Sex-Related Alcohol Expectancies And Perceptions Of Sexual Assault: Recognition Response Latency And Blame Attribution

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SEX-RELATED ALCOHOL EXPECTANCIES AND PERCEPTIONS OF SEXUAL ASSAULT: RECOGNITION RESPONSE LATENCY AND BLAME ATTRIBUTION

A Dissertation
presented in partial fulfillment of requirements
for the degree of Doctor of Philosophy
in the department of Psychology
The University of Mississippi

by

WALTER THOMAS RUEFF JR.

August 2017
ABSTRACT

Alcohol use has often been linked with sexual violence. Pumphrey-Gordon and Gross (2007) note that “among the numerous factors that have been associated with the occurrence of sexual assault, the use of alcohol is the most reliable” (p. 476). Novel autonomy places undergraduates at a nexus alcohol use and sexual experiences, as well as the potential negative consequences of both. This confluence of factors contributes to proportionally higher rates of risky sexual behaviors and sexual assaults among undergraduates. Alcohol expectancies, beliefs about the outcomes and consequence of drinking alcohol, have been shown to influence drinking behaviors, which have, in turn, been linked with higher rates of sexual activity and an increased incidence of sexual assault. (Goldman & Roehrich, 1991; Cooper, Frone, Russell, & Mudar, 1995). Individuals’ endorsements of sex-related alcohol expectancies (SRAE) have also been demonstrated to be predictive of various potentially detrimental behaviors such as increased drinking, and risky sexual behaviors. However, research regarding the role of SRAE in people’s perceptions of sexual violence as third-party observers is scarce. The purpose of this present investigation is to build upon extant sexual assault literature related to alcohol consumption, AE, SRAE, and perceptions of sexual violence, with a particular emphasis on response latency (how quickly individuals are able to recognize assaultive behavior) and victim blame attribution.

This study evaluated the relationship between AE, SRAE, and perceptions of sexual assault using an audio vignette depicting an acquaintance rape (Marx & Gross, 1995). Measures
assessing demographic factors, alcohol consumption patterns, AE, and SRAE were employed. Participants listened to the audio vignette depicting a sexual assault, which was prefaced as either involving alcohol or not involving alcohol, and were instructed to indicate when during the vignette the encounter had become inappropriate. They subsequently completed measures assessing blame attribution related to the vignette. It was expected that AE would account for unique variance in predicting response latency and victim blame attribution, after controlling for demographic factors, alcohol context, and drinking habits. It was also expected that SRAE would account for unique variance in response latency and victim blaming after all factors and AE were controlled for. These hypotheses were tested using hierarchical multiple regression analyses for response latency and victim blame models using the following steps: demographic factors (step 1), drinking habits (DDQ; step 2), alcohol context (step 3), AE (AEQ; step 4), and SRAE scores (AEQ SRAE subscale; step 5).

Findings indicate that, for response latency, AE was the only variable which was a unique predictor. For victim blame, demographic variables, alcohol context, and AE were all identified as unique predictors. SRAE were not found to account for unique variance in either model. Implications of findings are discussed.
DEDICATION

This dissertation is dedicated to the memory of my father, Walter Thomas “Tommy” Rueff, M.D. Thank you for teaching me how to live well.
## LIST OF ABBREVIATIONS AND SYMBOLS

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>AE</td>
<td>Alcohol Expectancies</td>
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<tr>
<td>SRAE</td>
<td>Sex-Related Alcohol Expectancies</td>
</tr>
<tr>
<td>DDQ</td>
<td>The Daily Drinking Questionnaire</td>
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<tr>
<td>AEQ</td>
<td>Alcohol Expectancies Questionnaire</td>
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<tr>
<td>PBQ</td>
<td>The Perceptions of Blame Questionnaire</td>
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<td>RL</td>
<td>Response Latency</td>
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<td>VB</td>
<td>Victim Blame</td>
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<td>HMR</td>
<td>Hierarchical Multiple Regression</td>
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ACKNOWLEDGMENTS

I would like to express my most sincere and deepest thanks to my advisor, Dr. Alan M. Gross, for his mentorship over this dissertation and throughout my graduate training.
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CHAPTER I

INTRODUCTION

Rates of college attendance in the United States have seen continual, dramatic increases over the past several decades. According to the U. S. Department of Education’s National Center for Education Statistics, college enrollment increased by 24% between the years of 2002 and 2012. Enrollment in 2- and 4-year postsecondary institutions is projected to include over 21 million students during the 2015-2016 academic year in the United States, with projected rates estimated to show continued increase. For the majority of individuals attending colleges, their undergraduate years mark a pivotal moment in their transition to adulthood, as they assume greater levels of autonomy and independence in their daily functioning and decision making. With novel freedoms come opportunities for novel difficulties as well.

