diagnosed with PTSD continue to experience symptoms long after the incident occurred (Peter-Hagene & Ullman, 2015). Rape has serious effects on the psychological health of the victims. Although no study had been done directly examining the relationship between rape myth acceptance and PTSD symptom severity, studies have shown that benevolent sexism affects rape myth acceptance and that rape myth acceptance affects how individuals attribute blame (Baugher, Elhai, Monroe, & Gray, 2010). The present research examined the effects of benevolent sexism, rape myth acceptance, and self-blame on PTSD symptom severity among women who have experienced sexual assault. Participants included 120 women who had experienced sexual assault who were recruited online through Amazon Mechanical Turk (MTurk). Participants completed measures through online survey software assessing benevolent sexist beliefs, rape myth acceptance, self-blame, and PTSD symptom severity. Findings suggest that benevolent sexism and self-blame predict the severity of PTSD symptoms, whereas rape myth acceptance does not. These findings are consistent with prior research and suggest avenues for further research and clinical intervention.

CHAPTER 1

THE EFFECTS OF RAPE MYTH ACCEPTANCE, BENEVOLENT SEXISM, CHARACTEROLOGICAL SELF-BLAME, AND BEHAVIORAL SELF-BLAME ON POSTTRAUMATIC STRESS DISORDER SYMPTOM SEVERITY

Many women are victims of sexual assault, and as a result they experience symptoms of posttraumatic stress disorder (PTSD; Campbell, Greeson, Bybee, & Raja, 2008; Elklit, Due, & Christiansen, 2009). This study seeks to examine several factors that may affect PTSD symptom severity. These factors include benevolent sexism, rape myth acceptance, and self-blame. Knowing how these factors affect symptom severity could enable clinicians to better identify and treat PTSD in sexual assault victims.

Sexual Assault

Sexual assault has taken many different forms including childhood sexual abuse, intimate partner violence (also known as domestic violence), and adult sexual assault. All of these can have negative and long-lasting effects on the victims. In their lifetime, fifty percent of women will experience at least one form of sexual assault (Campbell et al., 2008). Sexual assaults that employ the use of violence are the most traumatizing (Artime & Peterson, 2015). Rape is defined as nonconsensual sex obtained through intoxication, physical threat, or force (Artime & Peterson, 2015). Rape is traumatic because victims lose control over their bodies, which can lead to feelings of vulnerability, a loss of self-efficacy, and lower perceived control over their own recovery (Ullman & Peter-Hagene, 2014). Additionally, victims' cognitions regarding trust, intimacy, power, self-esteem, and the amount that they blame themselves for the assault further enhance the effects of the trauma (Artime & Peterson, 2015). Most rapes are perpetrated by someone known to the victim before the act (Artime & Peterson, 2015). Fifty percent of rape

victims suffer from PTSD, and for many it will be a chronic condition for most of their lives (Elklit et al., 2009).

Many factors are recognized to influence a victim's response to sexual assault, including social support, coping strategies, beliefs about sexual assault, and sexist beliefs. For example, rape victims are in need of a strong support system such as family, friends, community services, teachers, and others due to limited availability of resources for victims of rape (Elklit et al., 2009; Ullman & Peter-Hagene, 2014). Victims disclose their assault to at least one person, usually someone close to them, ninety-two percent of the time (Ullman & Peter-Hagene, 2014). Social reactions to this disclosure are important to the victim's recovery outcomes. Negative social reactions to disclosure are positively related to PTSD symptoms (Ullman & Peter-Hagene, 2014). Additionally, the coping strategies utilized may influence development of PTSD symptoms. Maladaptive coping strategies such as denial or substance use protect victims only temporarily at the cost of their long-term recovery (Ullman & Peter-Hagene, 2014). To keep maladaptive coping strategies from forming, victims need to be in control of their own recovery (Ullman & Peter-Hagene, 2014). However, cognitive factors such as the extent to which an individual holds benevolent sexist beliefs and beliefs about sexual assault may influence this process and have not been thoroughly explored.

Benevolent Sexism

Beliefs consistent with benevolent sexism may influence a victim's response to sexual assault. Sexism is a form of prejudice characterized by a deep dislike stemming from inflexible and inaccurate generalizations about women (Glick & Fiske, 1996). Benevolent sexism refers to stereotyping and role casting of women that is usually positive and pro-social and can present itself as helping or attention seeking (Glick & Fiske, 1996). Hostile sexism refers to hostility

towards women (Glick & Fiske, 1996). Ambivalent sexism is the combination of both hostile and benevolent sexism (Glick & Fiske, 1996). Although not overtly negative, benevolent sexism is still detrimental (Glick & Fiske, 1996).

