

STIGMATIC EFFECTS OF RAPE

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ABSTRACT

Some clinical and attitudinal issues of rape victim stigmatization are addressed in two studies. The clinical study provides figures for occurrence of sexual abuse and rape based on naturally occurring data obtained from the clinical records of 265 women admitted to two South African inpatient psychiatric units during 1987-1990. Of the total sample, 26.4% had a recorded history of sexual assault as children and/or adults. Analyses performed on subsamples (i.e., annual admissions to each unit) provided some higher figures, ranging from 29-37% in 1989 and 1990. Results are discussed in relation to prevalence findings reported elsewhere and to methodological issues. Representative extracts from the clinical records are presented to illustrate women's experiences of stigmatic effects of sexual assault. The attitudinal study utilised vignette methodology to investigate whether gender and previous sexual assault experience affected the degree to which stigmatizing attitudes towards rape victims were endorsed. A secondary objective was to examine psychometric evidence for a proposed three-dimensional model of stigma. Subjects were 100 young, white male and female South African university and teacher training college students. The vignette depicted an acquaintance rape scenario. The dependent variable was an 18-item Likert format stigma scale with items chosen to illustrate three dimensions of stigma: victim devaluation, social disruption and secrecy. The mean total stigma score for the sample was 70.94 which fell just outside the stigmatizing response range (stigma scale range = 18-108, stigmatizing range = 72-108). Eight of the eighteen stigma items elicited stigma-endorsing responses. There was no overall gender effect. Previous sexual assault experience had a weak but positive influence on the degree of victim stigmatization. The negative trend of the results was explained primarily in terms of sample variables and methodological issues. Psychometric data provided equivocal support for the scale's hypothesized dimensionality. Small sample size was a likely complicating factor. Clinically evident stigmatic effects are discussed in terms of their implications for levels of disclosure and help seeking, for the quality of care and understanding a rape victim can expect, and for her self-perception and self-esteem. Implications for clinical intervention with victims of rape are also considered.

TABLE OF CONTENTS

	Page
ACKNOWLEDGMENTS	ii
ABSTRACT	iii
LIST OF TABLES AND FIGURES	vii
CHAPTER 1 INTRODUCTION	1
Prevalence of rape	1
Stigma theory and research	2
Stigmatic effects of rape	6
Three-dimensional model of stigma	8
Devaluation	8
Social disruption	10
Secrecy and silence	10
Gender differences in attributions of stigmatic effects	10
Role of subjects' personal sexual assault experience	11
Research questions	11
Clinical study	11
Attitudinal study	12
CHAPTER 2 CLINICAL STUDY: EXPERIENCE OF SEXUAL ABUSE AND RAPE IN A CLINICAL SAMPLE	14
Aims	14
Method	14
Sample	14
Procedure	15
Results	15
Discussion	19
Case examples	21
Cases 1-6	21
Discussion and conclusions	23

CHAPTER 3	ATTITUDINAL STUDY	24
Aims and rationale		24
Method		25
Subjects		25
Materials		26
Procedure		27
Questionnaire administration		27
Item scoring		28
Follow-up contact		29
Test-retest procedure		29
Feedback of results to college participants		30
Results		30
Section 1: Analysis of attitudinal data		30
Summary statistics		30
Individual items		31
Victim devaluation		31
Social discomfort and disruption		33
Silence and secrecy		33
Interaction between subject gender and educational affiliation		34
Gender differences		34
Personal experience of sexual assault		35
Summary of results		37
Section 2: Stigma scale validity and reliability		38
Validity		38
Item analysis		38
Factor analysis		39
Reliability		41
Summary of results		42

	Page
CHAPTER 4 GENERAL DISCUSSION	43
Social stigma	44
Gender differences	46
Devaluation and self-stigmatization	47
Social disruption	49
Secrecy	50
Personal experience of sexual assault	50
Stigma scale: Psychometric findings	52
CHAPTER 5 CONCLUSION: CLINICAL IMPLICATIONS	54
REFERENCES	57
APPENDICES	63
Appendix A: Questionnaire	63
Appendix B: Definitions and terms	72
Appendix C: Statistical data	74

LIST OF TABLES AND FIGURES

		Page
Table	2.1 Reported Occurrence of Sexual Assault in a Female Psychiatric Sample	17
	2.2 Repeated Experience of Assault	18
	2.3 Women's Age at Time of First Reported Assault Experience	19
	3.1 Mean Scores for Stigma Items	31
	3.2 Item-Total Correlations: Items with Total Stigma Score	38
	3.3 Item-Total Correlations: Items with Total Dimension Scores	39
	3.4 Dimension Inter-correlations and Correlations with Total Stigma Score	39
	3.5 Unrotated Principal Axis Factoring: Stigma Scale	40
	3.6 Rotated Principal Axis Factoring: Stigma Scale	41
APPENDIX C		
	1. TWO-WAY ANOVA FOR STIGMA : GENDER BY EDUCATION	
	C-1 Cell Means and Standard Deviations	74
	C-2 ANOVA Summary Table	74
	2. MANOVA : GENDER EFFECT ON INDIVIDUAL ITEM SCORES	
	C-3 Multivariate Tests of Significance for Gender effect	74
	C-4 Univariate F-Test Summary Table : Item 2	75
	C-5 Univariate F-Test Summary Table : Item 6	75
	C-6 Univariate F-Test Summary Table : Item 10	75
	C-7 Univariate F-Test Summary Table : Item 11	75
	C-8 Univariate F-Test Summary Table : Item 16	75
	3. ANACOVA FOR STIGMA: GENDER (TREATMENT) BY SEXUAL ASSAULT EXPERIENCE (COVARIATE)	
	C-9 ANACOVA Summary Table	76
	4. TWO-WAY ANOVA FOR STIGMA : GENDER BY SEXUAL ASSAULT EXPERIENCE	
	C-10 Cell Means and Standard Deviations	76
	C-11 ANOVA Summary Table	76
APPENDIX C		
Figure	C-1 Unrotated Principal Axis Factor Solution: Scree Test	77
	C-2 Orthogonal Varimax Rotation: Scree Test	77

CHAPTER 1

INTRODUCTION

PREVALENCE OF RAPE

Overseas estimates of rape prevalence among non-clinical samples vary but results suggest that between 15-22% of women are victims of a completed rape at some point in their lives (Calhoun & Atkeson, 1991; Koss & Burkhardt, 1989; Koss & Oros, 1982). Where other forms of sexual assault are included, prevalence figures rise to 30% (Schur, 1983) while Koss (1985) found that 54% of a sample of 2 016 female college students had been subjected through coercion to some form of unwanted sexual activity. Prevalence figures for sexual assault among clinical samples are likely to be even higher (Levett, 1989b; Stone, 1989).

Local prevalence studies are rare. Levett (1989b) found that 31% of a sample of 94 South African university women students had experienced contact sexual abuse before the age of 18 years. Official annual figures for recorded rapes in the early 1980s were between 15 000 and 16 000, with 19 368 official cases in 1988 (Vogelman, 1990). However, since under-reporting of rape is estimated to be between 50-90% (Collings, 1986) unofficial annual figures for rape incidence are considerably higher, varying from 215 000 (Rape Crisis, 1991) to 390 000 (Vogelman, 1990).

In South Africa, sexual assault constitutes a significant social problem attested to by growing concern in the public and mental health spheres. It is recognised that because of stigmatization, revictimization by the criminal justice system and difficulties in getting adequate support from family, friends and community resources, resolution of reactions to rape is often complicated. Recent literature on the long-term effects of sexual assault (Collings, 1985; Emm & McKenry, 1988; Santiago, McCall-Perez, Gorcey & Bergel, 1985) suggests that helping clients to deal with long-term consequences constitutes an increasingly important area of clinical work. Koss and Burkhardt (1989) indicate that between 31-48% of rape victims eventually seek psychotherapy, often years after the assault and there is a trend in the literature away from the crisis model of rape counselling (Burgess & Holmstrom, 1977) towards consideration of the psychodynamics of rape victims and the need for psychotherapy (Forman, 1980; Green, 1988; Rose, 1986).

STIGMA THEORY AND RESEARCH

Goffman (1963) defines stigma as an attribute or undesired differentness that discredits the individual, reducing him or her in our minds "from a whole and usual person to a tainted and discounted one" (p.3). On the basis of particular physical, characterological or biological attributes, he or she is disqualified from full social acceptance. Goffman suggests that possession of such attributes is not sufficient cause for social disqualification since this rests upon an interactional process in which differentness is given social meaning. He further describes stigma as a special kind of relationship between attribute and stereotype.

The conceptual development of the notion of stigma which has taken place in the last decade within social psychological and sociological paradigms, draws much from Goffman's seminal ideas. Social psychologists tend to emphasize the cognitive basis of stigmatization as a process of categorizing differences towards which others hold negative attitudes and beliefs, a process that includes aspects of labelling and tends towards stereotyping (Coleman, 1986; Crocker & Lutsky, 1986). An attributional analysis of stigmatic effects is favoured by Weiner, Perry and Magnusson (1988) who argue that stigmas, as undesired qualities, represent negative outcomes which, as such, initiate attributional search to determine the origin of the stigma. According to attribution theory, the perceived cause of the stigma should then determine affective reactions and behavioural responses towards the stigmatized person as well as future expectations of them. Some authors note the motivational basis of stigmatization by invoking the Just World hypothesis to explain why people need to hold unjustifiable negative evaluations of victims of misfortune (Crocker & Lutsky, 1986; Jones, Farina, Hastorf, Markus, Miller & Scott, 1984). Katz (1979; 1981) proposes an ambivalence-response amplification theory which suggests that stigmatized individuals create ambivalence in their social environments which, in turn, intensifies negative or positive responses to them, depending on how the specific situation is structured.

Dimensions or aspects of stigma which moderate the stigmatizing process are noted, for example, concealability, severity, social

threat and perceived responsibility for the stigmatizing condition (Jones et al., 1984; Katz, 1981). The latter is particularly relevant with regard to rape where research suggests that rape victims are often considered to be responsible for having caused their own rape (Jones & Aronson, 1973; McCaul, Veltum, Boyechko & Crawford, 1990) and tend to accept more blame than seems objectively warranted (Becker, Skinner, Abel, Howell & Bruce, 1982). In the stigma literature, there is controversy over the centrality of attributed responsibility for the stigmatizing condition. While Weiner, Perry and Magnusson (1988) present empirical evidence to support an attributional analysis of reactions to stigma (e.g., stigmatized individuals elicit less anger, more liking and more pity when judged not to be personally responsible for the onset of their condition) generally, causal perceptions related to stigmas are regarded as having influence but not as being intrinsic to stigmatization (Crocker & Major, 1989; Stafford & Scott, 1986). Empirical studies of the relationship between attributions of responsibility and devaluation have demonstrated inconsistent results. Katz, Hass, Parisi, Astone, McEvaddy and Lucido (1987) found such a relationship with regard to chronic illness patients while Levett and Kuhn (1991) found no association between attributions of victim responsibility and of victim's feelings of shame (the consequent, from a symbolic interactionist perspective, of being disgraced and denigrated).

Social psychological analyses of stigma are also influenced by aspects of labelling theory, a perspective which is favoured by sociologists who see stigmatization as a deviantizing process (Birenbaum & Sagarin, 1976; Davis, 1980; Pfuhl, 1980; Schur, 1980). Stigmatized individuals are judged as illegitimate for participation in social interaction because, as norm violators, they are seen as inconsistent, unpredictable and a threat to interaction (Elliott, Ziegler, Altman & Scott, 1982). This approach emphasizes the normative nature of stigma and its sociocultural context, contending that categorization of stigma groups and their consequent inferiorization is linked to the structure of societies and intergroup relations within them and is a means of social control. From this perspective, the stigmatization of rape victims is one instance of the process of "labelling women deviant" (Schur, 1983).

Self-stigmatization (discussed also as "self-labelling") is one focus of stigma theory and is viewed predominantly from a symbolic interactionist perspective. Recent theoretical and empirical elaboration by Crocker and Major (1989) and Crocker, Voelkl, Testa and Major (1991) takes issue with the belief that social stigma, via self-stigmatization, necessarily results in lowered self-esteem and diminished self-concept. The authors present empirical evidence which suggests that stigmatizing conditions accompanied by a recognizable group identity may foster more frequent ingroup affiliations. Members of a stigmatized group then have access to certain self-esteem protecting mechanisms, such as attributing negative feedback to prejudice against their group and comparing their outcomes with those of the ingroup, rather than with the relatively advantaged outgroup. The extent to which a theory of the self-protective properties of stigma applies to rape victims is questionable given that, for the many women who do not disclose their experience or join a support group subsequently, there is no recognizable group identity.

Definitions of stigma drawn from stigma theory tend to be impressionistic and attest to what Davis (1980) calls the literary or dramatic nature of the concept, which does not readily yield operational definitions. Stigma is documented as referring to "outcomes of a discrediting process, where a target person is viewed as morally flawed and arouses revulsion" (Jones et al., 1984, p.297); stigma denotes "one's morally spoiled identity, one's social undesirability" (Pfuhl, 1980, p.202) and "conjures up images of blemished selves or discredited bodily or moral attributes" (Davis, 1980, p.207).

Unpacking these definitions reveals key cognitive, affective and behavioural response elements which are dynamically linked. At the cognitive level of categorization and stereotyping, are the components of difference and devaluation (with strong moral connotations); the stigmatized individual is perceived as a "special kind of person" (Pfuhl, 1980) a "damaged" person (Levett, 1989a), a "tainted" person (Goffman, 1963). Judgements of the stigmatized person as inconsistent and unpredictable are also central (Albrecht, Walker & Levy, 1982; Elliott et al., 1982). Thus on the affective level, stigmatized individuals engender

feelings of uneasiness, discomfort, threat and anxiety (because they are seen as "different" and people do not know how to behave around them and because of a primitive fear of contamination). Subsidiary feelings of sympathy and pity may be aroused (Burczyk & Standing, 1989) which has led to the suggestion that ambivalence is an important response component (Katz, 1981). It is also noted that while sympathy may represent genuine concern it may also represent a desire to avoid the appearance of being prejudiced and may thus be expressed in an exaggerated form, which is likely also to be experienced as stigmatizing by the recipient (Crocker & Major, 1989). By reference to a fundamental belief in the strongly negative and problematic character of a stigmatized person and to feelings of discomfort or revulsion aroused by what they have done (or what has been done to them) behavioural reactions are often of a hostile or dysfunctional nature. Avoidance and social rejection are the most commonly noted behavioural responses (Crocker & Lutsky, 1986; Katz, 1979) but also overprotectiveness and leniency (Levett, 1989a).

Stigma research has sought to investigate the relative stigmatization of specific disability groups (Schneider & Anderson, 1980), to demonstrate stigmatic responses to particular groups of persons, for example, blacks (Katz, 1981), cancer sufferers (Katz et al., 1987); to test one or other of the theoretical notions about the effects of stigma on social interactions and the self (Crocker et al., 1991; Gibbons, Stephan, Stephenson & Petty, 1980); and to identify stereotypic beliefs (i.e., characteristics of the "labeller") that exist in association with an attribute and influence stigmatization (Link, Cullen, Frank & Wozniak, 1987; Weidner & Griffitt, 1983).