Substance use, and alcohol use in particular, is commonly portrayed as a defining feature of life as an undergraduate in the United States (Patrick & Maggs, 2009; Schulenberg & Maggs, 2002). Alcohol has an almost inextricable role in the common mythos of the laissez-faire “college experience” (Maggs, 1997). Indeed, data support these cultural anecdotes, showing that rates of alcohol use and abuse sharply increased to a zenith among individuals ages 18 to 25 (SAMHSA; Substance Abuse and Mental Health Services Administration, 2007). Surveys conducted with samples of college students over the past several decades consistently indicate
elevated alcohol use compared to the general population, with some studies reporting that nearly half (44%) of students engage in regular episodes of heavy drinking (Johnston, O’Malley, Bachman, & Schulenberg, 2011; Presley, Leichliter, & Meilman, 1998). Federal authorities, such as the U.S. Department of Health and Human Services (2010) have also identified alcohol use among college students as a major public health epidemic.

As with alcohol, the development of intimate relationships and sexual experiences is also commonly understood to be a defining component of the college experience. In the college context, this burgeoning sexuality can often coincide with alcohol use, and may compound the potential risks associated with each (Arnett, 2004; Maggs & Schulenberg, 2004). Over 600 studies spanning the past 3 decades have generally exhibited a positive association between alcohol use and sex (Cooper, 2006). Alcohol use among young adults has been associated with increased rates of risky sexual behaviors, such as casual sex with multiple partners (Hendershot, Stoner, George, & Norris, 2007; White, Flemming, Catalano, & Bailey, 2009), unprotected sex (LaBrie, Ealywine, Schiffman, Pedersen, & Marriot, 2005; Hingson, Heeren, Winter, & Weschler, 2005), and an increased incidence of sexually transmitted illness (STI; Centers for Disease Control and Prevention, 2003; Cooper, 2002) in numerous studies (e.g., White et al., 2009; Cooper, 2006).

Alcohol use has also frequently been linked to sexual violence; as Pumphrey-Gordon and Gross (2007) state, “among the numerous factors that have been associated with the occurrence of sexual assault, the use of alcohol is the most reliable” (p. 476). Studies show that around 50% of acquaintance rapes involve alcohol use by the victim and/or perpetrator (Abbey, 2002; Marx, Nichols-Anderson, Messman-Moore, Miranda, & Porter, 2000; Ullman, Karabatsos, & Koss, 1999). Additionally, alcohol use by victims has been associated with increased rates of
completed rape, compared to attempted rape (Testa & Parks, 1996; Ullman & Brecklin, 2000). Through investigations into the link between alcohol and sexual violence, some researchers point to the cognitive and behavioral effects of acute alcohol intoxication. Steele and Joseph (1990) describe “alcohol myopia” as the process by which the interaction between alcohol’s impact on cognitive processing, and environmental cues drive behavior. In scenarios of conflict, marked by competing inhibitory and disinhibitory cues, alcohol effectively impedes cognitive processing to such an extent that only the most salient cues may be attended to. For intoxicated individuals in potentially sexual scenarios, the increased potency of disinhibitory cues (such as orgasm) becomes more salient than inhibitory cues (such as the potential risk of STI, pregnancy, relational turmoil, etc.) and so, alcohol contributes to more risky sexual behaviors, as well as sexual behaviors in general. Researchers such as Marx, Gross, and Adams (1999) have directly investigated the effects of acute intoxication in relation to decision making tasks related to vignettes of sexual violence; the authors interpret their findings, that intoxicated participants attend less to inhibitory cues (such as verbal resistance of their partner), as supportive of the alcohol myopia hypothesis.