Benevolent sexism has been found to positively correlate with patronizing behavior (i.e., when individuals treats others in a manner that suggests that they are superior to them; Dardenne, Dumont, & Bollier, 2007). Patronizing is a form of paternalist-based sexism that, similar to benevolent sexism, has positive and negative aspects (Dardenne et al., 2007). On the positive end of paternalistic sexism, women receive praise for acting in manners that are consistent with traditional gender roles. However, on the negative end, women are often assigned to devalued positions in society to suggest that they are incompetent (Dardenne et al., 2007). This aspect of patronizing behavior is similar to benevolent sexism in that benevolent sexism praises women who demonstrate characteristics that support the idea that they are dependent on men (Dardenne et al., 2007). Benevolent sexism is different in that it is generally implicit and typically not noticed by the actor or target (Dardenne et al., 2007).

The combination between hostile and benevolent sexism is achieved by separating women into the categories of good and bad. Separating women into categories can be the first step in justifying aggressive behaviors toward them (Viki, Abrams, & Masser, 2004). If a woman conforms to traditional gender roles, she may experience benevolent sexism, whereas women who do not conform may be met with hostile sexism (Viki et al., 2004). In the context of benevolent sexist beliefs, women are stereotyped as the protectors of sexuality and are saddled with most of the responsibility for sexual morality, which contributes to greater examination of women's motives and behavior than that of the perpetrators of sexual assaults (Viki et al., 2004). Due to this stereotype, society expects women to prevent sexual assault and to resist it should it

occur. Women are more often accused of lying regarding sexual assault versus other crimes (Sigurvinsdottir & Ullman, 2015).

Benevolent sexism has been found to have a negative impact on women's cognitive performance by reducing the strength of their working memory (Dardenne et al., 2007). Specifically, Dardenne conducted four experiments that examined the competing effects of benevolent and hostile sexism on cognitive performance. Participants included undergraduate women and women with a high school diploma or lower under the age of 42 (Dardenne et al., 2007). Job recruiters were confederates who interviewed the participants (Dardenne et al, 2007). Job recruiters either displayed behaviors consistent with benevolent sexism, hostile sexism, or neither (Dardenne et al., 2007). These behaviors were expressed versions of attitudes measured by the Ambivalent Sexism Inventory (ASI; Dardenne et al., 2007). The ASI measures an individual's level of benevolent and hostile sexism by asking the participant to agree or disagree on a Likert scale with a statement regarding the sexes and women's roles. A hiring decision test containing nine questions was administered to test their cognitive functioning through measuring their working memory (Dardenne et al., 2007). When asked about how they felt about the test, job, or recruiter behavior, participants typically did not identify them as sexist (Dardenne et al., 2007). These studies also found that benevolent sexism can lead to anxiety and a mindset of self-doubt and lower self-esteem (Dardenne et al., 2007). Hostile sexism was found to be more likely to facilitate external attribution of negative events (Dardenne et al., 2007). Thus, benevolent sexism was more likely to lead to higher levels of self-blame than hostile sexism because hostile sexism allows the woman to more easily identify the openly prejudiced offender as the one to blame.

Other factors can affect whether women hold beliefs consistent with benevolent sexism. One such factor is the woman's perception of the level of benevolent sexist beliefs held by her partner (Hammond, Overall, & Cross, 2016). In a series of studies, the ASI was used to examine participants' (i.e., women aged 17 to 48 from 91 couples in long-term relationships) own sexist beliefs, those of their partner, and what the participants perceived to be the beliefs of most men (Hammond et al., 2016). The results consistently suggested that if a woman believed her partner held beliefs consistent with benevolent sexism, then her beliefs would similarly be higher and more stable across time. Furthermore, if a woman perceived her partner to hold lower levels of benevolent sexism then she was likely to experience a decline in her benevolent sexist beliefs over time. The results of this study demonstrate that the beliefs of people close to an individual can have a large impact on their own beliefs and even safeguard them against beliefs that have been shown to have negative effects on post-trauma symptoms and recovery.

Several factors come into play when considering how sexist beliefs affect victims in legal, societal, and psychological areas. One study found that participants, both women and men, who scored high in benevolent sexism blamed the rape perpetrator less in an acquaintance rape scenario (Viki et al., 2004). However, benevolent sexism scores had no relation to how they reacted to perpetrators who were total strangers. The finding that benevolent sexism affects where a person assigns blame in rape scenarios suggests that a woman's attitude towards rape and the likelihood that she will blame herself for the event may be influenced by sexist beliefs.