Social psychologists who pursue attitudinal analyses of stigma focus on the content and nature of social beliefs about the stigmatized, underlying which is a concern about judgements of personal character. As a result, research on beliefs may document the existence of stigma where there is evidence that members of a particular social category are associated with a discredited personal character and social undesirability. The preferred methodologies are the vignette methodology, which allows for a personalization of the target to be evaluated, and a "category-

based" methodology where, for example, "alcoholism", "mental illness" (Tringo, 1970) or "people with cancer" (Katz et al., 1987) are rated on various scales. The most popular criterion measures are devaluation and avoidance/rejection. Katz et al. (1987) used a "moral worth" rating scale to demonstrate stigmatization of AIDS patients but failed to elicit the expected negative evaluation of cancer patients. Weidner and Griffitt (1983) utilized a "personal impressions scale" in an attempt to elicit "global disvaluation". The criterion of avoidance/rejection is usually operationalized by means of a social distance scale, originally developed by Bogardus (Foster & Louw-Potgieter, 1991). This has usefully been used in studies aimed at determining a hierarchical structure of specific stigma categories: physical disability, disease, deviant behaviour patterns (Albrecht, Walker & Levy, 1982; Tringo, 1970) but tends to elicit frankly accepting responses when applied to personalized targets (Link et al., 1987; Weidner & Griffitt, 1983). Finally, judgements of unpredictability and expectations of social discomfort as a measure of stigmatization have been demonstrated qualitatively, by use of open-ended questions (Albrecht, Walker & Levy, 1982).

The stigma of being raped receives fleeting attention in the main body of stigma theory (e.g., Crocker & Lutsky, 1986; Crocker & Major, 1989) usually as an example of an "invisible", "characterological" stigma that differs along prominent dimensions from those stigmatized conditions most often studied (e.g., race, physical disability and disease, criminality) and thus elicits different reactions from others and by the stigmatized themselves. In the deviancy literature, Schur (1980; 1983) discusses rape and the associated stigma within the broader context of the social control of women.

STIGMATIC EFFECTS OF RAPE

The early popular feminist literature on rape victimology (Brown-miller, 1975; Griffin, 1977) highlighted the negative social and psychological consequences for the victim of prejudiced, stereotyped and distorted beliefs about rape. The study of attitudes towards rape was subsequently taken up by psychologists in academic and applied domains. Stigmatic effects of rape, in particular, have been consistently reported but have received little systematic

examination. Anecdotal evidence and case history material attests to the widespread negative evaluation of the rape victim as "damaged goods" and less desirable (Weis & Borges, 1975), ostracized and rejected (Brodsky, 1976), isolated and excluded (Symonds, 1975), blamed and discredited (Schur, 1980) and as feeling herself to be tainted, "spoiled", contaminated, devalued and shamed (Levett, 1981; Sanders, 1980). These findings allude to a "commonsense" (see Appendix B for definition) notion of stigma and support what Schur (1983) has described as the "thoroughgoing stigma-reversal with respect to rape" (p.145) whereby socially constructed negative definitions and feelings associated with rape are attached as much or more to the victim, as to the perpetrator.

There is little work on South African attitudes to rape and sexual assault (Collings, 1987; Levett & Kuhn, 1991, Vogelmann, 1990), and in the broader rape literature only two studies have systematically examined the stigma of rape (Levett & Kuhn, 1991; Weidner & Griffitt, 1983). Weidner and Griffitt (1983), following Katz's (1979; 1981) definition of stigma as (a) the perception of a negative characteristic and (b) the global devaluation of the possessor, failed to demonstrate that a victim of rape was stigmatized. Arguing from a labelling perspective which emphasizes the role of observer characteristics in the stigmatization process, they shift their focus to identifying mediating subject variables (e.g., attitudes towards women) influencing victim perception. Methodological flaws may have contributed to Weidner and Griffitt's negative findings. There is no clear operational definition of stigma and the dependent variables - a social distance measure and a personal impressions scale - have questionable validity as measures of stigmatic effects. The social distance scale lacks sensitivity as a measure of "rejection" and is also particularly likely to elicit socially desirable responses due to its lack of subtlety (Gibbons et al., 1980). The Personal Impressions Scale includes ratings on factors such as sexual competence which go beyond commonsense and theoretically accepted notions of stigma. While vignette methodology is a popular and useful means of assessing attitudes, it must be used with particular care to ensure that, as far as possible, subjects respond to the salient (experimentally relevant) aspects of the vignette. Superfluous background information about the rape victim given in adjunct to

the rape vignette in Weidner and Griffit's study is likely to have influenced subjects' responses in uncontrolled ways.

Levett and Kuhn (1991), focussing on the effects on attitudes towards rape and rapists of class, sex and race discrimination in South Africa, demonstrated that women endorsed the response that a rape victim would feel "dirty and contaminated" (their working definition of stigmatization) more strongly on average than men, and suggest that further research into stigmatic effects is clearly indicated.

Several authors have demonstrated that the responses of rape victims to their experience are integrally linked to societal reactions (Renner, Wackett & Ganderton, 1988; Weis & Borges, 1975; Williams & Holmes, 1982). Not only attitudes but people's behaviour towards a woman often change with the knowledge that she has been sexually assaulted; they may become avoidant or over-protective of her and, either way, this can be experienced as stigmatization by the woman. She feels different or set apart (Levett, 1989a). Thus the significance of stigmatic effects lies not only in their implications for the social reception of the victim, but also for her self-perception.

THREE-DIMENSIONAL MODEL OF STIGMA

Commonsensibly, and with reference to theoretical and empirical studies, a three-dimensional model of stigma with relation to rape is suggested, comprising elements of victim devaluation, expectations of social disruption and secrecy around the rape.

Devaluation

Devaluation is noted to be the common factor in all definitions of stigmatization (Stafford & Scott, 1986) and is a central aspect of the stigmatic effects of rape (Levett, 1981). It is closely connected to attributions of damage and difference. Cultural expectations which place value on virginity and fidelity and on the responsibility of women for impulse control in sexual encounters leads others to perceive a rape victim as "spoiled", less desirable, inferior, and there is a shifting of blame to the woman, emphasising her deservingness and minimizing the seriousness of the rape (Weis & Borges, 1975).

From a symbolic interactionist perspective, a woman who has been raped is likely, through her awareness of others' devaluation of her, to incorporate negative evaluations into her self-concept and label herself as "marked" (i.e., the idea of a "looking-glass" self: Harré & Lamb, 1986; Shrauger & Schoeneman, 1979). From an alternative - but similar - perspective, in response to others' altered behaviour towards her, she is likely to engage in a self-fulfilling prophecy of role-appropriate behaviours, that is, the behaviours that are expected of a "rape victim" (Jussim, 1986; Levett, 1989a). In contrast to the symbolic interactionist perspective, the self-fulfilling prophecy perspective does not require that the woman who has been raped be aware of the stigmatizing attitudes of others for those attitudes to affect her self-concept. Either way, however, self-stigmatization is the result, with consequent lowered self-esteem. As Sanders (1980) states, the rape victim loses "face": both her positive social value as a person and her self-image are threatened.

To extend the explanatory power of stigmatic effects, a social constructionist view - based partly in the symbolic interactionist framework - understands that a powerful network of social representations of damage and difference plays an important role in mediating the meanings and consequences of the experience for a woman who has been sexually assaulted, and that there is a set of socially prescribed responses to the experience. As Levett (1989a) states, "The woman is seen as a victim, trapped or engaged at the centre of a network of meanings surrounding stigma, believing herself to be different and leading her life in this continuing belief" (p. 135). Thus, rape victims' reactions of shame, defilement, loss of self-esteem and feelings of isolation and rejection are strongly associated with the dynamic of stigmatization since they are a response to being devalued and seen as damaged by others. That these self-stigmatizing beliefs are often considered "natural" responses to a rape experience, attests to the strength and power of socially constructed images and stereotypes about human behaviour. (See Appendix B for discussion of implications of the term "victim" versus "survivor".)

Social disruption

Stigma has a disruptive influence because it calls into question the stigmatized person's ability to behave in a competent, consistent and predictable manner and thereby sustain smooth social interactions (Elliott et al., 1982). Because they are seen as "different", as having experienced something shameful, women who have been raped engender feelings of unease and embarrassment. People do not know what to say to them and expect them to behave in unpredictable ways. Feelings of betrayal of trust, shame and fear resulting from a rape experience may cause victims to withdraw socially and make sudden changes in their lifestyle which confirm others' expectations of disrupted interactions and feelings of discomfort.

Secrecy and Silence

Closely bound up with stigma is the secrecy and silence which surrounds the experience of sexual assault. Women's unwillingness to disclose having been raped because of fears of negative responses, both at interpersonal and institutional levels, is implicated in the under-reporting of rape (Collings, 1987; Koss, 1985) and in lower prevalence findings in some studies of rape and childhood sexual abuse (Levett, 1989b). It may also contribute to the traumatic effects of the experience according to several authors who claim that talking about a rape experience is a central factor in recovery (Cahill, Llewellyn & Pearson, 1991; Koss & Burkhart, 1989). Levett (1989b) usefully documents the dual and contradictory implications of this silence for stigmatic effects. On the one hand, non-disclosure protects the rape victim from those aspects of stigma which would result in her being treated as a "different" type of woman. On the other hand, it safeguards perpetrators and means that she bears a "secret trauma" and a private emotional burden of self-stigmatization because of the way in which such experiences are understood.

GENDER DIFFERENCES IN ATTRIBUTIONS OF STIGMATIC EFFECTS

Gender is a commonly used category of difference in studies examining attitudes towards rape (e.g., Kleinke & Meyer, 1990; Macrae & Shepherd, 1989; Ward, 1988; Weidner & Griffitt, 1983). While female and male children are vulnerable to sexual molestation, men and women are clearly differently situated as

potential victims of rape (Koss, 1985). Further, if the notion holds that men and women in most societies grow up with some basic differences in experience similar to cultural difference (Barrett, 1987), then differences in rape victim stigmatization and attributions of stigmatic effects by men and women may be expected.

ROLE OF SUBJECTS' PERSONAL SEXUAL ASSAULT EXPERIENCE

While it has been noted that the direction of the effect produced by contact with an attitudinal object is almost always complex (Burt, 1980), a recent study by Remer and Witten (1988) demonstrated prior rape experience (knowing a rape victim or having been victimized oneself) to have an important positive influence on conceptions of rape, even negating certain gender effects. They suggest the inclusion of prior rape experience as a control variable in studies examining attitudes towards rape. Logically, one can hypothesize that knowing someone who has been raped, or having been raped oneself, will undermine negative stereotypes, increase feelings of similarity with the victim and thus reduce stigmatic effects. However, attitudes towards a rape victim of subjects who have been sexually assaulted themselves may mirror strong feelings of self-stigmatization.

RESEARCH QUESTIONS

To address both the clinical and attitudinal issues involved in stigmatic effects of rape, two studies were conducted.

Clinical Study

This study addressed two questions, firstly, what is the prevalence of sexual assault in a South African clinical sample of women? While there are many women in the general population who privately suffer the consequences of rape (Koss, 1985) it is within clinical populations - psychiatric patients, women seen in clinical practice or by social agencies - that therapists must help victims of sexual assault with the short and long-term consequences, including stigmatic effects, of their experience. We need to know what numbers of women are involved. While overseas clinical prevalence studies suggest the figures are high, there are no local prevalence figures relating to clinical samples. To address this gap, prevalence data for sexual assault were obtained from the clinical

records of 265 women admitted to two South African inpatient psychiatric therapy units during the period 1987 - 1990.

The second question asked, how does stigma contribute to the patient's crisis of rape? Commonly reported reactions to sexual assault include feelings of betrayal of trust, fear, depression and disturbed social and sexual adjustment (Calhoun & Atkeson, 1991). Stigmatic effects, such as feelings of shame, self-blame and fears about what other people will think, are also an important part of the response (Levett, 1981; Nadelson, Notman, Jackson & Gornick, 1982; Weis & Borges, 1975). Representative extracts from clinical case material (of cases sampled in the prevalence study) are presented to illustrate patients' experiences of socially and self-stigmatizing consequences of rape.

Attitudinal Study

If stigmatic effects permeate the responses of sexual assault victims to their experience, the question is raised of how widespread are stigmatic attitudes in the general population? This relates directly to clinical issues since societal stigmatization can be expected to impact both on the quality of understanding and support which a rape victim will receive, and on her own understanding of the experience and self-perception.

Using vignette methodology, the attitudinal study examined stigmatic attitudes, conceptualized along a three-dimensional model comprising victim devaluation, social disruptiveness and secrecy, in a South African student sample. Differences in responses of men and women were also investigated and prior sexual assault experience was included as a control variable. A secondary objective was to assess psychometric data for support of the scale's theoretically-based three-dimensionality.

The focus of both studies is stigmatic effects of rape and for experimental purposes, in the attitudinal study, rape was clearly defined as an act of sexual coercion involving penetration (See Appendix B for rape definitions). However, current understanding favours a wider definition of rape, which refers to a broad range of types and levels of sexual victimization, on the basis of recent studies which suggest that rape trauma reactions may be experienced in response to seemingly mild acts of sexual coercion that may not

include penetration or physical violence (Calhoun & Atkeson, 1991) and that it makes no difference to average short or long-term responses whether rape is attempted or completed (Becker et al., 1982). Levett (1989a) states that in one sense it is accurate to think of a range of situations (i.e., rape, sexual assault, harassment, molestation) as "rape" since every instance of sexual abuse or assault is an instance in which relative power is inscribed in the recipient's consciousness (adult/child, male/female). It seems likely then that stigmatic effects are not limited only to victims of rape in the narrow sense of the term, nor only to adult victims. While it is recognised that children's reactions to sexual abuse involve a particular set of factors relating to developmental level and dependence on the family, stigmatic effects have been noted by Finkelhor and Browne (1985) to be one of four central trauma-causing factors in childhood sexual abuse. Thus, in the clinical study, prevalence data for experiences other than adult rape were included in the analysis and case material illustrative of stigmatic effects was drawn from patients' childhood as well as adult experiences of sexual assault. For similar reasons, in the attitudinal study, to assess the influence on stigmatization of respondents' prior sexual assault experience, a definition was employed which included any experience of contact sexual assault as a child or as an adult.

CHAPTER 2

CLINICAL STUDY: EXPERIENCE OF SEXUAL ABUSE AND RAPE IN A CLINICAL SAMPLE

Aims

Calhoun and Atkeson (1991) quote overseas prevalence studies which suggest that half of hospitalized adult psychiatric patients have histories of child sexual abuse and rape. The frequency of incestuous abuse tends to exceed that of the population as a whole (Stone, 1989) and there are likely to be higher numbers of cases of abuse involving repeated sexual intercourse or associated with physical violence (Levett, 1989b). These situations are regarded as very serious and generally more traumatic. While direct connections between sexual assault and psychiatric illness cannot be assumed, it is clear from the literature that many psychiatric patients are likely to have experienced sexual assault. This study utilized naturally occurring material, that is, sexual assault experiences reported in psychiatric case histories, to gain an indication of the number of women implicated in a South African psychiatric sample and to provide narrative responses illustrating the experience of stigma.

Method

Sample

The study was carried out in a clinical sample comprising the records of all female admissions to two South African inpatient psychiatric therapy units (referred to as Units A and B) for the four-year period 1987 to 1990. The writer, who served as an intern psychologist in both these units, gained permission from the hospital authorities for access to patients' confidential folders to conduct the search. A number of folders were unavailable for various reasons and some folders were missing clinical notes altogether. These cases were not included in the data analysis. For Unit A, there were 126 female admissions, 1987-1990, of which 116 were included in the study (six folders were not available, three folders lacked notes, one case was a readmission). Unit B had a total of 152 female admissions over the four-year period and 149 of those were included (one readmission and two cases referred via Unit A and included in its data were omitted).

Procedure

Data concerning sexual abuse and sexual assault were obtained from clerking and therapy notes. All documented instances of forcible rape, attempted rape, sexual abuse, molestation, incest, exposure to exhibitionists and to pornographic films were noted. The methodology is flawed by its retrospective reliance on case history material and, for several reasons, the figures thus obtained are likely to underestimate actual occurrence.