Alcohol myopia offers insight into the association between alcohol and sexual violence within the context of acute intoxication, but other researchers have suggested that this is only one facet of the relationship between alcohol and sexual aggression, and sexual behaviors in general. In their investigations into underlying motivations for drinking, researchers have focused on alcohol expectancies. Alcohol expectancies (AE) reflect people’s understandings and beliefs about the likelihood of experiencing positive and negative effects of drinking alcohol (Leigh, 1989; Cooper, 1994; Baer, 2002; Kuntsche, Knibbe, Gmel, & Engels, 2005). One aspect of alcohol expectancies involves the anticipated effects of alcohol intoxication in relation to sexual
activities (Goldman & Roehrich, 1991; Cooper, Frone, Russell, & Mudar, 1995). Sex-related alcohol expectancies (SRAE) have been described as the result of a “reciprocal or feedback association between expectancies about links between drinking and sex, sexual behaviors, and perceived positive and negative consequences of these events” (Patrick & Maggs, 2009, p. 473). Through the large amount of AE research (and a smaller body of work regarding SRAE) researchers have demonstrated the importance of anticipating positive consequences in predicting behavior.

Research involving SRAE continues to expand as investigators attempt to detail the relation between alcohol and sexual violence. While the majority of SRAE research has been aimed at the associations between participants’ SRAEs on their own patterns of behavior or responses to hypothetical scenarios (e.g., White, Flemming, Catalano, & Bailey, 2009; Patrick & Maggs, 2009; Pedersen, Lee, Larimer, & Neighbors, 2009), only a small number of studies have focused on SRAE effects on third-party perceptions of sexual assault. Related research has demonstrated that third-party perceptions of sexual assault are sensitive to a variety of contextual factors, such as relationship status, prior history of sexual activity, and alcohol use, to name just a few. Studies of rape attribution have indicated that perpetrators are often judged more leniently, while victims are evaluated more negatively, in cases involving alcohol (see Grubb & Turner, 2012). This phenomena has the dangerous implication of potentially suppressing disclosure rates by victims of rape and sexual assaults in which alcohol was involved. For these reasons, it is important to better understand the associations between individuals’ SRAE, and their perceptions of sexual violence as third-party observers. The following review of extant literature addresses these concerns, with particular emphases on sexual assault in the United
Sexual Assault in the United States

Sexual violence represents a prominent public health and safety concern in the United States. Surviving acts of sexual violence has been linked to various sequelae of negative physiological, psychological, social, and economic outcomes, which may manifest acutely or chronically (Basile & Smith, 2011). For example, acts of rape and sexual assault have been associated with a 90% increased likelihood of genital injury (Sommers, 2007), a 30% increased risk of contracting a sexually transmitted disease (Koss & Heslet, 1992), and an up to 26% increased rate of unwanted pregnancy (Holmes, Resnick, Kilpatrick, & Best, 1996; McFarlane et al., 2005). Surviving acts of sexual assault has also been linked with increased morbidity of psychological disorders such as Post-Traumatic Stress Disorder (PTSD) and Major Depressive Disorder (MDD; Sarkar & Sarkar, 2005), Generalized Anxiety Disorder (GAD), eating disorders, and sleep disorders (Burnam et al., 1988; Chen et al., 2010; Rothbaum, Foa, Riggs, Murdock, & Walsh, 1992; Sorenson & Golding, 1990).

The social and interpersonal effects of surviving sexual assaults are perhaps the least anticipated by the lay public. Victims of sexual violence are more likely to suffer disruptions in their close personal relationships, including those with intimate partners as well as those with friends and family members (Mackey et al., 1992; Crowell & Burgess, 1996). Resnick, Calhoun, Atkeson, & Ellis (1981) have even demonstrated that job performance, satisfaction and security are negatively impacted – even at an 8-month post-assault interval – by surviving sexual assault. Female survivors of sexual assault have significantly increased rates of seeking out medical
services, and spend significantly more money on medical-related expenses than non-victimized women (Golding, 1999; Jacques-Tiura, Tkatch, Abbey, & Wegner, 2010).