Rape Myth Acceptance

Another factor that has a potential effect on the victim's response to sexual assault and the severity of trauma-related psychological symptoms is their belief in rape myths. Rape myths are false beliefs regarding aspects of rape and are based on prejudices and stereotypes (Burt &

Albin, 1981). Individuals acquire rape myths through the media as well as from peers (Baugher, Elhai, Monroe, & Gray, 2010). By accepting rape myths, individuals assign blame to the victim (Baugher et al., 2010). Rape myths have also been shown to have a big impact on how people respond to rape victims (Viki et al., 2004).

Rape myth acceptance has been found to influence how much blame or liability individuals place on a perpetrator based on their physical stereotypes (Busching & Lutz, 2016). A study that pitted stereotypical representations of a rapist, thief, and lifesaver against each other in terms of liability in different rape scenarios and measured the participants' levels of rape myth acceptance found that higher levels of rape myth acceptance affected how individuals assessed a perpetrator's level of liability (Busching & Lutz, 2016). Participants judged a person's level of liability less accurately and made them more susceptible to stereotypes when they had higher levels of rape myth acceptance. Those that had what they defined as a stereotypical lifesaver face were rated by participants as being less liable than someone with a stereotypical thief or rapist face in rape scenarios (Busching & Lutz, 2016). Rape myth acceptance has been shown to influence an individual's ability to assess liability without severe interference of stereotypes.

Rape myth acceptance as well as victimization history had an effect on how well individuals judge risk (Yeater, Treat, Viken, & McFall, 2010). A more severe history of victimization was found to predict an individuals' use of a higher risk threshold meaning they need more risky information to be present to judge situations as risky (Yeater et al., 2010). More severe victimization history also led to a lower sensitivity to risk. Furthermore, greater rape myth acceptance was found to predict a lower sensitivity to risk related information (Yeater et al., 2010). These factors might lead victims to be at a higher rate of revictimization based on their impaired ability to assess risk and their lowered sensitivity to risk information.

Several factors have been found to affect belief in rape myths. Studies using the ASI have found that people with negative attitudes towards women and people who have strong beliefs consistent with rape myths often blame the victim (Baugher et al., 2010). These findings regarding the effects of negative attitudes towards women and belief in rape myths on victim blame suggest that hostile and benevolent sexist beliefs do influence rape myth acceptance. Other belief systems have also been found to affect people's views of rape and, in turn, rape myths. Individuals who support racism, classism, homophobia, religious intolerance, and ageism are more likely to believe in rape myths (Baugher et al., 2010). In contrast, people who support parental and marital roles that are egalitarian coupled with a negative attitude towards violence against women tend to show intolerance for rape (Baugher et al., 2010). The sexual trauma itself can also affect rape myth acceptance by either supporting or denying rape myths for the victim (Baugher et al., 2010).

A study examining whether attitudes towards women, sexual trauma history, gender role identity, and PTSD symptom severity were associated with rape myth acceptance was conducted. The study found that both attitudes towards women and sexual trauma history were linked to rape myth acceptance (Baugher et al., 2010). Gender role identity and PTSD symptom severity were not associated with rape myth acceptance, which may have been due to the limited number of participants with PTSD (Baugher et al., 2010). Baugher and colleagues examined 258 women and men college students using the Illinois Rape Myth Acceptance Scale (IRMA), ASI, and PCL-4 to examine participants' attitudes towards women, rape myth acceptance, and PTSD symptom severity (Baugher et al., 2010). No studies have been found that specifically examine the relationship between PTSD symptom severity and belief in rape myths. Understanding rape myth acceptance is important, because if clinicians who work with victims of rape know how the

belief in rape myths affects survivors, then they may be able to provide more effective treatment to the victim (Baugher et al., 2010).

Rape myth acceptance has been found to be influenced by a variety of factors. Research suggests that sexist beliefs lead to an increased belief in rape myths, and that those who believe in rape myths tend to blame the victim (Baugher et al., 2010). Also, the sexual trauma itself affects belief in rape myths by confirming or denying myths that relate to their trauma (Baugher et al., 2010). It is therefore possible that different sexual assault situations have different effects on the victim, and that the trauma, by increasing belief in rape myths, could directly affect how much blame victims attribute to themselves.