Firstly, in a number of cases in the Unit A subsample, details regarding a patient's sexual development and specifically sexual abuse or assault history, appear not to have been directly elicited and so relevant information was unavailable. These cases were included in the data analysis but counted as negative for abuse/assault experience where, in fact, they may not have been. Secondly, while instances of rape and attempted rape occurring over the age of approximately 13 years were usually fairly clearly documented, references to a patient's childhood experience of "sexual abuse", "molestation" or "incest" often lacked detailed elaboration and did not specify what form the abuse took (i.e., non-contact, contact, rape). For the analysis, these cases were included in the "physical contact sexual abuse" category, but not counted as rape. Thirdly, where clinical notes did not specify repeated sexual abuse/assault experiences, but where the fact of only one episode having occurred was not clear (e.g., "sexually abused at age 8") the experience was counted as a single one. Fourthly, while psychiatric patients - and particularly those entering a therapy programme - are more likely to have an emotional investment in disclosure, it is still probable that some patients whose clinical notes reflected no history of sexual abuse or assault, had chosen not to disclose.

Results

Of the 265 female admissions whose clinical notes were examined, 26.4% ($n = 70$) had reported one or more experience of sexual assault as a child and/or adult. Of these, 50% (35 women, 13.2% of N) had experienced rape, 4.3% (3 women, 1.1% of N) attempted rape, 40% (28 women, 10.6% of N) physical contact sexual abuse before age 18 (e.g., unwanted fondling of breasts, buttocks and genitalia, being coerced to touch the perpetrator's penis or to engage in oral-genital contact) and 5.7% (4 women, 1.5% of N) non-contact

sexual abuse (i.e., exposure to exhibitionists and to pornographic material). The figures quoted for attempted rape, physical contact and non-contact sexual abuse do not include women who reported these experiences in addition to rape experiences.

Results analysed by year and hospital unit indicate an escalation in the number of women admitted to Unit A with a reported history of sexual abuse/assault from 20.7% and 18.2% in 1987 and 1988, to 29.6% and 37% in 1989 and 1990 respectively. The figures for Unit B show a similar trend increasing from 23.5% to 26.7% to 35.0% through years 1987 - 1989, but with a surprising drop to 20% in 1990. These results are summarized in Table 2.1.

Of the total identified sexual assault sample, 38.6% (27 women, 10.2% of N) reported one experience and 61.4% (43 women, 16.2% of N) more than one experience of abuse/assault. Of the rape subsample, 51.4% (18 women) reported one, 17.1% (6 women) two, 11.4% (4 women) three, and 20% (7 women) more than three rape experiences. Results are summarized in Table 2.2.

Of the total sexual assault sample, 61.4% (43 women, 16.2% of N) reported having had their first experience of sexual abuse before age 14 years, a further 18.6% (13 women, 4.9% of N) their first experience from ages 14 to 17, and 20% (14 women, 5.3% of N) their first assault experience age 18 and above. Results are summarised in Table 2.3.

Table 2.1

Reported Occurrence of Sexual Assault in a Female Psychiatric Sample

Year	Type of Sexual Assault	Psychiatric Unit A		Psychiatric Unit B		Units A and B	
		Number of women	Percentage % of n	Number of women	Percentage % of n	Number of women	Percentage % of n
1987	Total identified sexual assault sample	n=29		n=34		n=63	
		6	20.7	8	23.5	14	22.2
	Rape	4	13.8	3	8.8	7	11.1
	Attempted rape	0	0	0	0	0	0
	Physical contact sex. abuse	1	3.5	4	11.8	5	7.9
Non-contact sexual abuse	1	3.5	1	2.9	2	3.2	
1988	Total identified sexual assault sample	n=33		n=45		n=78	
		6	18.2	12	26.7	18	23.1
	Rape	5	15.2	4	8.9	9	11.5
	Attempted rape	0	0	1	2.2	1	1.3
	Physical contact sex. abuse	1	3.0	6	13.3	7	9.0
Non-contact sexual abuse	0	0	1	2.2	1	1.3	
1989	Total identified sexual assault sample	n=27		n=40		n=67	
		8	29.6	14	35.0	22	32.8
	Rape	3	11.1	7	17.5	10	14.9
	Attempted rape	1	3.7	1	2.5	2	3.0
	Physical contact sex. abuse	4	14.8	5	12.5	9	13.4
Non-contact sexual abuse	0	0	1	2.5	1	1.5	
1990	Total identified sexual assault sample	n=27		n=30		n=57	
		10	37.0	6	20.0	16	28.1
	Rape	7	25.9	2	6.7	9	15.8
	Attempted rape	0	0	0	0	0	0
	Physical contact sex. abuse	3	11.1	4	13.3	7	12.3
Non-contact sexual abuse	0	0	0	0	0	0	
1987 to 1990	Total identified sexual assault sample	n=116		n=149		n=265	
		30	25.9	40	26.9	70	26.4
	Rape	19	16.4	16	10.7	35	13.2
	Attempted rape	1	0.9	2	1.3	3	1.1
	Physical contact sex. abuse	9	7.8	19	12.8	28	10.6
Non-contact sexual abuse	1	0.9	3	2.0	4	1.5	

Note. Figures for Attempted rape, Physical contact sexual abuse and Non-contact sexual abuse do not include women who reported these experiences in addition to Rape experiences.

Table 2.2

Repeated Experience of Sexual Assault

Year		Psychiatric Unit A		Psychiatric Unit B		Units A and B	
		Number of women	Percentage %	Number of women	Percentage %	Number of women	Percentage %
1987		n=29		n=34		n=63	
	Total sexual assault sample:						
	a) One experience	0	0	3	8.8	3	4.8
	b) Two or more experiences	6	20.7	5	14.7	11	17.5
1988	Rape subsample:						
	a) One rape experience	0	0	3	8.8	3	4.8
	b) Two or more experiences	4	13.8	0	0	4	6.3
	Total sexual assault sample:	n=33		n=45		n=78	
a) One experience	3	9.1	4	8.9	7	9.0	
b) Two or more experiences	3	9.1	8	17.8	11	14.1	
1989	Rape subsample:						
	a) One rape experience	2	6.1	3	6.7	5	6.4
	b) Two or more experiences	3	9.1	1	2.2	4	5.1
	Total sexual assault sample:	n=27		n=40		n=67	
a) One experience	3	11.1	6	15.0	9	13.4	
b) Two or more experiences	5	18.5	8	20.0	13	19.4	
1990	Rape subsample:						
	a) One rape experience	2	7.4	4	10.0	6	9.0
	b) Two or more experiences	1	3.7	3	7.5	4	6.0
	Total sexual assault sample:	n=27		n=30		n=57	
a) One experience	6	22.2	2	6.7	8	14.0	
b) Two or more experiences	4	14.8	4	13.3	8	14.0	
1987 to 1990 incl	Rape subsample:						
	a) One rape experience	4	14.8	0	0	4	7.0
	b) Two or more experiences	3	11.1	2	6.7	5	8.8
	Total sexual assault sample:	n=116		n=149		n=265	
a) One experience	12	10.3	15	10.1	27	10.2	
b) Two or more experiences	18	15.5	25	16.8	43	16.2	
1987 to 1990 incl	Rape subsample:						
	a) One rape experience	8	6.9	10	6.7	18	6.8
b) Two or more experiences	11	9.5	6	4.0	17	6.4	

Note. Total identified sexual assault sample $n = 70$.
Rape subsample $n = 35$.

Table 2.3

Women's Age at Time of First Reported Assault Experience

Year	Women's age at time of first assault ^a	Psychiatric Unit A		Psychiatric Unit B		Units A and B	
		Number of women	Percentage %	Number of women	Percentage %	Number of women	Percentage %
1987		n=29		n=34		n=63	
	Abuse before age 14	2	6.9	5	14.7	7	11.1
	Abuse age 14 - 17	2	6.9	3	8.8	5	7.9
	Assault after age 17	2	6.9	0	0	2	3.2
1988		n=33		n=45		n=78	
	Abuse before age 14	1	3.0	9	20.0	10	12.8
	Abuse age 14 - 17	1	3.0	4	8.9	5	6.4
	Assault after age 17	4	12.1	0	0	4	5.1
1989		n=27		n=40		n=67	
	Abuse before age 14	5	18.5	11	27.5	16	23.9
	Abuse age 14 - 17	1	3.7	0	0	1	1.5
	Assault after age 17	2	7.4	2	5.0	4	6.0
1990		n=27		n=30		n=57	
	Abuse before age 14	4	14.8	6	20.0	10	17.5
	Abuse age 14 - 17	2	7.4	0	0	2	3.5
	Assault after age 17	4	14.8	0	0	4	7.0
1987 to 1990 incl		n=116		n=149		N=265	
	Abuse before age 14	12	10.3	31	20.8	43	16.2
	Abuse age 14 - 17	6	5.2	7	4.7	13	4.9
	Assault after age 17	12	10.3	2	1.3	14	5.3

^a Figures are for women whose first experience occurred in each age range. Women who experienced abuse/rape before and after age 14 are included in the under 14 age group.

Discussion

The total sexual assault figure (26.4% of the sample) and the figure for rape only (13.2%) are lower than those reported in other studies. Painter (1986) gives figures for North American, clinically-based studies of child sexual abuse of around 35%, while Calhoun & Atkeson (1991) indicate that the combined sexual abuse and rape figure is closer to 50%. However, averaging figures across the two units over the four-year period obscures some significantly higher figures in certain subsamples. The overall sexual abuse/assault figures for Unit A in 1989 and 1990 (29.6% and 37% respectively) and for Unit B in 1989 (35%) do approximate the North American figures quoted in Levett (1989b). The drop in reported experience for Unit B in 1990 (to 20%) is difficult to understand but - given the small sample size of 30 - may be due to chance.

Figures for the reported experience of rape seem particularly low (13.2% of the total sample over the four years, although Unit A in

1990 provided a figure of 25.9%). This is likely not to be an accurate reflection of either the sample or the population because of the cases (approximately 20 or 28.5% of the identified abuse/assault group) where experiences were recorded as, for example, "molestation" or "sexual abuse" with no further details; these cases were included as contact abuse and not as rape to avoid artificially inflating rates for rape but, of course, the opposite effect may have resulted.

The combined abuse/assault figures include only four cases where non-contact abuse, and only three where attempted rape, were the only experiences recorded (i.e., 90% of the identified abuse/assault group comprised women who had experienced physical contact abuse and/or completed rape). Given Levett's (1989b) findings in a non-clinical sample that 52.5% of 61 experiences (reported by 41 women) before 18 years were non-contact experiences, the findings of the present study may certainly under-reflect experience of non-contact sexual abuse. The literature shows that many women who have experienced sexual intercourse against consent, through force, do not view themselves as rape victims especially when the assailant was known to them (Koss, 1985). Thus, it seems even more likely that many women will not consider having been touched in a sexual way as a child, or having been the target of unwanted sexual comments as a teenager, as instances of "sexual abuse" - however unpleasant they were - and will not report them spontaneously to a clinician unless specifically asked about the occurrence of such situations.

The escalating trend for reported experience of sexual abuse/assault over the four years, particularly for Unit A, deserves comment. It was noted that, with admissions to Unit A, clinicians were more systematic in eliciting information about sexual abuse and assault in 1989 and 1990 than in previous years. Thus, the apparent upward trend is more likely to reflect a growing awareness among clinicians of the possibility of abuse/assault as a salient factor in a patient's history and a greater conscientiousness in giving time to this in clerking, than reflecting a real increase in occurrence.

CASE EXAMPLES

Representative extracts of clinical material were drawn from the cases of women with a history of sexual abuse or rape. The purpose was to provide narrative responses, drawn from naturally occurring material, illustrating the experience of stigmatic effects. All identifying data have been changed. Case material has been edited, but not altered or interpreted.

Case 1

Vivian, a 25-year-old, single, nursing sister who lives alone, was referred four days after a violent rape by a friend's husband. She presented with continual crying, recurrent nightmares, decreased sleep, loss of appetite, one episode of bedwetting and persistent recollections of an experience at age 10 when a friend of her parents had rubbed his penis against her while she was in bed one night. The rape was her first experience of sexual intercourse.

As reported in the clerking notes, Vivian had gone to a party one evening with a girlfriend who wanted to stay on when Vivian asked to leave at 11:30 pm. Faced with walking home, she accepted a lift from another friend's husband. He saw her to her flat and they chatted inside, with the door open, for about 10 minutes. She then thanked him and asked him to leave. He jumped up, locked the door and said, "Ek gaan jou nou naai". She pleaded and rationalised but he grabbed her around the neck and punched the side of her head. She lost consciousness for some 10 minutes. He then raped her between two and four times while holding a knife to her throat, and inserted his penis into her mouth twice. She continued to struggle and was repeatedly beaten and punched. The episode lasted one-and-a-half hours until she managed to signal through a window to some neighbours who had been alerted by the noise. The rapist fled through the back door. The police were summoned and she was taken to a general hospital overnight. She was later referred to Unit A when it became clear that she was not coping.

In the clerking interview, she reported feeling dirty, unclean, humiliated and guilty and she suspected others were looking at her. She also felt abused, very angry, and scared of men. In the first few weeks of individual and group therapy she continued to feel violated, dirty and degraded. She feared what people would think of her when she returned to her home town and worried that they would talk about and judge her experience. She reported feeling guilty, that people would say that she must have led the rapist on, seeing that he was a married man. She also expressed much anxiety about her future: would she have sexual problems? What would her husband say if she were to get married? Would he continually refer to the experience when angry?

Case 2

Jennifer, a 40-year-old, recently separated mother of two, was referred to Unit A for depression relating to longstanding marital problems. Her case history revealed that at age 23 she was raped while walking home one evening, by her boyfriend's friend who was accompanying her. He had pushed her to the ground and held her down despite her resistance. She reported that she had trusted him and that it was her first experience of sexual intercourse. She

fell pregnant and her boyfriend and the friend arranged a backstreet abortion. She experienced the rape and abortion as "traumatic" and, as a practising Catholic, felt very guilty. She felt "desperate and alone", did not report the rape and told no-one else about it.

Her boyfriend, who had previously pursued her, called her a "whore" and said that he would marry her as no one else would have her now. She reported that she did not love him but also believed that no one would want her after what had happened - at least he knew about the episode - and she married him one year later.

Case 3

Marilyn, a 32-year-old, single, unemployed secretary referred to Unit A for depression, reported to her clinician that her first and only experience of sexual intercourse was when she was raped at age 25 by a male colleague at work. She did not report the incident and told only her father (her mother was deceased) who blamed her and stated, "women like you should be thrown with stones". At the time she felt "filthy".

Case 4

Jennifer, a 16-year-old scholar, living at home, was referred to Unit B with an eating disorder and depression. Salient factors in her history were that she had been sexually molested at age seven by a 10-year-old neighbour, and raped at age 10 by a friend's father. She kept this incident a secret. She engaged in promiscuous sexual behaviour from 13 years onwards, often with men about 10 years her senior - in her words, to punish herself as it always recalled the rape and made her feel like "trash".

Case 5

Susan, a married housewife with three children, was referred to Unit B for debilitating depression. On clerking, she reported nothing of note in her sexual history. However, in the course of therapy, it emerged that she had been sexually molested as a child (no details recorded) and had never previously disclosed her experience. The clinical notes record that she felt "dirty and ashamed" and that she felt it to be her "intimate secret".

Case 6

Avril, a 22-year-old, single, receptionist was referred to Unit B for dysthymia. She was referred via another psychiatric unit where, on admission, she had disclosed for the first time a history of incestuous abuse. The clinical notes record that between 13 and 15 years old she was forced by her stepfather to engage in oral sex. He insisted that she keep it secret and she did not tell her mother for fear of being blamed. The abuse ended when she got a steady boyfriend. Her parents divorced when she was 19 years old and she moved in with her stepfather "who needed her and made her feel special". He then started to make repeated sexual overtures when inebriated, which she resisted, culminating in a violent attempted rape several months prior to her admission.