Obtaining accurate and consistent estimates for women’s experiences of sexual victimization and men’s perpetrations of sexual aggression has been challenging. Researchers over the past four decades have criticized governmental definitions of rape and sexual assault for being too narrowly circumscribed, and producing restricted prevalence estimates (Abbey, Parkhill, & Koss, 2005). Additional limitations in survey methodology, related to survey-item wording and data collection procedures, have similarly led to depressed and variable rates throughout the literature (Rueff & Gross, [under review]; Koss, 1993; Fisher, Cullen, & Turner, 2000; Kolivas & Gross, 2007; Fisher, 2009). Advances in survey development, such as increased specificity for screening items (Lynch, 1996), a greater emphasis on anonymity (Abbey, Parkhill, BeShears, Clinton-Sherrod, & Zawacki, 2006), and the implementation of behaviorally-specific survey items (Koss, Gidycz, & Wisniewski, 1987) has led to increases in prevalence and incidence rates of sexual violence. Still, many researchers contend that many acts of sexual violence go unreported.

The field of sexual violence research has seen notable developments in attempts to achieve more accurate, and wider reaching prevalence rates. The Sexual Experiences Survey (SES; Koss & Oros, 1982; Koss, Gidycz, & Wisniewski, 1987) has become perhaps the most widely used assessment tool for rape and sexual assault prevalence estimates (Kolivas, 2009). Previous research has demonstrated the importance of survey wording specificity for the purpose of accurate disclosure (Fowler, 1992; Schaeffer & Presser, 2003). Subjects tend to omit responses (even to pertinent questions) if there is incongruity between the wording of a question and how they label their own experiences; this should be a particular concern of sexual assault
researchers, since many victims and perpetrators do not label their experiences as “rape” or “sexual assault,” even in instances which meet the technical definition (Koss, 1993; Fricker, Smith, Davis, & Hanson, 2003).

In response to this potential problem, Koss and colleagues opt not to include terms or labels such as “rape” or “sexual assault,” which may potentially be misinterpreted or stigmatizing. Rather, items of the SES are meant to be behaviorally-specific descriptors of an event’s occurrences. The item wording of the SES is meant to decrease ambiguity as well as to foster uninhibited disclosure – by allowing a more objective reporting of events without the need for stigma-laden identifiers (Abbey et al, 2006). Widespread usage of the SES has helped to establish rape and other forms of sexual violence as more pervasive problems than estimates from previous surveys would have suggested.

In the United States, estimated incidence rates of criminal activity (including sexual violence) are reported annually by various governmental agencies. The Federal Bureau of Investigation’s (FBI) Uniform Crime Reports (UCR) and the Bureau of Justice Statistics’ (BJS) National Crime Victimization Survey (NCVS) are considered to be two of the most important contemporary sources of estimated incidences of sexual violence (Kolivas, 2009). Prevalence rates rendered by these various report exhibit some notable variability. These variations highlight the sensitivity of self-reported rates of experiencing sexual violence, to various methodological approaches. More generally, this variability provides researchers with a robust example of how social stigma is likely to influence disclosure rates of sensitive experiences.

The UCR is an annual report of crime statistics from the preceding year, and are limited to only include crimes which have been reported to law enforcement. According to the UCR, approximately 84,767 incidences of rape were reported to law enforcement in 2010 (FBI, 2011).
This translates to a rate of approximately 54.2 incidences of rape for every 100,000 women in the U.S., with an average of about 1 rape occurring every 6.2 minutes (FBI, 2011). The UCR defines rape as forcible completed rape or forcible attempts to commit rape. With a relatively narrow scope including only forcible rapes which have been reported to police, it is likely that the UCR’s figures underestimate the prevalence of sexual victimization. The accuracy of UCR rape estimates have been challenged by research demonstrating that victims of rape and attempted rape frequently do not report the crimes to police (BJS, 2011; Clay-Warner & Burt, 2005; Fisher et al., 2000; Koss et al., 1987).

Rather than relying solely on reported crimes, the NCVS obtains data on unreported crimes as well as by conducting interviews with a nationally representative sample of individuals. Information obtained through this sample (n = 73,283 individuals in 2010) is extrapolated to calculate national estimates. According to the NCVS, approximately 188,380 instances of rape/sexual assault occurred during the year of 2010, translating to about 13 out of every 10,000 women (BJS, 2011). Compared to the UCR, higher incidence rates reported in the NCVS seem commensurate with the assumption that victims of sexual violence often do not report to law enforcement authorities; according to the NCVS, incidents of rape/sexual assault are reported to the police only 50% of the time.