Self-Blame

Self-blame is related to the loss of control that occurs during the assault and the internal responsibility felt by the victim (Sigurvinsdottir & Ullman, 2015). Self-blame is common after sexual assault, so much so that it is much more common after sexual assault than any other crime (Sigurvinsdottir & Ullman, 2015). Most victims engage in some form of self-blame (Frazier, 1990). Self-blame has two subsets: behavioral self-blame and characterological self-blame (Sigurvinsdottir & Ullman, 2015). Behavioral self-blame refers to the victims' belief that their behavior led to the assault or that they could have done something different to avoid it (Sigurvinsdottir & Ullman, 2015). Behavioral self-blame has been found to predict feelings of being able to avoid past traumas (Frazier, 1990). Both self-blame and maladaptive beliefs have been found to lead to higher levels of psychological distress (Koss, Figueredo, & Prince, 2002). Characterological self-blame is when the victim feels that there is something inherently wrong with them, that they have a character flaw that caused the assault (Sigurvinsdottir & Ullman, 2015). Both behavioral self-blame and characterological self-blame have been found to be

associated with depression following rape (Frazier, 1990). Characterological self-blame has stronger negative effects than behavioral self-blame, but both lead to poorer post-trauma adjustment (Sigurvinsdottir & Ullman, 2015). However, most victims will attribute the majority of the blame to external factors even though they place some on themselves (Frazier, 1990). Self-blame also leads to an increased risk for re-victimization (Sigurvinsdottir & Ullman, 2015). Several factors can lead to increased self-blame. Some self-blame originates from victims' beliefs that they are being blamed by society for their assault (Baugher et al., 2010). Personal characteristics such as exposure to violence and characteristics of the rape were found to influence the strength of self-blame and individuals' maladaptive beliefs about themselves and others (Koss et al., 2002). Negative social reactions to the victim's assault disclosure lead to greater victim self-blame (Ullman & Peter-Hagene, 2014). Just as negative social reactions have an effect, so do positive reactions (Ullman & Peter-Hagene, 2014). Positive reactions, although they don't prevent PTSD symptoms from forming or entirely negate self-blame, can mitigate the amount and severity of symptoms as well as lower the level of self-blame (Ullman & Peter-Hagene, 2014). However, studies have shown that victims give more weight to negative social reactions than positive ones (Sigurvinsdottir & Ullman, 2015). Characterological self-blame has been shown to mediate the relation between negative social reactions and PTSD symptoms, such that individuals with higher levels of characterological self-blame experience more PTSD symptomatology in response to negative social interactions (Sigurvinsdottir & Ullman, 2015). Characterological self-blame should be targeted during treatment because it appears to be a mechanism through which social reactions can influence recovery.

PTSD Symptom Severity

Roughly 35 to 50 percent of victims of sexual assault begin to experience symptoms of PTSD relatively early after the assault (Elklit et al., 2009). A majority of victims of sexual assault who are diagnosed with PTSD continue to have symptoms long after the incident occurred (Peter-Hagene & Ullman, 2015). Many factors can affect the severity of the PTSD symptoms in cases of sexual assault. These factors include self-blame, holding beliefs consistent with benevolent sexism, and rape myth acceptance. For example, research suggests that self-blame and negative social reactions lead to increased PTSD symptom severity (Peter-Hagene & Ullman, 2015). Assaults that followed the consumption of alcohol increased symptom severity by having an effect on whether social reactions were negative or positive. More negative social reactions from those to whom the victim discloses the assault to as well as increased victim self-blame lead to more severe symptoms (Peter-Hagene & Ullman, 2015). By increasing self-blame, benevolent sexism has been shown to have a positive correlation with the severity of PTSD symptoms; the more individuals hold beliefs consistent with benevolent sexism, the worse their symptoms have been found to be (Viki et al., 2004). Although research has not directly examined the relationship between rape myth acceptance and PTSD symptom severity, studies have investigated how benevolent sexism affects rape myth acceptance and how rape myth acceptance impacts where individuals attribute blame (Baugher et al., 2010).

Other factors that have been found to impact the severity of PTSD symptoms following rape are sociodemographic factors such as race and marital status, the characteristics of the rape itself, and the levels of social support (Mgoqi-Mbalo, Zhang, & Ntuli, 2017). For example, research suggests that unmarried individuals hold an increased risk for developing post-rape PTSD and depression (Mgoqi-Mbalo et al., 2017). Specifically, unmarried women were six times

more likely to develop PTSD than married women. Unmarried women's higher odds of developing PTSD are likely due to the lower levels of partner support in unmarried women. Unemployment was also found to be a characteristic that increased the likelihood of developing PTSD (Mgoqi-Mbaloet al., 2017). Another characteristic that increased the risk of PTSD was revictimization. If the assault involved a weapon or any violence the likelihood of PTSD developing was increased (Mgoqi-Mbalo et al., 2017). Many factors have been shown to impact the risk of PTSD developing following rape. By uncovering the effects of these factors and by finding others we can better equip ourselves to help those suffering from PTSD.