She reported that after the abuse started she felt sex was "dirty" and she felt guilty and defiled. She had sexual intercourse with her first boyfriend at age 15 and reported that at age 19 she took on many sexual partners and "behaved like a slut".

Discussion and Conclusions

These cases are broadly representative of the range of sexual assault experiences reported in the clinical records. Cases where rape precipitated psychiatric admission were rare. However, as in Cases 2 to 5 presented here - although it may not be clear from the brief clinical extracts - history of sexual assault was often clearly implicated in the aetiology of the patient's presenting complaints.

In all the cases presented, stigmatic effects were an important part of the patient's response to the sexual assault. In five of the cases there had been no or limited disclosure after the assault due to feelings of shame and guilt and expectations of being blamed and denigrated. In Cases 2 and 3, stigmatizing responses of significant others confirmed and exacerbated the patients' feelings of guilt, isolation and the need to maintain silence. In Case 1, stigmatic effects - largely internalised or "in the victim's head" - played a central role in her post-traumatic experience. Part of her immediate response were feelings of being dirty, unclean, humiliated and guilty. (The effects of a previous undisclosed episode of childhood abuse are likely to have contributed to this reaction). In a situation where clearly she was not blameworthy, she assumed - on the basis of being a single woman and her assailant a married man - that others would hold her responsible for what had happened. Her concerns about future relationships, while realistic at that stage of her recovery, also attest to stigmatizing notions of rape victims being unacceptable and "used goods". In Cases 4 and 6, the young women's sexual promiscuity can be understood in terms of a self-fulfilling prophecy, their acting out of the role of "spoiled goods" through their awareness of prevailing social expectations of "the kind of girl" who is raped.

While the figures for sexual abuse and rape obtained in this study may be lower than those reported elsewhere, they nonetheless represent a considerable number of women. The clinical extracts attest to these women's experiences of stigmatic effects, both internalised notions of damage and shame and devaluing, stereotyped reactions of others. It is the latter that the following attitudinal study examined.

CHAPTER 3 ATTITUDINAL STUDY

AIMS AND RATIONALE

The primary aim of this study, which utilized the vignette methodology introduced by Jones and Aronson (1973), was to examine whether gender and experience of sexual assault affects the degree to which female rape victims are stigmatized. Stigmatizing attitudes are widely reported and have been shown to impact directly and indirectly on the victim's responses to the assault (Levett, 1981; Weis & Borges, 1975). Employing a hypothetical scenario is a useful means of gaining insight into what a victim may experience after an assault by defining the probable social norms and judgements with which she must cope and which prepare her to be an unwitting accomplice in her own stigmatization.

Subject gender has been found in some (but not all) studies to influence responses to rape victims, although the direction of the effect has not been consistently demonstrated (Macrae & Shepherd, 1989; Tetreault & Barnett, 1987). In the present study, differences in the responses of men and women were investigated, with no clear expectations about outcome. Prior experience with rape has also been demonstrated to influence victim perception and to negate gender effects (Remer & Witten, 1988) and was thus included as a control variable. On the basis of prior research (Barnett, Sinisi & Quackenbush, 1991) it was hypothesized that subjects who had had experience with sexual assault would be less likely to endorse stigmatizing responses.

The dependent variable was a stigma scale comprising 18 items generated to tap victim devaluation, judgements about the victim's social inconsistency and expectations of disrupted interactions with her, and the likelihood of/need for secrecy around the assault. These three themes or dimensions of reactions to stigmas (referred to as Devaluation, Disruption and Secrecy) were drawn from current rape and stigma literature as reflecting attitudes and related behaviours most commonly experienced by rape victims as socially stigmatizing and as representing aspects of self-stigmatization.

Respondents were undergraduate teacher training college and university students. This sample was chosen for two reasons. Firstly, as educated young men and women - future teachers, lawyers, health professionals - their attitudes will influence the attitudes of others and the kind of social reception sexual assault victims can expect. Secondly, women in the 16-24 year old age group are a high-risk group for rape by virtue of their age (Koss, Dinero, Seibel & Cox, 1988) and thus stigmatic effects would be tapped among men and women for whom the issue of rape is highly pertinent.

Relatively few standardized psychometric instruments in the assessment of rape attitudes exist (the most prominent work in this field is by Burt, 1980; Feild, 1978; Larsen & Long, 1988; Ward, 1988) and none relates specifically to stigmatic effects. A secondary objective of the study was to investigate, post hoc, the dimensionality of the scale to determine psychometric support for the theoretically-based model of stigma utilized in the study and to assess its usefulness for future research. Thus, while the overall internal consistency of the scale was not expected to be high, given the heterogeneity of the operational definition of stigma, statistical evidence for the internal consistency or validity of the dimensions was sought.

METHOD

SUBJECTS

The sample comprised 100 white South African university (63%) and teacher training college (37%) students, 50 male and 50 female. The average age of the sample was 19.9 years (range 18 to 24 years) and the majority were unmarried (98%). The home language for 97% was English and undergraduate students (first to third year) comprised 92% of the sample. Sixty-six percent came from the Western Cape, 13% from Pretoria/Witwatersrand and the remaining 11% from Natal, the Eastern Cape, Orange Free State and Zimbabwe.

Of the approximately 120 teacher training college students invited to participate in the study, there were 37 volunteers. When these subjects were informed that the research involved attitudes towards sexual assault and that they could withdraw at any stage, all agreed to continue and, apart from sporadic missing data, completed the questionnaire. Similarly, with university students, while six

men and one woman refused to participate, all refusals occurred before the researcher had informed them of the specific topic of the research. In other words, there were no refusals on the basis of the research pertaining to sexual assault.

MATERIALS

The questionnaire (see Appendix A) comprised a vignette followed by 18 questions (i.e., the stigma scale) which referred to it, a further two questions eliciting information about previous sexual assault experience and a final open-ended question eliciting perceived reasons for rejection of rape victims.

The vignette (See Appendix A) depicted an acquaintance rape scenario. Recent research shows that many women who are raped know the attacker (Koss et al., 1988) and "date rape" is an issue of particular concern on campuses. In parenthesis, after the vignette, a definition of rape was given, taken from the work of Koss (1985): "Rape: Oral, anal or vaginal intercourse submitted to against one's will through the use of force, or threat of force". The 18-item stigma scale comprised statements concerning stigmatizing attitudes, with responses elicited on a 6-point Likert scale, from 1 = strongly disagree, to 6 = strongly agree). The scale was reversed every few questions (i.e., 1 = strongly agree, etc.) to prevent patterning of responses (see Appendix A for complete Likert scale).

The 18-item scale was drawn from a larger original pool of items generated to tap stigmatic effects of rape with emphasis on attitudes that reflect the three themes of Devaluation, Social Disruption and Secrecy. Items were based on typical statements and ideas associated with stigmatic effects extracted from current literature, particularly studies which have identified these attitudes and associated behaviours as being experienced by victims as stigmatizing or as representing aspects of self-stigmatization. The victim devaluation dimension contained items most commonly associated with the notion of stigma. Approximately 21 items were then selected in discussion with a senior psychologist familiar with work in the area. The researcher administered these items in random order to five associates, asking them to assign each item to whichever of the abovementioned three stigma themes they felt it most appropriately belonged. On the basis of their responses, 18

items were retained. Two of the final items were taken from Levett and Kuhn's (1991) attitude study (questions 5 and 13) and one item (question 7) from Feild's (1978) Attitudes towards Rape Scale, also included in Ward's (1988) Attitudes toward Rape Victims Scale. These items were modified slightly. Items 3,5,7,10,13 and 16 were intended to measure victim devaluation, items 1,4,9,11,14 and 17 social disruption and items 2,6,8,12,15 and 18 the dimension of silence/secrecy (see Appendix A for complete items). Items were randomly mixed to prevent a response to one Secrecy item, for example, too directly influencing a response to another similar item. Space was made available after each question for subjects to clarify their responses.

Two questions following the stigma scale were concerned with subjects' previous experience of sexual assault. The first defined sexual assault as "forced sexual contact at any age, without consent, involving touching or penetration" (taken from Schur, 1983) and asked subjects to indicate their level of sexual assault experience on a 6-point scale. Subjects who endorsed responses 1 to 5 (i.e., had been sexually assaulted themselves or knew somebody who had been) were asked to answer a second question measuring the extent to which the sexual assault experience affected them emotionally on a 6-point scale (1 = not at all, to 6 = extremely). (See Appendix A for complete items).

A final, open-ended question asked respondents to give possible reasons why some people do not like to be around someone who has been raped/sexually assaulted. This question was not intended for direct analysis and was included to elicit ideas relating to rejection - an aspect of stigma not directly measured by the stigma scale - in case these helped to explain or clarify other findings.

PROCEDURE

Questionnaire administration

Permission for access to the two student populations was gained from the respective institutional authorities.

At the teachers' training college, the researcher addressed a group of approximately 120 students asking for volunteers to complete a short attitude questionnaire as part of a Masters level psychology research project. Anonymity was stressed. At this stage sexual

assault was not mentioned to reduce the possibility of a self-selected sample related specifically to experience of this kind. Owing to the nature of the study, much care was paid to ethical considerations. Participants who met with the researcher later the same day, were informed that the questionnaire concerned attitudes toward sexual assault and that they were free to withdraw at any stage. They were handed a self-administered questionnaire which they completed immediately.

University students were approached individually by the researcher as they sat studying in the university library and were asked to participate in a psychology Masters research project by completing a questionnaire concerning attitudes towards sexual assault. Anonymity was stressed. Those who agreed were given the self-administered questionnaire to complete immediately and were asked to leave it face down on their desk for the researcher to collect within the half-hour.

The questionnaire was self-administered. The front page introduced the study in general terms. The second page elicited subject-related information while preserving anonymity. Instructions at the top of the third page requested participants to read the scenario below and answer all the questions which followed it, circling the number which reflected their response. They were told that there were no right or wrong answers, that their own immediate response was what was required, and that space was provided after each question should they wish to clarify their answers. The vignette, 18-item stigma scale, and the additional questions followed. On a separate page at the end of the questionnaire subjects were asked to write their name and telephone number if they wanted or were willing to talk more about the issues addressed in the questionnaire. Confidentiality was assured. This had two purposes. Firstly, on ethical grounds, a means to follow-up subjects who wished for it was required. Secondly, this group provided a sub-sample for retesting.

Item Scoring

Items 1,2,4,7,8,12,14 and 17 of the stigma scale were scored on a 6-point scale from 1 = strongly disagree, to 6 = strongly agree. The reversed Likert scale (i.e., 1 = strongly agree, etc.) for items 3,5,6,9,10,11,13,15,16 and 18 was recoded and items scored as

for the rest. Individual item scores were then totalled, giving the stigma scale a range of 18-108 (i.e., 18 items, lowest possible score per item = 1, highest possible score per item = 6). The format of the Likert response scale forced subjects into "agree" or "disagree" response categories (i.e., no "neutral" choice permitted). Since agreement to a stigmatizing item was indicated by a response of 4,5 or 6, total scores of 72 and above (i.e., 4 x 18 = 72) were taken to represent the stigmatizing range.

The question eliciting information about subjects' previous sexual assault experience was scored on a 6-point scale. Scoring was reversed for data analysis with 1 = no personal sexual assault experience, to 6 = have been sexually assaulted yourself. Where subjects indicated more than one type of experience (e.g., sexually assaulted themselves and had been told by someone else of their experience) the more direct experience was scored.

Follow-up contact

All subjects ($n = 19$) who gave their names were telephoned by the researcher and asked if there was anything further they wanted to discuss about the questionnaire. Fifteen responded negatively, saying that they had provided their names in case they could be of further help; two participants elaborated on difficulties they had had in answering the questions because so little information had been provided about the protagonists; and two women (both with a history of personal sexual assault) indicated that they would like to talk more in person about the questionnaire. Meetings were arranged with each of these participants where they both spoke about their past experiences in relation to the issues addressed in the questionnaire. The researcher felt that neither required therapeutic intervention.

Test-retest procedure

For test-retest reliability purposes, all participants who gave their names (with the exception of the last two mentioned above) were asked at the end of the telephone interview if they were prepared to complete the questionnaire again approximately one month hence. All 17 agreed. Sixteen of these were successfully contacted after the lapsed time and the questionnaire was readministered individually at the college, university or in participants' homes. Participants were instructed not to answer

the final open-ended question and were reminded to give their immediate response and not to try and recall how they had answered previously.

Feedback of results to college participants

By arrangement with the college administration it was agreed that the researcher would feedback the results of the study to interested participants. This was done.

RESULTS

SECTION 1: ANALYSIS OF ATTITUDINAL DATA

While post hoc item analysis indicated that items 3 and 6 of the scale correlated $<.20$ with total stigma score, these questions were included in the data analysis. On an attitude scale of this type, a person's response to each question is in part influenced by all the preceding questions. Thus, it was felt that omitting certain questions would constitute an uncontrolled variable. On the basis of equivocal psychometric evidence for the scale's dimensionality as postulated (reported in Section 2 of the Results) the sub-scales of Devaluation, Disruption and Secrecy were not analysed as separate dependent variables.

Summary statistics

The independent variables were subject gender and educational affiliation (college or university). While the latter was not of experimental interest, it was included in the initial analysis to ensure that it was not a source of uncontrolled variance. Previous sexual assault experience, included as a control variable, was treated correlationally and as a covariate. The dependent variables were overall stigma score (comprising 18 stigma items) and individual stigma items. Out of 100 subjects, 94 had complete data on total stigma score. Due to missing values on some of the questions, 6 cases were omitted.

The mean total stigma score for the student sample ($N = 94$) was 70.94 ($SD = 7.4$, range = 51-89). The range of possible total stigma scores was 18 to 108, with the stigmatizing response range taken to be 72 and above. Thus, the mean total stigma score obtained falls just outside the stigmatizing range. The mean for male participants was 70.98, $SD = 7.45$ ($n = 45$) and for females 70.90, $SD = 7.44$

($n = 49$). Mean item scores are presented in Table 3.1: eight of the 18 stigma items had mean scores ≥ 4.0 , implying a stigmatizing response.

Table 3.1

Mean Scores for Stigma Items

Item	Mean M	St.Dev. SD
1. Jane's experience will make it difficult for her to relate to people as she did before.	5.18 ^a	0.72
2. People who know about Jane's rape will probably avoid discussing it with her.	4.48 ^a	0.96
3. If they knew about what had happened, Jane's lecturers would be more lenient with her than with other students.	3.40	1.15
4. Jane's behaviour is likely to be unpredictable after the assault.	4.29 ^a	1.09
5. Jane is likely to feel dirty and contaminated after the assault.	5.16 ^a	1.09
6. Jane's rape experience should be kept secret.	2.52	1.38
7. A raped woman is a less desirable woman to many men.	3.31	1.31
8. Jane will only discuss the rape with her closest friend or her mother.	4.26 ^a	1.09
9. If Jane were an acquaintance of yours, you would find it difficult to act naturally around her after hearing about the incident.	3.47	1.42
10. Jane's reputation is likely to suffer after the rape as some people may feel that is was her fault.	3.67	1.38
11. When a woman has been raped, she is likely to burst into tears at the slightest provocation.	3.51	1.08
12. It is likely that Jane will not discuss her experience with anyone.	3.55	1.16
13. Jane is likely to feel guilty or ashamed after the assault.	4.70 ^a	1.11
14. After someone has had the kind of experience Jane has had, she will probably make unexpected changes in her lifestyle/daily routine.	4.60 ^a	1.05
15. Jane is unlikely to report this incident to the police.	3.55	1.26
16. Jane is likely to feel like "spoiled goods" after the assault.	4.70 ^a	0.82
17. If Jane were an acquaintance of yours, you would not know what to do to help her get over the incident.	3.47	1.44
18. It is not likely that Jane will tell her boyfriend about the rape.	3.18	1.33

Note. Items scored on a 6-point scale ranging from 1 = strongly disagree, to 6 = strongly agree.