Although the NCVS demonstrates higher sensitivity than the UCR, researchers have criticized its methodology and the meaningfulness of its reported rates of sexual violence. The BJS acknowledges the potential for inaccuracies in their data, and indeed the difficulty faced by all sexual violence researchers, when they state:

The measurement of rape or sexual assault represents one of the most serious challenges in the field of victimization research. Rape and sexual assault remain sensitive subjects that are difficult to ask about in the survey context. As part of the ongoing redesign of
the NCVS, BJS is exploring methods for improving the reporting of these crimes (BJS, 2011, p. 14)

This statement further illustrates the point that victims are often reluctant to report “sensitive,” potentially stigmatizing information.

Other governmental surveys, such as the Centers for Disease Control and Prevention’s (CDC) National Intimate Partner and Sexual Violence Survey (NISVS; Black et al. (2011), have sought to cast a wider net in the assessment and detection of sexual assault, by broadening definitions. Firstly, rape is defined as completed, or attempted, unwanted penetration of any orifice by the use or threat of physical force, and includes instances in which a victim is unable to give consent (for example, due to being drunk or drugged). Black et al., further specify three categories of rape: completed forced penetration, attempted forced penetration, and completed alcohol or drug facilitated penetration (p. 17). Secondly, sexual coercion is any unwanted orifice penetration which occurs as a result of the victim being pressured into the act in a manner which is nonphysical. Catalysts for sexual coercion might include being persistently begged or nagged for sex, threats of relational or social consequences for not providing sex (e.g. ending the relationship, or spreading rumors), or use of authority to pressure a victim. The third category, unwanted sexual contact, consists of any unwanted sexual experience which falls short of penetration (for example, fondling or kissing). Lastly, non-contact unwanted sexual experiences include unwanted experiences of a sexual nature which do not involve physical contact (for example, verbal harassment or exposing ones genitals to a victim).

The NISVS is a nationally representative survey of adults in the United States. It measures rates of sexual violence, in addition to intimate partner violence and stalking, across an individual’s lifetime, as well as within the prior 12 months. The survey was conducted via telephone random digit dial. It included individuals from each of the 50 states, with a total
usable sample size of 16,507 completed surveys (7,421 men and 9,086 women). Results from the NISVS indicate that 12.3% of women have experienced a completed, forced rape in their lifetime. Further, 5.2% have experienced an attempted forced rape, and 8.0% have experienced a completed forced rape which was facilitated by alcohol or drugs (Black et al., 2011, p. 18). Of the women who have been raped, more than half (51.1%) report that the perpetrators were intimate partners (either current or former). Approximately 40.8% of victims were raped by an acquaintance, someone they knew who was not a current or former intimate partner. The NISVS also assesses perpetrator traits, though it does so indirectly via victim report.

A trained contingent of all female interviewers administered the survey over the telephone to each consenting participant. Black et al. determined that female interviewers would be more likely to have participants feel comfortable enough to disclose experiences with sexual violence than would male interviewers (p. 11). Regardless of interviewer gender, research suggests that methodologies which lack a level of anonymity produce depressed estimates of sexual violence, for victimization as well as perpetration (Kolivas, 2009).

Despite the commendable efforts which have been made over the previous decades of sexual assault research, obtaining accurate prevalence rates of sexual assault is a challenging prospect which many believe is inherently encumbered by the sensitive nature of subject matter itself. An increased understanding of the reasons or motivations for failing to disclose experiences of sexual assault would better equip future researchers for the challenge they face. The current study attempts to partially pursue this interest by assessing how individuals label the experiences of others, as well as how alcohol and individuals’ beliefs about alcohol may color their perceptions of sexual encounters, thus potentially effecting disclosure rates. In this study, the role of alcohol, and alcohol expectancies, is of particular interest.
**Alcohol Expectancies**