Hypotheses

Benevolent sexism has been shown to have a positive correlation with the severity of PTSD symptoms, inasmuch as individuals holding beliefs consistent with benevolent sexism are more likely to have more severe PTSD symptoms (Glick & Fiske, 1996). Benevolent sexist beliefs have also been shown to lead to an increased belief in rape myths and victim self-blame (Baugher et al., 2010). Rape myth acceptance in and of itself has been shown to also increase victim self-blame and outsider blame on the victim (Baugher et al., 2010). All three of these factors are connected and all have an effect on the severity of PTSD symptoms.

Rape has serious effects on the psychological health of the victims. This study will explore the hypotheses that:

1. Higher scores of benevolent sexism will predict more severe PTSD symptoms.
2. Higher scores of behavioral self-blame will predict more severe PTSD symptoms.
3. Higher scores of characterological self-blame will predict more severe PTSD symptoms.
4. A higher belief in rape myths will predict worse PTSD symptoms

5. Benevolent sexism, behavioral self-blame, characterological self-blame, and rape myths will interact to predict worse PTSD symptoms.

Several of these hypotheses have been evaluated previously, and data have supported the idea that these factors are inter-connected. However, a study examining the effect of belief in rape myths on the severity of PTSD symptoms has yet to be conducted.

METHOD

Participants

A sample of 120 females were recruited online via Amazon Mechanical Turk (MTurk). MTurk is an online service that links "workers" (i.e., participants) to studies in which they can participate in exchange for a small fee. Inclusion criteria required participants to have experienced at least one sexual assault and be a woman over the age of 18 at the time of participation. Females who were actively receiving treatment for PTSD were excluded from participating.

Measures

Benevolent sexism. The ASI (Glick & Fiske, 1996) includes 22 statements regarding men, women, and their relationships, which participants rate on a Likert-type scale ranging from 0 (*disagree strongly)* to 5 (*agree strongly).* The ASI has two subscales: hostile and benevolent sexism, each with 11 items. For the purposes of this study, only the benevolent sexism subscale was used. This study examined only benevolent sexism because benevolent sexism refers to the stereotyping and role casting of women and is hypothesized to cause more severe PTSD symptoms, more so than hostile sexism. The ASI has demonstrated good reliability ($\alpha = .85$) and validity (Glick & Fiske, 1996). Reliability was measured for this specific sample (see Table 1).

Rape myth acceptance. Rape myth acceptance was assessed using the 22-item updated Illinois Rape Myth Acceptance Scale (IRMA; Payne, Lonsway, & Fitzgerald, 1999; McMahon & Farmer, 2011). Participants rated their belief in rape myths (e.g., "If both people are drunk, it can't be rape") on a Likert-type scale of 1 (*strongly agree)* to 5 (*strongly disagree).* The IRMA includes four subscales, including "she asked for it," "he didn't mean to," "it wasn't really rape," and "she lied." Scores were summed for a cumulative score; lower scores indicated greater acceptance of rape myths. The IRMA scale has been shown to have good internal consistency (α = .93), divergent validity, and convergent validity (Payne, Lonsway, & Fitzgerald, 1999). Reliability was measured for this specific sample (see Table 1).

Self-Blame. Self-Blame was assessed using The Rape Attribution Questionnaire (RAQ), a 25-item self-report scale that measures the victims' beliefs about what led to the assault (Frazier, 2003). Participants rate how often they have thought the particular item about the cause of their assault from 1 *(never)* to 5 *(very often*; Frazier, 2003). It measures five types of attributions for the assault including: behavioral and characterological self-blame, blaming the perpetrator, society, and chance (Frazier, 2003). For the purposes of this study, only the subscales for behavioral self-blame and characterological self-blame were used. The other three were not used because this study sought to examine the effects of self-blame on PTSD symptom severity and the other three subscales evaluate the victim attributing the assault to external factors. The RAQ has good internal consistency (α = .87) and a test-retest reliability coefficient ranging from r = .64 to 79 (Frazier, 2003). Reliability was measured for this specific sample (see Table 1).

PTSD symptom severity. Symptoms of PTSD were measured using the PTSD Checklist for the DSM-5 (PCL-5), a 20-item self-report scale (Weathers et al., 2013). Participants rate their

symptoms on a Likert-type scale of 0 (*not at all)* to 4 (*extremely)* based on how much they have been bothered by that symptom in the past month. The PCL-5 is comprised of PTSD symptoms from the Diagnostic and Statistical Manual of Mental Disorders (DSM-5; American Psychiatric Association, 2013) and holds strong test-retest reliability (r = .82), internal consistency (α = .94), convergent validity (r = .74 to .85), and discriminant validity (r = .31 to .60; Blevins, Weathers, Davis, Witte, & Domino, 2015). Reliability was measured for this specific sample (see Table 1).