^a Mean scores falling within the stigmatizing response range for individual items.

Individual Items

Victim Devaluation

Three questions embodying notions commonsensically associated with socially and self-stigmatizing attitudes elicited consistently highly stigmatizing responses in contrast to the more varied responses elicited for other questions. Forty-seven percent of all subjects attributed the highest possible "dirty and contaminated" score of 6 to the victim ($M = 5.2$) and 94% of all subjects endorsed stigmatizing responses (i.e., 4, 5 or 6). Test-retest correlation for this item was high with Pearson's $r(14) = .87$, $p < .01$. For the two questions referring to how guilty or ashamed, and how much like "spoiled goods" the victim is likely to feel after the assault, 47% and 46% respectively of all subjects attributed the second highest score of 5 to the victim (both $M_s = 4.7$), and 89% and 94% respectively of all subjects endorsed responses in the stigmatizing range. Levett and Kuhn's (1991) findings for the "ashamed" item are comparable; they reported that 48.6% of subjects attributed the

highest possible "ashamed" score to the victim, and 92% fell into the top half of the distribution of responses.

While some subjects qualified their responses by commenting that the extent to which the victim would experience the above self-attitudes depended on the kind of person she was, how much she blamed herself (etc.), others (at least 11% of subjects who wrote comments) stated that to feel guilty or ashamed, like "spoiled goods" or dirty and contaminated after such an assault are "normal", "natural", "instinctive" responses which "most" rape victims feel. Illustrative comments include, "Rape is vulgar and anyone who is raped... has the right to feel dirty"; "I agree [that she will feel dirty and contaminated], especially if she knows that other people around her are aware of her experience". However, a small number of respondents ($n = 3$) indicated an awareness of socially dictated responses, for example, "Women have been told that they are 'spoiled goods' after a rape - no matter if she was the victim or not"; "those are the feelings [i.e., dirty and contaminated] we're told to feel"; and, in response to the "guilty or ashamed" item, "Females are stereotyped and told that only bad things happen to bad girls".

The question eliciting the extent to which subjects believed a raped woman to be a less desirable woman to many men demonstrated a non-stigmatizing response overall ($M = 3.3$) and a wide range of responses (48.5% respondents disagreed with this attitude, 51.5% agreed). Interestingly, this item, more than any of the others dealing with victim devaluation, prompted spontaneous comments from subjects referring to victim stigmatization. Examples include, "It should not be the case, but rape has a negative stigma..." ; "Common perception from a man - she is 'used goods'" [this comment was made before the item mentioning "spoiled goods"]; "As much as it is ludicrous, men who value innocence could find the woman contaminated"; "[Yes], Because of the stigma attached to rape".

Concerning the question of whether the victim's lecturers would be more lenient with her than with other students after the assault, the overall mean score of 3.4 indicated non-endorsement on average of this response, while 41% of subjects indicated their disagreement more or less strongly. Respondents' qualifying comments are again elucidating, suggesting that for some, at least,

their vested interest as "fellow" students influenced their attitudes. An example reads, "There are many students striving for similar goals - many girls are raped, if every lecturer was lenient to girls who had been sexually assaulted this would be very unfair". In a different sample, the response might have been different.

Social discomfort and disruption

Subjects' attributions of the victim's predictability and stability in social interactions tended to be consistently negative. Eighty-six percent of all subjects endorsed the highest or second highest possible response pertaining to the victim's difficulties in relating socially as she used ($\bar{M} = 5.2$); 69% of all respondents agreed more or less strongly that her behaviour was likely to be unpredictable after the assault ($\bar{M} = 4.3$), and 79% of respondents that she was likely to make unexpected changes in her lifestyle after the assault ($\bar{M} = 4.6$). However, the two questions asking for subjects' perceived personal difficulties in acting naturally around the victim after hearing about the incident and in knowing how to help her get over the incident, elicited a wider range of responses with lower overall mean scores ($\bar{M} = 3.5$ for both questions). The issue of social desirability is implicated.

Silence and secrecy

The majority of subjects indicated agreement (more or less strongly) with the statements that people who knew about the rape would avoid discussing it (81%, $\bar{M} = 4.5$), that the victim would be likely only to discuss the rape with her closest friend or her mother (80%, $\bar{M} = 4.3$), and 51% that she would not discuss it with anyone ($\bar{M} = 3.5$). However, 78% of all respondents disagreed that the rape should be kept secret ($\bar{M} = 2.5$). It would thus appear that subjects personally endorsed secretiveness less strongly than they attributed it to others and to the rape victim herself. However, scrutiny of subjects' qualifying comments on this question suggests that the Likert scale responses may have been misleading, since many subjects who did not endorse secrecy still felt that only certain people should know and that the victim's identity should be protected. At least 25% of 70 subjects who commented on this item indicated that while they believed the victim should talk to family, close friends, a counsellor or the police, the incident should not be made public (except as a statistic) and her anonymity

should be preserved. Illustrative comments are, "Not the fact that there was a rape, but Jane herself should be protected from publicity"; "It would be easier for her if people didn't know. People will feel uncomfortable around her knowing what happened"; "It should be kept secret that it happened to Jane, but what happened should not"; "... one does not go public with news of this nature"; "Better for her family [to keep it secret]". Thus, while the question was a useful one, the wording was perhaps not sufficiently clear.

Interaction between subject gender and educational affiliation

No effects were expected to result from students' educational affiliation (university versus teachers' training college) since both groups were similar in terms of age, race and educational level. However, to clarify the picture, data were initially analysed with a 2 (subject gender) x 2 (college versus university) analysis of variance (ANOVA). The results were all negative. There was no significant gender by educational affiliation interaction ($F [1,90] = .43, p = .51$) and no significant main effects for gender ($F [1,90] = .05, p = .83$) or for education ($F [1,90] = .00, p = .99$). See Appendix C for table of cell means and ANOVA summary table.

Gender differences

The results of the two-way ANOVA indicated that the degree of stigma assigned to the rape victim by men did not differ significantly from that assigned by female subjects in general. However, on scales of this kind, analyses based on total (averaged) scores can obscure more specific differences. Particularly since psychometric data pointed to the heterogeneity of items, gender differences on individual questions were investigated. Since 18 items were under examination, resulting in repeated comparisons, the difficulty of an inflated Type I error rate was pertinent (Howell, 1987, p. 326). To control this, a multivariate analysis of variance (MANOVA) was utilized.¹ Since a significant overall gender difference was obtained ($F[18,75] = 2.29, p = .0068$) univariate tests of significance were performed to establish on

1 While the error rate has been controlled for in this procedure, the familywise or experimentwise error rate in an exploratory study such as this - where sets of comparisons are run - remains a difficulty. I have attempted to provide a measure of control by calculating exact p values instead of employing the $p = .05$ criterion.

which items the gender differences occurred. The MANOVA summary table and summary tables for the significant univariate F -tests (items 2,6,10,11 and 16) are set out in Appendix C.

Women attributed greater feelings of devaluation to the victim than men, endorsing the response that she is likely to feel like "spoiled goods" ($M = 4.92$) more strongly than did male subjects ($M = 4.49$, $F(1,92) = 8.25$, $p = .005$). Women also believed with greater conviction that the victim's reputation is likely to suffer after the assault as some people would feel it was her fault (female $M = 4.08$, male $M = 3.25$, $F(1,92) = 10.0$, $p = .002$). There was no significant gender difference on the question concerning how dirty and contaminated the victim would feel after the assault ($F[1,92] = .00$, $p = .956$). On the same question, Levett and Kuhn (1991) did find gender differences reflected, although these occurred in interaction with assailant race and class. Similarly, where Ward (1988) demonstrated that men judged a raped woman as a less desirable woman than did female subjects, this finding was not replicated here in response to the slightly modified item ("A raped woman is a less desirable woman to many men").

Concerning expectations of social disruption/discomfort, only one question elicited gender differences. While both the male and female average response fell into the non-stigmatizing range on item 11 (male $M = 3.3$, female $M = 3.7$) men disagreed less strongly that when a woman has been raped she is likely to burst into tears at the slightest provocation ($F[1,92] = 4.53$, $p = .036$).

Two of the questions concerning silence around the rape, elicited significant gender differences. Male respondents believed more strongly than females that people who knew about the victim's rape would avoid discussing it with her (male $M = 4.7$, female $M = 4.3$, $F(1,92) = 5.88$, $p = .017$). While both men and women disagreed on average that the victim's experience should be kept secret (male $M = 2.9$, female $M = 2.1$) male respondents disagreed less strongly ($F[1,92] = 8.98$, $p = .0035$).

Personal experience with sexual assault

Two female subjects did not answer the question. Of the remainder ($N = 98$) 70% ($n = 69$) reported that they had been sexually assaulted or that they knew someone who had been. Of these, 18.8%

($n = 13$) reported more than one previous exposure. Of the 48 women respondents, 18.8% ($n = 9$) reported having been sexually assaulted themselves, with 4% ($n = 2$) of the 50 male respondents identifying themselves as victims of rape. Excluding self-identified sexual assault victims, 59.2% ($n = 58$) reported knowing a sexual assault victim and 29.6% ($n = 29$) that they had no personal experience of sexual assault (five of these commented that they had, however, had substantial media exposure).

Sixty-seven of the 69 subjects who reported experience of sexual assault completed the subsequent question relating to the emotional impact of the experience. Correlation with the sexual assault experience item was significant (Spearman's $r_s(65) = .358, p < .01$). Remembering that the scale for the sexual assault experience item was reversed for analysis, a low but significant correlation suggests a trend towards more direct experience of sexual assault having stronger emotional impact.

For the total sample, the correlation between previous sexual assault experience (of any degree) and total stigma score was significant (Pearson's $r(96) = -.23, p < .01$). In other words, the more direct subjects' experience of sexual assault, the less they tended to stigmatize the rape victim. Again, the correlation is low and the finding must be regarded as a trend only. One-way analysis of covariance (ANACOVA) was carried out to investigate whether, if the variance that can be attributed to sexual assault experience is removed, we have a clearer picture of effects of subject gender on stigma score. Non-significant results ($F[1,89] = .50, p = .48$) indicated that personal experience with sexual assault was not obscuring possible gender effects. (Kerlinger [1985] indicates that where correlations fall below $p < .05$, analysis of covariance is unlikely to provide further elucidation). The ANACOVA summary table is set out in Appendix C.

Data on the sexual assault experience item were then recoded, dividing subjects into two groups, those who had identified themselves as sexual assault victims ($n = 11$) and those who had not ($n = 87$) and total stigma scores were compared using an independent two-tailed t test. The difference between the two groups' overall endorsement of stigmatic effects ($M_s = 67.55$ and 71.42 respectively, $t[12] = -1.61, p = .13$) was not significant. Data

were recoded again, further differentiating subjects on the basis of their degree of exposure to sexual assault (i.e., no experience of sexual assault, acquaintance with a victim, personal experience of sexual assault). Total stigma scores were then analysed in a 2 x 3 (gender by sexual assault experience) analysis of variance (ANOVA). There was no significant interaction ($F[2,86] = .41, p = .67$) and no significant main effect for gender ($F[1,86] = .05, p = .82$), or for sexual assault experience ($F[2,86] = .50, p = .61$). Cell and marginal Ms and SDs, and the ANOVA summary table are set out in Appendix C.

Summary of results

Mean total stigma score for the sample was 70.94 (SD = 7.4, range = 51-89) which falls just outside the stigmatizing response range of 72 and above (scale range = 18-108). Male M = 70.98 (SD = 7.45) and female M = 70.90 (SD = 7.44). Eight of the 18 stigma items had mean scores falling in the stigmatizing response range for items (i.e., a score of 4,5 or 6) and three items embodying notions commonly associated with stigma (i.e., "spoiled goods", dirty and contaminated, guilty or ashamed) were consistently strongly endorsed by the majority of subjects.

There was no significant interaction between subject gender and educational affiliation (i.e., college/university) and no significant main effect for either variable on total stigma score. Significant gender differences on five individual items were found: women attributed stronger feelings of devaluation to the victim than men on items 10 and 16; men disagreed less strongly than women that when a woman has been raped she is likely to burst into tears at the slightest provocation (item 11); and men endorsed silence around the rape more emphatically than women on items 2 and 6.

A weak positive correlation exists between degree of sexual assault experience and strength of emotional impact. A weak negative correlation was found between sexual assault experience and stigma score (i.e., the more direct the experience of sexual assault, the less the tendency to endorse stigmatic responses.) Variance in subjects' experience of sexual assault was not found to be obscuring gender differences.

SECTION 2: STIGMA SCALE VALIDITY AND RELIABILITY**Validity****Item Analysis**

Item analysis was performed (a) to investigate statistically the scale's homogeneity or heterogeneity; (b) to establish which, if any, items might be influencing the study findings due to low correlations with total test score; (c) to establish whether a priori theory-based hypothesized item groupings (dimensions) correspond to actual item groupings.

Pearson's product moment correlations for items with total stigma score (questions 1 to 18 summed) are set out in Table 3.2, grouped according to the a priori dimensions, Devaluation, Disruption and Secrecy, each comprising 6 items. Two items (3 and 6) correlate $<.2$. A correlation of $<.3$, rounded off, is a commonly used criterion for exclusion of items in scale construction (Ward, 1988). The uniformly low item-total correlations point to the heterogeneity of the scale.

Table 3.2

Item-Total Correlations: Items with Total Stigma Score

Devaluation Questions	Total Stigma	Disruption Questions	Total Stigma	Secrecy Questions	Total Stigma
3	.20	1	.28*	2	.28*
5	.35*	4	.32*	6	.12
7	.55*	9	.36*	8	.37*
10	.29*	11	.45*	12	.30*
13	.57*	14	.39*	15	.38*
16	.33*	17	.35*	18	.49*

Note. n = 94. * $p < .01$, two-tailed, Pearson's product-moment correlation coefficient; df = 92.

Dimension item-total correlations are presented in Table 3.3, together with correlations of items with total scores for alternative dimensions (e.g., Devaluation items with total Disruption score). The trend of higher within-dimension item-total correlations provides some evidence for content validity of the scale's dimensionality. While these correlations are significant, they are still uniformly low which suggests that the dimensions themselves are not homogeneous. Dimension inter-correlations and correlations with total stigma score are presented in Table 3.4.

Table 3.3

Item-Total Correlations: Items with Total Dimension Scores

Total Devaluation		Total Disruption		Total Secrecy	
Devaluation 3 items	.42**	Disruption 1 items	.43**	Secrecy 2 items	.36**
5	.51**	4	.40**	6	.40**
7	.61**	9	.54**	8	.44**
10	.52**	11	.49**	12	.56**
13	.56**	14	.54**	15	.52**
16	.49**	17	.55**	18	.56**
Disruption 1 items	.18	Devaluation 3 items	.02	Devaluation 3 items	-.01
4	.20	5	.12	5	.10
9	.10	7	.36**	7	.18
11	.25*	10	.02	10	.08
14	.17	13	.26*	13	.36**
17	-.002	16	.03	16	.17
Secrecy 2 items	.19	Secrecy 2 items	.04	Disruption 1 items	-.01
6	-.05	6	-.07	4	.07
8	.06	8	.27**	9	.14
12	.11	12	-.02	11	.18
15	.13	15	.18	14	.07
18	.26*	18	.26*	17	.17

* $p < .05$. ** $p < .01$, two-tailed.

Table 3.4

Dimension Inter-correlations and Correlations with Total Stigma Score

	Devaluation	Disruption	Secrecy
Disruption	.28*		
Secrecy	.24*	.23*	
Stigma	.73**	.71**	.69**

* $p < .05$. ** $p < .01$, two-tailed.