Popular concern about problems related to drinking alcohol has increased in recent years, as reflected by increased attention from the media and researchers alike (Monk & Heim, 2013). Researchers attempting to identify motivations for alcohol use have emphasized cognitive patterns which may moderate drinking, such as outcome expectancies (McAlaney & McMahon, 2007). Defined as “explicit or implicit beliefs about the likely results of alcohol consumption” (Reich, Below, & Goldman, 2010, p. 539), alcohol expectancies (AE) have been shown to be positively associated with acute and long-term increases in alcohol consumption (Brown, Goldman, Inn, & Anderson, 1980; Goldman, 1994; Aas, Leigh, Anderssen, & Jakobsen, 1998; Anderson, Grunwald, Bekman, Brown, & Grant, 2011). In addition, meta analyses (Hull & Bond, 1986; Carey, 1995) have also shown that AE are predictive of variations in amounts of alcohol consumed. Furthermore, in situ observational studies have, as well, found a positive relationship between AE, and amount of alcohol consumed (Roehrich & Goldman, 1995; Bot, Engels, & Knibbe, 2005; Larsen, Engels, Wiers, Granic, & Spijkerman, 2012).

Studies have also differentiated between characteristics and associated features of positive versus negative AE. Perhaps unsurprisingly, results have indicated that positively-valenced AE are predictive of drinking alcohol (Leigh & Stacy, 2004), while negatively-valenced AE are predictive of decreased alcohol consumption (Fromme & D’Amico, 2000). Similarly, results from longitudinal study suggest that positively-valenced AE predicted hazardous alcohol use, out to one year, while negatively-valenced AE did not (Zamboanga, Horton, Leitkowski, & Wang, 2006). Brown et al.’s (1980) early investigation of AE included
the development of an alcohol expectancy questionnaire, which assessed participants’
effectancies for enhancement in social and sexual prowess, associated with drinking alcohol.

Numerous studies find associations between alcohol expectancies and patterns of alcohol consumption. Baldwin, Oei, and Young (1993) reported that individuals with positive AE were more likely to consume greater quantities of alcohol, though they did not report drinking more frequently. These findings have corroborated those of other studies, in suggesting that positive AE are associated with increased likelihood of participating in drinking games, and binge drinking episodes (Ham, Zamboanga, Olthuis, Casner, & Bui, 2010). Other studies have supported these findings as well, noting that that positive AE are more associated with how much one drinks (quantity), while negative AE are greater predictors of how often one drinks (frequency; Lee, Greely, & Oei, 1999; Oei & Baldwin, 1994). Adding further complexity to the associations between consumption and AE, some studies indicate that differing aspects of alcohol consumption patterns result from divergent outcome expectancies. For example, Carey (1995) finds that positive, general outcome expectancies were predictive of the quantity of alcohol consumed, while positive, sexual outcome expectancies were predictive of the frequency of consumption. As Monk and Heim (2013) point out, the relationship between alcohol outcome expectancies and alcohol consumption is “clearly complex” (p. 548). Monk and Heim further suggest that standard practice for future investigations of AE should include measures of both quantity and frequency of alcohol consumption.

Alcohol expectancies also seem to affect consumption behaviors differentially across age groups. While the majority of AE research has been conducted using college student samples (Mcalaney, Bewick, & Bauerle, 2010), some have utilized national surveys (Leigh & Stacy, 2004) and community-based samples (Lee, Greely, & Oei, 1999; McMahon, Jones, &
O’Donnell, 1994). Researchers have found that an age of 35 years, separates how AE predict consumption; they found that negative AE better predicted consumption in older individuals, while younger individuals’ consumption rates were better predicted by positive AE (Leigh & Stacy, 2004). Lundahl, Davis, Adesso, and Lucal (1997) also found that younger individuals (participants younger than 20 years old) are more likely to exhibit AE related to a number of distinct factors – such as a sense of increased power, social prowess, and sexual enhancement – as well as general, global positive effects. As AE are proposed to (at least, partially) result from actual experiences with alcohol (Jones, Corbin, & Fromme, 2001), findings of varied sensitivities to AE across age groups may evince effects of more extensive learning histories in older individuals.