Procedure

The present research was approved by the Marshall University Institutional Review Board (Project number: 998566-1; see Appendix A). Potential participants were recruited online through MTurk. Given that Amazon is an international corporation, MTurk provides rapid access to potentially large samples. A link to the survey (administered through http://www.Qualtrics.com) was provided for those interested in participating. Participants consented to take part in this study prior to answering any questions. Participants completed demographic information, including questions regarding their gender, sexual trauma history, whether they have received treatment, and age, then answered the four questionnaires. Upon completion of the study, participants received a completion code to enter into the MTurk website to receive payment for participation ($0.10). At the end of the surveys, information to access counseling services was provided and the participants were fully debriefed.

RESULTS

Participants

A total of 479 participants responded to the present study on MTurk. Of these participants, 236 were excluded because they were male, 45 women were excluded because they had not experienced a sexual assault, and 53 women were excluded because they were currently

undergoing treatment, which could impact the dependent variable. The final sample included 120 participants. The average age within this sample was *M*= 29.47 (*SD* = 8) years. Of the 120 participants 44% were White, 6% were Black or African American, 4% were American Indian or Alaska native, 40% were Asian, 6% were other; two participants identified as more than one of the above categories. Participants were generally well educated; 1.69% of participants had less than a high school diploma, 7.5% were high school graduates, 19.16% had some college but no degree, 5.83% held an associate's degree, 49.16% held a bachelor's degree, 15% held master's degrees, and 1.66% held a doctoral degree. Half of participants (50%) were married, 5% were widowed, 5% were divorced, 5% were separated, and 35% were never married.

PTSD Symptom Severity

A score of 55 or greater on the PCL-5 is generally considered consistent with a diagnosis of PTSD. In the current sample, 64.2% of the participants in this study scored above the cut-off score. The average score was 60.47 with a standard deviation of 19. Almost two-thirds of the sample held PCL-5 scores consistent with PTSD. The national rate of PTSD in sexual assault victims is 35-50% (Elklit et al., 2009), therefore the current sample had higher rates of PTSD than expected. For the means, standard deviations, and ranges of the current sample for each measure see Table 1.

Associations between Self-Blame, Benevolent Sexism, Rape Myths, and PTSD

PTSD symptom severity was positively correlated with benevolent sexism, behavioral self-blame, and characterological self-blame (see Table 2). However, PTSD symptom severity was not correlated with rape myth acceptance. Benevolent sexism, characterological self-blame, and behavioral self-blame were all correlated. Rape myth acceptance was only correlated with characterological self-blame and benevolent sexism. Correlations between rape myth acceptance

and characterological self-blame and benevolent sexism suggest that even though rape myth acceptance is not associated with PTSD symptoms directly, it may indirectly affect PTSD symptom severity through its associations with benevolent sexism and characterological self-blame.

Prediction of PTSD Symptom Severity

A multiple regression was used to analyze whether rape myth acceptance, benevolent sexism, behavioral self-blame, and characterological self-blame predicted the severity of PTSD symptoms as well as to determine the individual strength of the potential effects of each variable. Given that these variables were found to be highly correlated, their levels of collinearity were also examined. A multiple regression model using all four independent variables was created, and the model accounted for 54% of the variance in PTSD symptoms. However, rape myth acceptance did not have a significant effect in the model, so it was removed from future iterations of the model. Collinearity testing found that all the independent variables were somewhat collinear. But, characterological self-blame and behavioral self-blame had a very low eigenvalue of .066 which indicates very high collinearity between the two variables. When the regression was run, it was found that characterological self-blame enveloped the variance accounted for by behavioral self-blame. This finding led to behavioral self-blame also being removed from the model. A simpler model including only characterological self-blame and benevolent sexism accounted for 52.9% of the variance in PTSD symptoms (see Table 3). Characterological self-blame was the strongest predictor of PTSD symptom severity when compared with behavioral self-blame, benevolent sexism, and rape myth acceptance. These results support the hypotheses that benevolent sexism and characterological self-blame predict the severity of PTSD symptoms.