Factor Analysis

Factor analysis (principal axis factoring) was also performed on the 18-item stigma scale to investigate its dimensionality. The unrotated solution produced five factors according to the Proportion criterion. Of these, two factors were retained on the basis of Kaiser's criterion (Kim & Mueller, 1978) and three using a scree test (see Appendix C). Factor 1 (eigenvalue = 2.07) accounted for 37.4% of the variance, factor 2 (eigenvalue = 1.38) for 24.9% and factor 3 (eigenvalue = .83) for 15%. Only items with loadings $\geq .30$ were retained (Kerlinger, 1985). The three factors did not

mirror the hypothesized dimensions. Results of the unrotated principal axis factoring are presented in Table 3.5.

Table 3.5

Unrotated Principal Axis Factoring: Stigma Scale

Items	Factor 1	Factor 2	Factor 3	Communality
Q 13 (Dev) ^a	.61	-	-	.51
11 (Dis) ^b	.53	-	-	.30
18 (Sec) ^c	.49	-	-	.29
16 (Dev)	.49	-	-	.43
15 (Sec)	.43	-	.31	.36
14 (Dis)	.40	-	-	.29
4 (Dis)	.38	-	-.34	.31
9 (Dis)	-	.58	-	.38
7 (Dev)	.33	.49	-	.45
3 (Dev)	-	.42	-	.32
1 (Dis)	-	.38	-	.32
8 (Sec)	-	.37	-	.25
17 (Dis)	-	-	.53	.37
Eigenvalues	2.07	1.38	.83	
Proportion of variance	37.4%	24.9%	15.0%	

Note Three factors retained on the basis of the scree test.
Only items with loadings $\geq .30$ retained.

a Dev = A priori Devaluation dimension.

b Dis = A priori Disruption dimension.

c Sec = A priori Secrecy dimension.

Orthogonal varimax rotation was performed in an attempt to produce a clearer factor structure. Results are presented in Table 3.6. On the basis of this solution, four factors were retained using Kaiser's criterion, but only two using a scree test (see Appendix C). Factor 1 (eigenvalue = 1.52) accounted for 27.4% total variance; factor 2 (eigenvalue = 1.11) 20% total variance; factor 3 (eigenvalue = 1.05) 18.9% total variance; factor 4 (eigenvalue = 1.0) 18% total variance. The factors which emerged from this solution again did not confirm the hypothesized dimensions. However, the two items loading most heavily on factor 1 (items 13 and 16) are Devaluation items which allude to commonsense notions frequently associated with stigma (i.e., "spoiled goods", guilty or ashamed) and three of the four items loading on factor 2 (items 1, 4 and 14) are Social Disruption items relating to expectations that a rape victim will behave in ways that make her "different" from before.

The difficulty in interpreting the factor solutions is due in part to the unstable factor structure (evidenced possibly by the application of Kaiser's criterion and the scree test producing different numbers of factors). The unstable factor structure results from there being too few subjects for the number of items being investigated; a minimum of ten subjects per item would be needed to produce stable factors (Kerlinger, 1985).

Table 3.6

Rotated Principal Axis Factoring: Stigma Scale

Items	Factor 1	Factor 2	Factor 3	Factor 4	Communality
13 (Dev) ^a	.64	.31	-	-	.51
16 (Dev)	.62	-	-	-	.43
11 (Dis) ^b	.38	-	-	-	.30
12 (Sec) ^c	.33	-	-	-	.13
1 (Dis)	-	.51	-	-	.32
14 (Dis)	-	.44	-	-	.29
8 (Sec)	-	.43	-	-	.25
7 (Dev)	-	-	.60	-	.45
3 (Dev)	-	-	.46	-	.32
9 (Dis)	-	-	.42	-	.38
2 (Sec)	-	-	.41	-	.20
4 (Dis)	-	.31	-	.42	.31
10 (Dev)	-	-	-	.36	.25
18 (Sec)	.31	-	-	.32	.29
6 (Sec)	-	-	-	-.52	.28
Eigenvalues	1.52	1.11	1.05	1.00	
Proportion of variance	27.4%	20.0%	18.9%	18.0%	

Note. Orthogonal varimax rotation performed.
Four factors retained according to Kaiser's criterion.
Only items with loadings $\geq .30$ retained.

^a Dev = A priori Devaluation dimension.

^b Dis = A priori Disruption dimension.

^c Sec = A priori Secrecy dimension.

Reliability

(1) The internal consistency of the stigma scale was moderate with Cronbach's alpha coefficient of .58 (Ghiselli, 1981). When questions 3 and 6 were omitted from the calculation (on the basis of item-total correlations of $< .30$) Cronbach's alpha increased to .63. Cronbach's alpha for each of the three dimensions were: Devaluation = .45, Disruption = .37 and Secrecy = .30.

(2) The external reliability or stability of the stigma scale was calculated using the test-retest method with 16% ($n = 16$) of the

original sample. First administration mean score was 73.73 ($SD = 9.19$), second administration mean score was 73.9 ($SD = 9.06$). Pearson's $r(14) = .78$, $p < .01$, indicating moderately high test-retest reliability.

Summary of Results

Validity - Item analysis demonstrated that items 3 and 6 correlated very poorly with total stigma score ($< .2$) and uniformly low item-total correlations throughout point to the scale's heterogeneity.

Evidence of the hypothesized three-dimensional model of stigma is equivocal. The pattern of significant dimension item-total correlations lends some support to the model, but again uniformly low correlations suggest that the dimensions themselves are not homogenous. Unrotated and rotated principal axis factoring produced solutions which did not correspond directly to any of the three hypothesised dimensions, due in part to there being too few subjects per item to produce stable factors.

Reliability - Internal consistency was low-moderate as expected (Cronbach's $\alpha = .58$); test-retest reliability was somewhat higher (Pearson's $r(14) = .78$, $p < .01$).

CHAPTER 4 GENERAL DISCUSSION

The figures which emerged from the clinical study indicate that between 26-37% of women in the psychiatric sample had experienced sexual assault at some time in their lives. Due in most part to methodological problems, these figures are lower than those reported in other clinically and non-clinically based studies (e.g., Calhoun & Atkeson, 1991; Koss & Burkhardt, 1989; Levett, 1989b). Representative clinical case extracts suggest that for many of these women, the negative, devaluing attitudes of others, as well as internalized stigmatizing thoughts and feelings, contributed to the trauma of the experience to a lesser or greater extent. Expectations of negative social reactions, as well as negative self-evaluation, led to very limited disclosure, reporting and help-seeking at the time of the assault.

Linked to the clinical issues, the attitudinal study investigated the effect of subjects' gender and experience of sexual assault on the degree of stigma assigned to a rape victim. The results of this study must be evaluated with caution. Firstly, the sample of 100 is a small one. Secondly, linguistically-oriented psychosocial analysis, as well as feminist post-structuralist theory, suggests that situational context, emotional investment and many other variables affect who a person is in an ongoing, fluctuating way. Thus, one cannot expect consistent sets of beliefs from people, nor consistent responses at different times. Davies and Harré (1990) postulate that because of the social/grammatical construction of the person as a unitary, knowable identity, we assume it is possible to make a set of consistent choices within only one discourse. However, through language, people acquire beliefs about themselves and others which do not necessarily form a unified whole and they shift from one to another way of thinking as the discourse shifts. An individual emerges through these processes of social (conversational) interaction, not as a relatively fixed end product, but one who is constituted and reconstituted. Thus, attitudes towards stigmatized groups are continually constructed as people select, organize and evaluate their own social experiences.

SOCIAL STIGMA

The mean total stigma score for the sample fell just outside the stigmatizing response range and 8 of the 18 individual items produced stigmatizing scores. The most likely explanation for the negative trend of these findings lies in the nature of the sample. Moss and Ewing (1989) demonstrated that undergraduate subjects compared with registered voters held fewer negative attitudes towards battered women and were not as subject to gender differences. In general, it could be argued that a student sample, particularly one drawn from "liberal" tertiary establishments, could be expected to be more open-minded and questioning than the population at large and thus less likely to endorse stereotypical ideas of stigma in relation to sexual assault victims. Furthermore, the issue of sexual assault has a high profile on many university and college campuses. Notably, on the two campuses sampled, foyer displays of rape statistics and newspaper articles, posters advertising on and off campus rape crisis services, and reports of ongoing research into the problem of sexual assault on campus were observed. Broad dissemination of information about rape among the students in this study is likely further to have eroded stereotypical attitudes.

Limitations relating to the use of vignette methodology may also be implicated. While vignette methodology allows for the presentation of information to stimulate elaboration of beliefs about the subject presented, much rests on how the information is presented in the scenario. Information should be sufficient for subjects to base their judgements on but not so detailed that it directs attention away from generalized assumptions and stereotypic associations. Burt and Albin (1981) warn that while vignette methodology usefully draws on cognitive processes, information processing and stereotyping, it can also draw on the whole cultural and ideological "baggage" which surrounds rape.

Studies such as this one in which participants evaluate others from written material elicit responses which are not necessarily comparable with how participants would evaluate real people, since the dynamics of actual interactions differ greatly from vignette simulation. (However, Macrae and Shepherd [1989] cite research which suggests that stereotypical expectations may have greater

effect in the real world than in empirical studies). Attitudinal measures are more under conscious control than actual interactions and, as such, are vulnerable to socially desirable responses, especially when subjects feel that they are being evaluated. In the present study, these are suggested by the discrepancy between participants' assessment of the degree of socially disruptive behaviour likely to be engaged in by a rape victim, and their own feelings of discomfort around her (which one would expect to be related). Crocker and Major (1989) state that expressions of prejudice and discrimination (i.e., stigma) are highly socially undesirable and that behavioural measures in stigma research have been shown to reveal prejudice when attitudinal measures do not. Finally, even when no conscious attempt to deny or conceal negative attitudes is made, the ability of attitudes to predict behaviour is not consistent.

Despite the attitudinal study's failure to find a stigmatizing overall effect, the finding that almost half of the individual items elicited stigmatizing responses - together with the clinical case history material illustrating victims' experiences of stigma - provides some support for widely reported stigmatic effects of sexual assault (e.g., Green, 1988; Levett, 1981; Sanders, 1980).

The reactions of family and friends are important because part of the consequences of rape for the victim will relate directly to the nature and quality of understanding and support which she receives (Levett, 1989a). The clinical case extracts (Cases 2 and 3) pertinently illustrate this. The finding in the attitudinal study that the extent of stigmatization of the target victim was not significantly less among men and women who reported knowing sexual assault victims is particularly pertinent in this regard. While social support has long been considered integral to positive rape resolution, only recently have researchers and practitioners noted that significant others experience personal difficulties resulting from the rape which may threaten even previously stable relationships with the rape victim (Emm & McKenry, 1988; Sharma & Cheatham, 1986). Some of these difficulties relate directly to the activation of stereotypical perceptions of the victim as now being tainted and unacceptable, evoking feelings of discomfort and repulsion and even primitive fears of contamination (Levett, 1981; Symonds, 1975).

The framework of understanding set out in the introduction to this study makes sense of these reactions in terms of the social construction of emotions, which recognizes the role of culturally given or common meanings for events (Harré, 1987) and thus reflects socio-political variables which are particularly important in a feminist understanding of rape. However, an alternative framework provided by the psychoanalytic perspective, focussing on unconscious processes to understand human behaviour, offers insights that are equally invaluable in making sense of the psychological consequences and damaged relationships that may result from a rape. Rose (1988) explains the intense emotional responses of significant others to the rape victim as countertransferential responses which can profoundly affect the extent of the victim's losses resulting from the rape. Thus, for example, significant others' feelings of helplessness and vulnerability may be defended against by their openly stating how they would have acted differently to prevent the rape, which is likely to be experienced as blaming by the victim. Of particular relevance to stigmatic effects is Rose's understanding of the psychodynamics underlying the "damaged goods" attitude. She suggests that the victim is experienced by significant others as a narcissistic object that has been damaged or lost; cultural attitudes which have reflected and reinforced the attitude that women are property enhance and justify the feelings of loss. As a result, the victim is not empathized with but is instead devalued and experienced as damaged goods, of which significant others want to dispose to defend against their sense of narcissistic injury.

GENDER DIFFERENCES

The question of gender differences produced equivocal results in the attitudinal study as in previous research (e.g., Macrae & Shepherd, 1989; Burczyk & Standing, 1989). It has been suggested that because men and women are differentially threatened by rape, they could be expected to evaluate rape and rape victims differently. However, some researchers argue that gender is not necessarily a meaningful category of difference in rape studies since the ideology and myths about rape, which influence perceptions of the victim, are distributed throughout the population so that between-group differences fade in comparison with within-group differences (Burt & Albin, 1981; Tretreault &

Barnett, 1987). Furthermore, recent ideas in social psychology problematize the rigid categories of gender on which comparisons between male and female attitudes are fundamentally based (Barrett, 1987; Davies & Harré, 1990).

Devaluation and Self-Stigmatization

While there was no difference overall in the extent of stigmatization by male and female subjects, differences emerged in relation to specific questions which, despite the abovementioned reservations, have practical implications for rape victims. Importantly for the issue of self-stigmatization, social stigma relating to victim devaluation held more strongly for women than for men. Women identified more with the victim's feeling of being "spoiled goods" after the assault than did men and believed with greater conviction that her reputation was likely to suffer as some people would believe the rape was her fault. The implications of social stigma for a raped woman's self-perception have been outlined in the introductory chapter and are, perhaps, most easily understood in terms of the mechanism of self-fulfilling prophesy. Thus Renner, Wackett and Ganderton (1988) demonstrated, with reference to 231 rape cases dealt with by a rape crisis service, that increased amounts of guilt were related to being blamed more by parents and significant others and were associated with a poor level of final integration. Similarly, Levett (1989a) reported findings of a study by Elwell and Ephros (1987) which suggest that sexually abused children are more likely to have a negative definition of their situation when a great number of family and neighbours know and talk about it, particularly when insensitive comments and intrusive interventions are made.

From a social constructionist perspective, what a woman feels, thinks and does in response to rape is influenced not only by others' but also by her own conceptions of what she does or does not have the right to feel, think and do (Harré, 1987; Levett, 1989a). If a woman brings to a sexual assault experience preconceived ideas and expectations of a rape victim as "spoiled goods" or guilty and tainted, the more readily she will assimilate these notions into her self-concept and the more likely she is to act out of a sense of unworthiness and powerlessness.

Recent theoretical developments (Crocker et al., 1991; Crocker & Major, 1989) problematize the necessarily negative effects of social stigma on feelings of self-worth and self-esteem with respect to an individual's personal identity, as symbolic interactionist and self-fulfilling prophecy perspectives hold. Crocker and Major (1989) cite longstanding empirical evidence which supports the conclusion that prejudice against members of some stigmatized groups generally does not result in lowered self-esteem and explain the discrepancy by reference to self-protective attributional functions of social stigma. They acknowledge, however, that stigmas vary on a number of dimensions, some of which moderate the use of self-protective strategies, and suggest that their theory most readily applies to the stigmas of race, gender and physical handicap. Stigmas which differ considerably from these, like that of being a rape victim, inhibit the use of self-protective strategies, and leave members vulnerable to lowered self-esteem.

The moderating factors are outlined below, with comments relating to their relevance to the stigma of rape:

- (1) Time since acquisition of the stigma: Individuals recently and suddenly stigmatized lack the strategies of self-protection that membership from birth in a stigmatized group can provide. Crocker and Major would argue that when a woman is raped, it will take her time to learn to compare her outcomes with other similarly stigmatized individuals and this may never happen if she does not, for example, join a support group.
- (2) Concealability of the stigma: While individuals with concealable stigmas face less prejudice and fewer negative interactions than those with visible stigmas, they are again denied the use of ingroup comparison which relies on identification with similarly stigmatized individuals. This factor relates to the contradictory implications of non-disclosure of sexual abuse on stigmatic effects, discussed in the Introduction.
- (3) Acceptance of negative attitudes towards the stigmatized group: Those who have internalized society's negative views of their group are particularly at risk for low self-esteem.