DISCUSSION

The present research examined the impact of benevolent sexism, characterological self-blame, behavioral self-blame, and rape myths on PTSD symptoms. The findings support current literature that suggests benevolent sexism and self-blame, characterological self-blame especially, have an impact on the severity of PTSD symptoms. However, acceptance of rape myths did not impact the severity of PTSD symptoms, though it did correlate with benevolent sexism and self-blame. The overall model used in this study accounted for a large portion of the variance of PTSD symptoms. However, the model suggests that most of this variance is accounted for by characterological self-blame and benevolent sexism. The variables were highly collinear and even though behavioral self-blame by itself had a small effect, its effect was completely enveloped by the effects of characterological self-blame.

The finding that benevolent sexism impacts severity of PTSD symptoms is consistent with prior studies, which have demonstrated a similar relationship between these variables (Dardenne et al., 2007; Sigurvinsdottir & Ullman, 2015; Viki et al., 2004). Benevolent sexist beliefs were found to be related to every variable in this study, whereas other studies have found benevolent sexism to be detrimental by itself (Glick & Fiske, 1996), the current study supports past research that has connected benevolent sexism to variables such as self-blame and rape myth acceptance which have also been found to have negative effects (Sigurvinsdottir & Ullman, 2015; Viki et al., 2004). The results of the present study are not surprising given the consistency of previous research on the negative effects of benevolent sexist beliefs (Dardenne et al., 2007; Glick & Fiske, 1996; Sigurvinsdottir & Ullman, 2015; Viki et al., 2004). The finding that benevolent sexism affects the severity of PTSD symptoms can be problematic because of the nature of benevolent sexism. Specifically, benevolent sexism has been found to lead to a mindset

of self-doubt, anxiety, and a lowered self-esteem (Dardenne et al., 2007). Actions that occur because of beliefs in benevolent sexism appear pro-social and are not seen as negative. By accepting benevolent sexist beliefs, the victim is giving in to beliefs that she is inferior to men and should be taken care of by men. Benevolent sexist beliefs may lead her to believe that she did something wrong to have led to her becoming a victim (Peter-Hagene & Ullman, 2015; Sigurvinsdottir & Ullman, 2015). With increasing numbers of studies highlighting the negative consequences of benevolent sexism, it becomes more evident that this belief system is problematic.

The present study provides corroborating evidence that characterological self-blame will lead to more severe PTSD symptoms. This finding is consistent with prior research that suggests that self-blame has a negative impact on the severity of PTSD symptoms (Baugher et al., 2010; Frazier, 1990; Koss et al., 2002; Sigurvinsdottir & Ullman, 2015; Ullman & Peter-Hagene, 2014). Victims who blame themselves for their assault based on a perceived character flaw or a perceived action will have worse PTSD symptoms and potentially worse treatment outcomes (Sigurvinsdottir & Ullman, 2015). Characterological self-blame has been previously associated with increased post-rape depression (Frazier, 1990). As in previous literature, characterological self-blame was shown to predict the severity of PTSD symptoms. The strength of the effect of characterological self-blame on PTSD symptom severity might stem from the relative permanence of character traits. If victims believe that their assault was caused in some way by a character flaw, then they may be more likely to perceive their assault as something that may happen again or was unavoidable because the perceived cause is their own character. By being aware of the effects of characterological and behavioral self-blame, those who work with victims of sexual assault can assess and approach these beliefs to hopefully reduce the severity of the

victims' possible PTSD symptoms and help them realize that they are not at fault for what happened to them.

The present study did not find rape myth acceptance to be directly linked to PTSD symptom severity. No other studies have been conducted that directly examined whether rape myth acceptance predicts the severity of PTSD symptoms. However, it has been shown to directly influence and be influenced by other factors such as benevolent sexism that do have an impact on PTSD symptoms in previous research (Baugher et al., 2010; Viki et al., 2004). Previous research has also connected rape myth acceptance levels to the ability of individuals to assess risk and their sensitivity to risk related information (Yeater et al., 2010). Considering the previous research connecting rape myth acceptance to factors that have been shown to have an impact of PTSD symptom severity, it was somewhat surprising that the present research found that rape myth acceptance was not related to PTSD symptom severity. The lack of connection between rape myth acceptance and PTSD in the present study may be due to the limitations of the study noted below, particularly the relatively small sample size and the reliance on online survey data. Rape myth acceptance has been found to have an impact on an individual's perceptions of the victims and perpetrators of sexual assault (Busching and Lutz, 2016; Viki et al., 2004; Yeater et al., 2010). Rape myth acceptance may not have a direct effect on PTSD symptom severity but, by altering the perceptions of individuals in regard to the victims and perpetrators, rape myth acceptance can impact how a victim is treated in clinical, social, and legal situations regarding the sexual assault. Reducing acceptance of rape myths could be beneficial for many victims of sexual assault, and education for others could also improve access to social support by reducing stigma.