This relates to the implications for self-labelling of the prior acceptance by rape victims of negative stereotypes about sexual assault, and appears to have been a powerful dynamic in the response of Case 1 to her rape experience.

- (4) Responsibility for the stigmatizing condition: Individuals who are judged as personally responsible for their condition are more highly stigmatized by others and blaming oneself may make a stigmatized person particularly vulnerable to low self-esteem. The issues of blame and attribution of responsibility in relation to rape have been outlined.
- (5) Centrality of stigma in the self-concept: The more a stigmatizing condition is a core aspect of a person's identity, the more likely they are to identify with other similarly stigmatized individuals and thus have access to self-esteem protecting strategies. By way of comment, it would seem that negative consequences for self-esteem are far more likely for rape victims who both accept stigmatizing attitudes and who experience the sexual assault as a violation of their sense of self, as profoundly affecting their identity (Rose, 1986; Sanders, 1980).

Social Disruption

Concerning the items tapping notions about the victim's behaviour and interactions after the assault, only one item produced a significant gender difference, with women disagreeing less strongly than men that when a woman has been raped she is likely to burst into tears at the slightest provocation. Since both men and women disagreed on average, this difference is not particularly meaningful, especially since none of the other items associated theoretically with the 'idea of disrupted social interactions following rape produced significant gender differences. This, in itself, is surprising given research findings which demonstrate that men identify less with rape victims than do women and show less empathy (Macrae & Sheperd, 1989). Logically, it would follow that men would find aspects of a woman's behaviour after rape more unpredictable than would other women, and they would be likely to feel less comfortable around her.

Secrecy

Male subjects believed more strongly than females that people who knew about the rape would avoid discussing it with the victim. This question was intended to tap ideas about silence surrounding rape but may have more to do with men's reported unease about knowing what to say to a woman who has been raped and apprehension about saying the wrong thing (Emm & McKenry, 1988) although this difference was not reflected in the Social Disruption items.

Men and women disagreed on average that a rape incident should be kept secret (although many believed that the victim's identity should not be revealed publicly because of negative societal reactions, a topical debate in the media). However, men were less sure about this than women. While pressure from women's groups and increased media coverage has undoubtedly positively influenced attitudes towards rape in some segments of the population, this gender difference in a group of people whom one might expect to hold relatively liberal and favourable attitudes towards women, may reflect still the underlying notion of women as men's sexual property. For men, keeping a rape secret may have to do with protecting the value of their property and avoiding stigma by association.

PERSONAL EXPERIENCE OF SEXUAL ASSAULT

The figure of 18.8% of women in the attitudinal study who identified themselves as victims of rape and contact sexual abuse is lower than Levett's (1989b) figure of 31% for reported prevalence of contact childhood sexual abuse in a similar sample of undergraduate women students. This may be due to methodological issues which she outlines, suggesting that while women student samples may appear - on the basis of generally low refusal rates - to be more compliant than general populations of women when asked to complete questionnaires in the classroom setting, this compliance may result from the structural power dynamic of researcher/student and the expectations in those settings for cooperation with research. Thus, feeling coerced, student participants may choose to misinform or withhold information, especially in a sensitive area of human behaviour like sexual assault where there is much to lose from disclosure. Levett addressed some of these issues by conducting her prevalence study

in the context of small-group discussion around issues of gender socialization which facilitated, rather than expected or demanded, disclosure. In this study, where no such provisions were made, it is likely that findings related to sexual assault experience were affected by the active manoeuvres of some subjects (e.g., omitting the question altogether) to avoid being forced into disclosure.

The main purpose of this question, however, was to investigate whether personal experience with sexual assault (knowing a rape victim or having been assaulted oneself) influenced subjects' endorsement of stigmatic effects of rape. Results indicated that the predicted correlation of more direct assault experience with decreased overall endorsement of stigmatizing attitudes was low, but significant, with the trend in the expected direction. While Burt (1980) and Feild (1978) demonstrated similarly negative findings, Remer and Witten (1988) found that prior rape experience influenced conceptions of rape (as more similar to assault than to love-making) and negated certain gender effects. Barnett, Sinisi and Quackenbush (1991) demonstrated that men's perceptions of a rape victim did not differ from those of female subjects in general, but from those of women who identified themselves as rape victims. In the present study, these findings were not replicated either, and although the group of self-identified women sexual assault victims had the lowest mean total stigma score, this did not differ significantly from that of the rest of the sample or subgroups within it.

An explanation for these findings could lie in the likelihood that the influence of personal experience with sexual assault on rape attitudes depends on familiarity and particularly on direct interaction with the victim at the time of the assault. In this study, of the 70% of subjects who reported some degree of previous sexual assault experience, 80% were referring to incidents they had heard about from a third party (i.e., there was no direct contact with the victim regarding the assault) or to incidents recounted to them by the victim but which had occurred in the past. While the significant but low correlation found between subjects' level of prior rape experience and its emotional impact on them does not positively support this explanation, nor does it disprove it.

There is no way to differentiate a subject who, for example, recalling being shocked when they had heard that an acquaintance had been raped, strongly endorsed the emotional impact of the experience, from another who similarly did so but on the basis of an incident in which their sister had been raped; yet the influence on attitudes towards rape of the latter experience is likely to be far greater.

In addition, as previously discussed, dissemination of information about rape and increased awareness of its consequences among the students in this study possibly obscured or weakened differences in levels of victim stigmatization that may exist, in other populations, between people who have had personal experience of rape and people who have not.

The finding that the degree of emotional effect did not correlate highly with the level of prior sexual assault experience suggests that the impact of rape - one's own or someone else's - is moderated by many factors. This issue will be drawn into the conclusions of the study.

STIGMA SCALE: PSYCHOMETRIC FINDINGS

On the basis of a theoretically-based dimensional model of stigma the questionnaire was intended to measure three areas or aspects of rape stigma: victim devaluation, social disruption and secrecy/silence around the rape. Psychometric data do not support the postulated dimensionality of the scale. Dimension item-total correlations were significant but uniformly low, and coefficients of internal consistency for dimensions were low-moderate. Unrotated and rotated principal factor analysis produced solutions which did not clearly reflect the three hypothesized dimensions. The implications are not that these aspects of the stigma of rape lack theoretical and clinical soundness, but that they do not comprise easily identifiable sets of homogeneous ideas or attitudes. In other words, the scale's item heterogeneity may reflect the heterogeneity or complexity of the definition of stigma operationalized in this study. In accord with this, the scale as a whole showed low internal consistency with somewhat higher test-retest reliability. In all, these results present the scale, as a psychometric instrument, in an equivocal light and refinement, including standardization, would be required if it were to be used

in future rape studies. Certainly that it should produce replicable results as it stands is unlikely. However, these findings are not surprising against the background of recent ideas in the social psychology of selfhood (Davies & Harré) which, by implication, cast doubt on the very meaning of validity and reliability of scales which claim to measure sets of attitudes held by people as though these were systematic and well-developed.

CHAPTER 5

CONCLUSION: CLINICAL IMPLICATIONS

Stigmatic effects contribute to every rape victim's trauma, in the short and long term, and are an important focus for clinical intervention. Not every woman who is raped is affected equally; there are many variables which moderate the impact of sexual assault such as prior psychological adjustment, life stressors, family support and cognitive and behavioural coping strategies (Calhoun & Atkeson, 1991). However, the interpersonal nature of rape and the pervasive, malevolent social context which attends it means that all victims experience some degree of direct trauma from the rape itself and psychological consequences resulting from the stigmatization and revictimization that are commonly experienced after the assault. Issue-oriented, short-term therapy is crucial for the recovery of many rape victims. The longer-term effects of rape and the time required to resolve them have also been documented and there is increasing recognition of the need for psychotherapy with some rape victims (Forman, 1980; Koss & Burkhardt, 1989; Nadelson et al., 1982; Rose, 1985; Sales, Baum & Shore, 1984). Because the social stigma of rape prevents women from seeking help timeously, clinicians also play a role in identifying and treating chronic rape responses in which the extent of victim self-stigmatization can be expected to be great.

Clinicians who favour individual psychotherapy utilize various models. Koss and Burkhardt (1989) suggest a cognitive perspective to understand the long-term impact of rape and the process of resolution. They propose that a woman who accommodates stigmatization and victimization by assimilating degradation and helplessness into her beliefs, will see herself as damaged and unworthy. The aims of therapy are to help her redefine the rape as "no reflection on her", as "bad luck", so that she can regain the ability to see herself as worthwhile and an active agent, and to guide her into positive life experiences which reinforce a changed cognitive appraisal of the sexual assault.

Rose (1985), from an ego psychology and object relations perspective, conceptualizes the symptoms and defences of rape victims not as a normal response to a stressful event, but as

pathological responses resulting from massive psychic trauma. Regression leads to a loss of the victim's sense of self as her prior level of functioning is superseded by affects, conflicts and defences associated with the regression. Stigmatic effects, such as expressions of feeling dirty, damaged and spoiled as a woman, are understood as identification with the aggressor resulting from intense conflicts over control and dependency activated by the rape. Working through takes place through the interpretation of defenses and underlying conflicts, although Rose agrees that recovery is complicated by the frequency with which societal responses of blaming and rejection confirm the victim's projections.

Other clinicians stress the role of group therapy, both in its own right and as an adjunct to individual therapy, in dealing with long-term effects of rape (Sharma & Cheatham, 1986). In enabling victims to meet other victims and share feelings with those who truly understand, it allows specifically for fuller resolution of issues relating to stigmatization: shame, secrecy, difference, isolation. The outcomes of group therapy most commonly reported by victims are increased self-esteem, feeling less guilty and ashamed, the unburdening of secrecy and the feeling of being less alone (Cahill, Llewellyn & Pearson, 1991).

The effect of stigmatization by family and friends on a rape victim's resolution of her experience is likely to be extremely negative since social support has been suggested to be the single most important factor in recovery (Emm & McKenry, 1988). The perceptions and fears of significant others must be addressed in clinical work where they are contributing to negative consequences for the victim.

Finally, therapists are not immune to the sociocultural influences which have forced the longstanding repression and denial of sexual assault. Whatever model of therapy is chosen, therapists working with rape victims need to be aware of their own hidden biases and stereotypes about rape, anti-victim feelings and feelings of discomfort with or aversion to the topic. By avoiding talk of the experience, by focussing on the issue of what the client might have done to avoid the rape - which she will experience as blaming - and in many other subtle ways, therapists may act out stigmatic effects counter-transferentially. Furthermore, for a female therapist,

discussion of rape can serve as a reminder of her own vulnerability and result in overidentification with, or defensive attempts to gain distance from, the client. Therapists must continually confront and re-evaluate their attitudes and responses to clients who have been sexually assaulted and must work through, in supervision or in their own therapy, negative countertransference if they are not to contribute to and confirm the victim's feelings of stigmatization.

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APPENDIX A: QUESTIONNAIRE

Dear Participant

I am a Masters student in Clinical Psychology at the University of Cape Town and am interested in your ideas to assist with my research. The results of my study will be submitted in partial fulfillment of my degree. More importantly, they will help me and others understand more about the complexities of people's attitudes and guide us in the provision of relevant therapeutic treatment where it is required. Your participation is therefore valuable and much appreciated.

The attached questionnaire forms the basis of my study. You may remain anonymous if you prefer to do so.

Yours sincerely

Deborah Smith
BA HONS (UCT)

Supervisor: Associate Professor Ann Levett
Child Guidance Clinic UCT

Please supply information regarding the following details about yourself. Please tick the appropriate box where required.

		Office use.
1. Sex:	Male	<input type="checkbox"/>
	Female	
2. Age:		<input type="checkbox"/>
	Degree/Diploma; Year:	<input type="checkbox"/>
3. Marital Status:	Never married	<input type="checkbox"/>
	Married	
	Living together	
	Divorced	
	Widowed	
4. Home language:	English	<input type="checkbox"/>
	Afrikaans	
	Other <input type="checkbox"/> Specify:	
5. Home Town/City:		<input type="checkbox"/>

Office use.

1.

4.

5.

7.

8.

9.

INSTRUCTIONS

Please carefully read the scenario presented below and answer the questions that follow. There are no right or wrong answers. Space is provided after each question for comments, should you want to clarify your answer.

**ANSWER ALL THE QUESTIONS
YOUR OWN IMMEDIATE RESPONSE
IS WHAT IS REQUIRED**

SCENARIO

Jane, a 22-year-old student, was watching television alone in her flat one evening when the doorbell rang. At the door was Simon, a young man from one of her lectures. He said he'd come by for a chat and to borrow some lecture notes. Jane invited him in, offered him some coffee and they sat in the lounge and talked for a while. Jane then went to the bedroom to fetch the notes from a file on her desk. Simon followed her into the room, grabbed her and tried to kiss her. Jane pulled away, saying "No!", but Simon shoved her onto the bed and raped her.

[Rape: Oral, anal or vaginal penetration submitted to against one's will through the use of force, or threat of force.]

QUESTIONS

Please circle the number of your response

	Office use.
<p>1. Jane's experience will make it difficult for her to relate to people as she did before.</p> <p style="text-align: center;"> 1 2 3 4 5 6 Strongly Disagree Not sure but Not sure but Agree Strongly disagree probably probably agree disagree agree </p> <p>Comments:</p> <p>.....</p>	10. <input style="width: 30px; height: 30px;" type="text"/>
<p>2. People who know about Jane's rape will probably avoid discussing it with her.</p> <p style="text-align: center;"> 1 2 3 4 5 6 Strongly Disagree Not sure but Not sure but Agree Strongly disagree probably probably agree disagree agree </p> <p>Comments:</p> <p>.....</p>	11. <input style="width: 30px; height: 30px;" type="text"/>

Please circle the number of your response

Office use.

3. If they knew about what had happened, Jane's lecturers would be more lenient with her than with other students.

1	2	3	4	5	6
Strongly agree	Agree	Not sure but probably agree	Not sure but probably disagree	Disagree	Strongly disagree

12.

Comments:

.....

4. Jane's behaviour is likely to be unpredictable after the assault.

1	2	3	4	5	6
Strongly disagree	Disagree	Not sure but probably disagree	Not sure but probably agree	Agree	Strongly agree

13.

Comments:

.....

5. Jane is likely to feel dirty and contaminated after the assault.

1	2	3	4	5	6
Strongly agree	Agree	Not sure but probably agree	Not sure but probably disagree	Disagree	Strongly disagree

14.

Comments:

.....

6. Jane's rape experience should be kept secret.

1	2	3	4	5	6
Strongly agree	Agree	Not sure but probably agree	Not sure but probably disagree	Disagree	Strongly disagree

15.

Comments:

.....

Please circle the number of your response

7. A raped woman is a less desirable woman to many men.

1	2	3	4	5	6
Strongly Disagree	Disagree	Not sure but probably disagree	Not sure but probably agree	Agree	Strongly agree

16.

Comments:

.....

8. Jane will only discuss the rape with her closest friend or her mother.

1	2	3	4	5	6
Strongly Disagree	Disagree	Not sure but probably disagree	Not sure but probably agree	Agree	Strongly agree

17.

Comments:

.....

9. If Jane were an acquaintance of yours, you would find it difficult to act naturally around her after hearing about the incident.

1	2	3	4	5	6
Strongly agree	Agree	Not sure but probably agree	Not sure but probably disagree	Disagree	Strongly disagree

18.

Comments:

.....

10. Jane's reputation is likely to suffer after the rape as some people may feel it was her fault.

1	2	3	4	5	6
Strongly agree	Agree	Not sure but probably agree	Not sure but probably disagree	Disagree	Strongly disagree

19.

Comments:

.....

Office use.

Please circle the number of your response

Office use.

11. When a woman has been raped she is likely to burst into tears at the slightest provocation.

1	2	3	4	5	6
Strongly agree	Agree	Not sure but probably agree	Not sure but probably disagree	Disagree	Strongly disagree

20.

Comments:

.....

12. It is likely that Jane will not discuss her experience with anyone.

1	2	3	4	5	6
Strongly disagree	Disagree	Not sure but probably disagree	Not sure but probably agree	Agree	Strongly agree

21.

Comments:

.....

13. Jane is likely to feel guilty or ashamed after the assault.

1	2	3	4	5	6
Strongly agree	Agree	Not sure but probably agree	Not sure but probably disagree	Disagree	Strongly disagree

22.

Comments:

.....

14. After someone has had the kind of experience Jane has had, she will probably make unexpected changes in her lifestyle/daily routine.

1	2	3	4	5	6
Strongly disagree	Disagree	Not sure but probably disagree	Not sure but probably agree	Agree	Strongly agree

23.

Comments:

.....

Please circle the number of your response

Office use.

15. Jane is unlikely to report this incident to the police.

1	2	3	4	5	6
Strongly agree	Agree	Not sure but probably agree	Not sure but probably disagree	Disagree	Strongly disagree

24.

Comments:
.....

16. Jane is likely to feel like "spoiled goods" after the assault

1	2	3	4	5	6
Strongly agree	Agree	Not sure but probably agree	Not sure but probably disagree	Disagree	Strongly disagree

25.

Comments:
.....

17. If Jane were an acquaintance of yours, you would not know what to do to help her get over the incident.

1	2	3	4	5	6
Strongly disagree	Disagree	Not sure but probably disagree	Not sure but probably agree	Agree	Strongly agree

26.

Comments:
.....

18. It is not likely that Jane will tell her boyfriend about the rape.

1	2	3	4	5	6
Strongly agree	Agree	Not sure but probably agree	Not sure but probably disagree	Disagree	Strongly disagree

27.

Comments:
.....

Please circle the number of your response

19. Please circle the number which best reflects your prior experience of sexual assault (ie forced sexual contact at any age, without consent, involving touching or penetration):

- 1 Have been sexually assaulted yourself.
- 2 Have had interaction with someone close to you soon after they were sexually assaulted.
- 3 Have been told by someone close to you about their past sexual assault experience.
- 4 Have heard indirectly that someone you know has recently been sexually assaulted.
- 5 Have heard indirectly that someone you know was sexually assaulted some time in the past.
- 6 Have had no personal exposure to sexual assault via direct or indirect contact with someone who has been sexually assaulted.

Comments:
.....

If your response to question 19 was No. 6, do not answer the following question. Please answer if your response fell between Nos. 1 to 5:

20. To what extent did the sexual assault experience affect you emotionally?

- | | | | | | |
|------------|----------|----------|------|-----------|-----------|
| 1 | 2 | 3 | 4 | 5 | 6 |
| Not at all | A little | Somewhat | Much | Very Much | Extremely |

Comments:
.....

21. Some people do not like to be around someone who has been raped/sexually assaulted. Why do you think they feel this way?

.....
.....
.....

Office use.

28.

29.

If you are willing to talk a bit more about some of these issues in a short interview, please write your name and telephone number in the space provided below.

Confidentiality will be kept.

.....
.....

Thank you for your participation.

APPENDIX B: DEFINITIONS AND TERMS

Definition of "Rape":

In South Africa, legally rape is separated into two categories (Vogelman, 1990):

1. Statutory rape, which applies to a man who engages in sexual intercourse with a female under the age of consent (i.e., under 18 years of age) even if she participates willingly.
2. Forcible rape, which consists of intentional unlawful sexual intercourse with a woman without her consent. Intercourse is described as any degree of vaginal penetration by the male penis.

This definition of rape is considered inadequate for several reasons, one of which is that it excludes other forms of coercive and intrusive sexual contact frequently engaged in by rapists, such as oral and anal intercourse. Precise definitions of sexual abuse and rape are important for research, particularly prevalence studies where variations in prevalence figures need to be carefully interpreted (Levett, 1989b; O'Hagen, 1989). In the present attitudinal study, a definition of rape, broader than the legal South African definition but including penetration as a criterion, was added to the vignette for clarity, since in an earlier pilot study conducted by the writer, misunderstanding of key terms by some subjects confounded findings (Smith, 1988). The definition, drawn from the work of Koss (1985), described rape as: "Oral, anal or vaginal intercourse submitted to against one's will through the use of force or threat of force."

"Victim" versus "Survivor"

In the report I refer to rape "victim" whereas many, particularly feminist writers working in the field, prefer the term "survivor". To label a woman who has been raped a "victim" (and for her to define herself as such) invokes the discourse of difference, damage and stigma and reproduces the notion that she is impotent, passive and "marked" for life (Levett, 1989a). While the term "survivor" does imply active coping and overcoming of the negative effects of an experience for which she is not responsible, simply changing terminology will not succeed in transforming the subjective

experience of the raped woman nor the attitudes of others, without work on the broader social structures. Further, it is important to recognise that women who are raped have been victimized and are stigmatized in the context of Western socio-cultural norms. While this does not mean that they are doomed to continue their lives as victims, as damaged and devalued, many do unless they receive help from some source. These are the women most clinicians see, whether or not their problems are presented as rape-related (Calhoun & Atkeson, 1991).

Definition of "Commonsense"

According to Burt and Estep (1981) quoted in Levett (1989a) "commonsense" refers to information described as "in the air". Commonsense ideas associated with the stigma of rape include dirty and contaminated, spoiled goods, guilty and ashamed, defiled and degraded.

APPENDIX C: STATISTICAL DATA

1. TWO-WAY ANOVA FOR STIGMA: GENDER BY EDUCATION

Table C-1

Cell Means and Standard Deviations

		Education		Marginal ^a
		College	University	
Gender	Male	n = 5 M = 72.2 SD = 5.63	n = 40 M = 70.83 SD = 7.69	n = 45 M = 70.98 SD = 7.45
	Female	n = 30 M = 70.37 SD = 6.09	n = 19 M = 71.74 SD = 9.30	n = 49 M = 70.90 SD = 7.44
	Marginal ^a	n = 35 M = 70.63 SD = 5.99	n = 59 M = 71.12 SD = 8.17	n = 94 ^b M = 70.94 SD = 7.40

^a Marginal Ms weighted by cell sizes.

^b N = 94. Six cases omitted due to missing data.

Table C-2

ANOVA Summary Table

Source	df	SS	MS	F	p
Education	1	.00	.00	.00	.99
Gender	1	2.73	2.73	.05	.83
Educ.X Gend.	1	24.23	24.23	0.43	.51
Error	90	5065.23	56.28		
Total	93	5092.19			

2. MANOVA: GENDER EFFECT ON INDIVIDUAL ITEM SCORES

Table C-3

Multivariate Tests of Significance for Gender Effect

Test Name	Value	F Num.	df	Den. df	p
Wilk's Lambda	.65	2.29	18	75	.0068
Pillai's Trace	.35	2.29	18	75	.0068
Hotelling-Lawley	.55	2.29	18	75	.0068
Roy's Greatest Root	.55	2.29	18	75	.0068

Note. S = 1, M = 8, N = 36.5 (i.e., parameters utilized by the SAS computer package for calculating the MANOVA).

Table C-4

Univariate F-Test Summary Table: Item 2

Source	df	SS	MS	F	p
Gender	1	5.14	5.14	5.88	.0172
Error	92	80.35	.87		
Total	93	85.49			

Table C-5

Univariate F-Test Summary Table: Item 6

Source	df	SS	MS	F	p
Gender	1	15.42	15.42	8.98	.0035
Error	92	158.07	1.72		
Total	93	173.49			

Table C-6

Univariate F-Test Summary Table: Item 10

Source	df	SS	MS	F	p
Gender	1	17.39	17.39	10.0	.0021
Error	92	160.02	1.73		
Total	93	117.41			

Table C-7

Univariate F-Test Summary Table: Item 11

Source	df	SS	MS	F	p
Gender	1	5.14	5.14	4.53	.036
Error	92	104.35	1.13		
Total	93	109.49			

Table C-8

Univariate F-Test Summary Table: Item 16

Source	df	SS	MS	F	p
Gender	1	5.27	5.27	8.25	.0051
Error	92	58.78	.64		
Total	93	64.05			

3. ANACOVA FOR STIGMA: GENDER (TREATMENT) BY SEXUAL ASSAULT EXPERIENCE (COVARIATE)

Table C-9

ANACOVA Summary Table

Source	df	SS	MS	F	p
Sex. ass.exp.	1	306.76	306.76	5.7	.019
Gender	1	26.8	26.8	.5	.482
Error	89	4787.03			
Total	91	5093.83			

4. TWO-WAY ANOVA FOR STIGMA: GENDER BY SEXUAL ASSAULT EXPERIENCE

Table C-10

Cell Means and Standard Deviations

Sexual Assault Experience

		No Experience	Know a Victim	Personal Experience	Marginal ^a
Gender	Male	n = 18 M = 72.11 SD = 7.19	n = 25 M = 70.28 SD = 7.90	n = 2 M = 69.50 SD = 4.95	n = 45 M = 70.98 SD = 7.45
	Female	n = 8 M = 71.13 SD = 5.19	n = 30 M = 72.03 SD = 7.82	n = 9 M = 67.11 SD = 8.10	n = 47 M = 70.94 SD = 7.59
	Marginal ^a	n = 26 M = 71.81 SD = 6.56	n = 55 M = 71.24 SD = 7.83	n = 11 M = 67.55 SD = 7.48	n = 92 ^b M = 70.96 SD = 7.48

^a Marginal Ms weighted by cell sizes.

^b N = 92 Eight cases omitted due to missing data.

Table C-11

ANOVA Summary Table

Source	df	SS	MS	F	p
Gender	1	3.04	3.04	.05	.818
Sex. Ass. Exp.	2	57.07	28.53	.50	.607
Gend. X S.A.E.	2	46.49	23.24	.41	.666
Error	86	4886.05	56.81		
Total	91	4992.65			

5. FACTOR ANALYSIS OF STIGMA SCALE

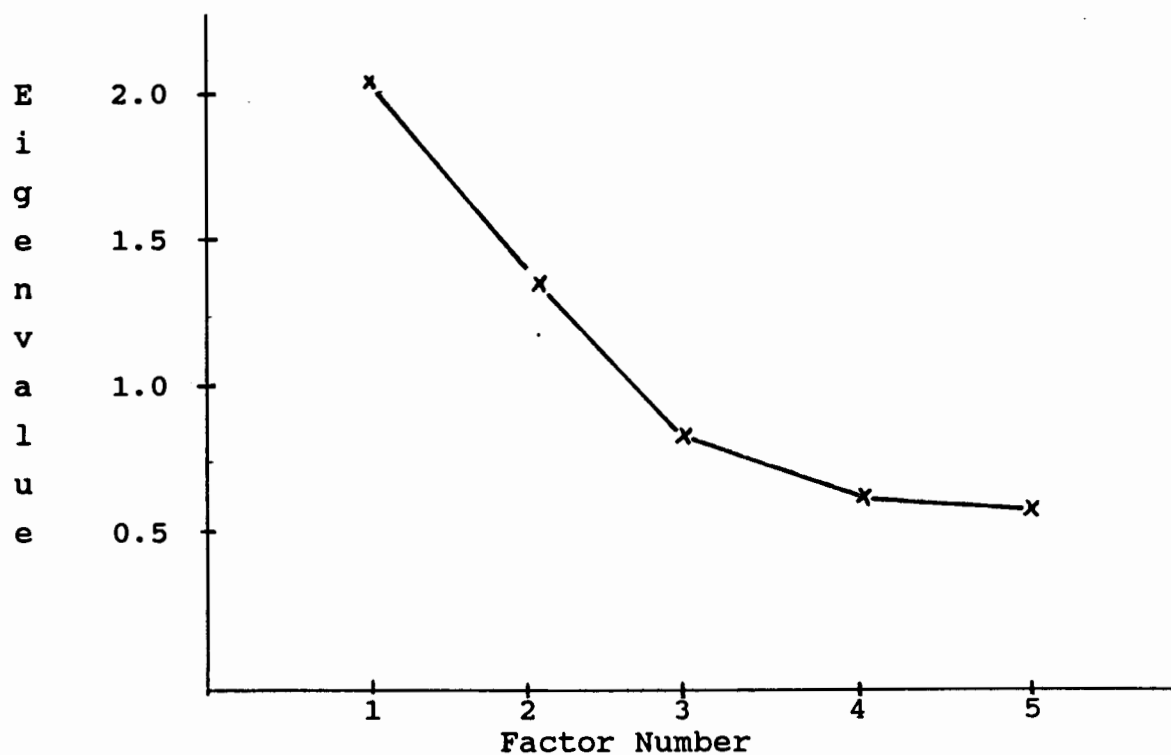


Figure C-1. Unrotated principal axis factor solution: Scree test.

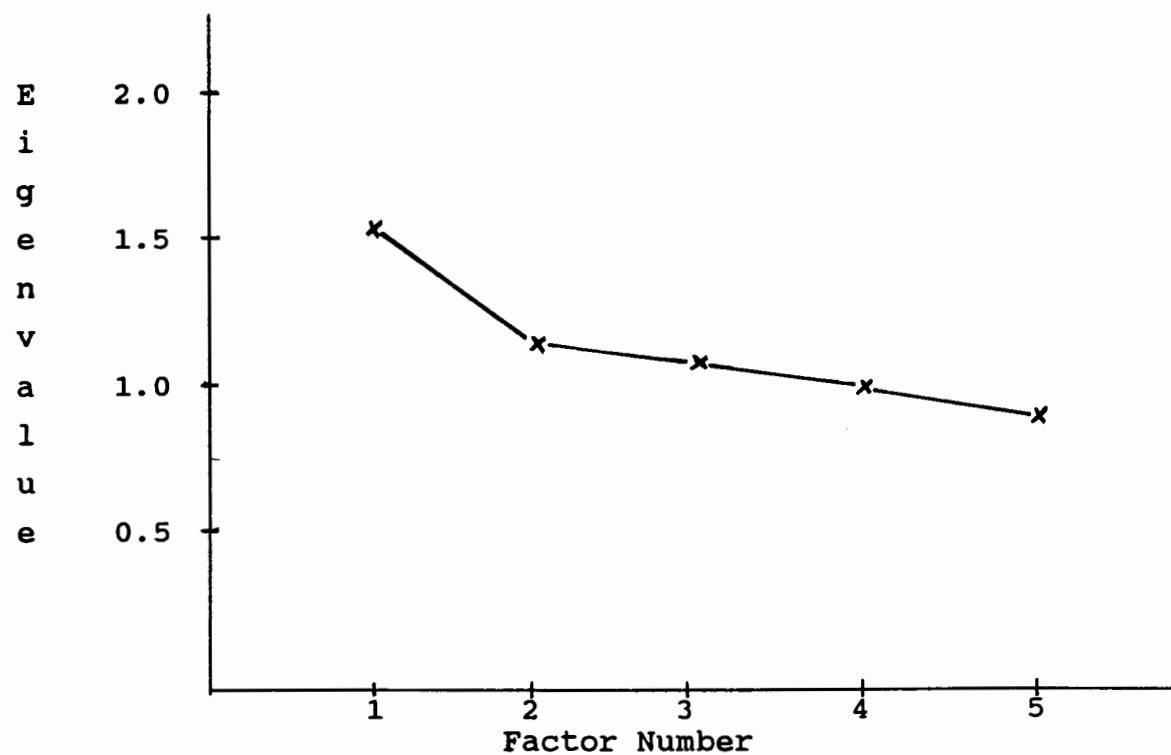


Figure C-2. Orthogonal varimax rotation: Scree test.