Limitations

A limitation for the present study is that the measures were given to participants in an anonymous online survey. Using anonymous online surveys has the disadvantage of having difficulty reaching parts of the population due to inability to access the internet, such as people who live in remote areas and the elderly. The most common limitation with using online surveys is survey fraud. Many people participate in online surveys for monetary incentive of some kind and care little about the study itself. Given that there was a monetary incentive component to this study, it is likely that some participants committed survey fraud. Due to these issues, the present research cannot provide conclusive evidence that any of the independent variables affects the severity of PTSD symptoms. The number of participants is another limitation. By having a larger sample, the present study may have had more power to detect relationships between variables.

Conclusion

Despite these limitations, the results of the present research supported results of the previous literature regarding benevolent sexism, self-blame, and the severity of PTSD symptoms. However, it found that rape myth acceptance was not directly associated with PTSD severity. Further research is still needed to better understand the effects these variables may have on the severity of PTSD symptoms as well as ways to combat them to help victims of sexual assault. In the future, more studies should be conducted which examine the potential relationship between rape myth acceptance and PTSD, because this was the first study to do so. Benevolent sexism, rape myth acceptance, and self-blame have all been shown to impact a variety of areas such as PTSD symptom severity, coping mechanisms, victim and perpetrator blame, and several others (Baugher et al., 2010; Peter-Hagene & Ullman, 2015; Sigurvinsdottir & Ullman, 2015; Viki et al., 2004). By adding to the literature of these topics, individuals in fields that work with victims

of sexual assault can be better equipped to handle and understand many of the variables that can play a role in the victim's overall outcome following the assault.

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Appendix A: Approval Letter

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IRB1 #00002205
IRB2 #00003206

January 5, 2017

Brittany Canady, Ph.D.
Psychology Department

RE: IRBNet ID# 998566-1
At: Marshall University Institutional Review Board #2 (Social/Behavioral)

Dear Dr. Canady:

Protocol Title:	[998566-1] The Effects of Rape Myth Acceptance, Behavioral Self-Blame, Characterological Self-Blame, and Benevolent Sexism on PTSD Symptom Severity
Expiration Date:	January 5, 2018
Site Location:	MU
Submission Type:	New Project APPROVED
Review Type:	Exempt Review

In accordance with 45CFR46.101(b)(2), the above study and informed consent were granted Exempted approval today by the Marshall University Institutional Review Board #2 (Social/Behavioral) Designee for the period of 12 months. The approval will expire January 5, 2018. A continuing review request for this study must be submitted no later than 30 days prior to the expiration date.

This study is for student Jacob Camp.

If you have any questions, please contact the Marshall University Institutional Review Board #2 (Social/ Behavioral) Coordinator Bruce Day, ThD, CIP at 304-696-4303 or day50@marshall.edu. Please include your study title and reference number in all correspondence with this office.

Appendix B: Tables

Table 1

Descriptive Statistics for Primary Study Variables

				Range	
	M	*SD*	α	*Potential*	*Actual*
PTSD Symptom Severity (PCL-5)	60.47	19.00	.954	20-100	20-100
Behavioral Self-Blame	14.56	5.03	.802	5-25	5-25
Characterological Self-Blame	13.55	4.83	.793	5-25	5-25
Benevolent Sexism Subscale	41.24	10.48	.805	11-66	16-61.6
Rape Myth Acceptance (IRMA)	76.74	22.15	.762	0-110	27-110

Table 2

Correlations Between Study Variables

		1	2	3	4	5
1	PTSD Symptom Severity (PCL-5)	--				
2	Behavioral Self-Blame	.615**	--			
3	Characterological Self-Blame	.713**	.771**	--		
4	Benevolent Sexism	.433**	.300**	.425**	--	
5	Rape Myth Acceptance (IRMA)	-.149	-.102	-.221*	-.219*	--

Note. **p< .01, *p< .05.

Table 3

Evaluation of Regression Models Predicting PTSD Symptom Severity

	t	***P***	β	***F***	***df***	***p***	**Adj R^2**
Model 1				33.91	4,115	<.001	.525
Behavioral Self-Blame	1.70	.09	.64				
Characterological Self-Blame	4.85	<.001	2.03				
Benevolent Sexism	2.37	.02	.31				
Rape Myth Acceptance	.29	.77	.02				
Model 2				65.66	2,117	<.001	.521
Characterological Self-Blame	9.21	<.001	2.54				
Benevolent Sexism	2.26	.03	.29				