In addition to age, gender has also been identified as a variable which accounts for some notable variations in the impact of alcohol expectancies. Borjesson and Dunn (2001) found that AE related to social facilitation (the belief that drinking improves one’s effectiveness in social situations) was the most commonly endorsed AE by both men and women, and the most common AE associated with alcohol consumption across gender. However, other studies involving gender and AE have identified gender as a differentiating variable, and one which additionally varies based on an individual’s perceptual orientation – that is to say, their expectancies of how alcohol will affect individuals of their same gender, individuals of a different gender, as well as themselves personally (Bond, Roberts, Greenfield, Korcha, Yu, & Nayak, 2010; Nyaronga, Greenfield, & McDaniel, 2009). For example, men who expected that alcohol increases women’s confidence, happiness, and enjoyment during social activities, consumed more alcohol compared to those who did not. Alternatively, women tended to drink more if they expected alcohol to reduce men’s tension, and increase men’s sense of romance.
With regards to their expectations related to members of their same gender, both men and women endorsed social facilitation AE for members of their same gender group. Additionally, women expected drinking to positively enhance mood in other women. With regard to personal endorsements of AE, findings indicate that women more strongly endorse social enhancement AE than men, when controlling for quantity of alcohol consumed (Read, Wood, Lejuez, Palfai, & Slack, 2004). Among men, however, social enhancement AE were more closely, positively associated with alcohol consumption quantity. In other words, Read et al. (2004) found that AE related to social enhancement may be linked to heavier drinking in men, but not in women. Interestingly, when alcohol consumption quantity is controlled for, AE related to sexual enhancement are equivalent across genders (Mulligan, Rauch, & Bryant, 2000).

In regards to the complex nature of the relationships between AE, gender, and alcohol consumption, Monk and Heim (2013) summarize the current state of AE research by stating, “such findings demonstrate the interactive importance of both the participant’s gender and the gender of the target of the questions…The relationship between gender, expectancies, and consumption is, therefore, seemingly multi-faceted” (pp. 549-550). These authors go on to emphasize that, in addition to gender, AE researchers need pay close attention to variations in participants’ personal alcohol consumption patterns – with regard to both quantity and frequency of alcohol consumed.

Other research has demonstrated that contextual effects towards AE are sensitive to gender as well. For example, Kirmani and Suman (2010) found that men tend to more frequently endorse positive AE than women; conversely, women are more likely to endorse negative AE than men. Kirmani and Suman’s findings contradict those of Borjesson and Dunn (2001), which, as discussed above, indicate that positive AE (specifically, that alcohol improves social
situations) were most common among men and women. However, it seems likely that
differences in nationality and culture, between the two samples used for these studies, may
account for the observed differences – participants in the Kirmani and Suman study were Indian,
while participants in Borjesson and Dunn were American. Given the likely impact of cultural
context, and differences in socialization and typically held ideas about alcohol across
nationalities, studies conducted with American samples likely offer a unique perspective on AE.
This seems especially true in consideration of American laws which tend to mandate a higher
legal drinking age than many international societies – an age (21) which bisects typical college
student populations. Furthermore, given Jones et al.’s (2001) assertion that AE are partially
rooted in actual experiences with alcohol, it could be assumed that most American, college-
student samples represent a unique opportunity for researchers to investigate AE during a crucial
phase in their development and establishment, at the confluence of several important factors –
such as increased independence, emerging sexuality, and the legal availability of alcohol.

Aside from factors related to culture and nationality, an ever-growing body of research
points to other important contextual factors which affect alcohol consumption and AE.
Generally speaking, research shows that drinking alcohol tends to be personally preferred – and
that evaluations of others drinking alcohol tend to be more positive – when drinking occurs in the
context of a social group or activity, compared to when alone (O’Hare, 1990; Lo Monaco,
Piermatteo, Guimelli, & Ernst-Vintila, 2011). A number of environmental contexts have been
identified as predictive of increased alcohol consumption (both quantity and frequency), such as
drinking games (Clapp, Shillington, & Segars, 2000), college fraternity and sorority parties
(Paschall & Saltz, 2007), and bars (Treno, Alaniz, & Gruenewald, 2000; Demers et al., 2002).
Social context, as well, has been identified as a predictive factor for alcohol consumption.
Studies have indicated that increased consumption of alcohol is more likely in groups (Demers et al., 2002), while with friends (Clapp, Lange, Wong Min, Shillington, Johnson, & Voas, 2003), as a member of a fraternity or sorority (Park, Sher, & Krull, 2008), and as part of a mixed-gender group (Senchak, Leonard, & Greene, 1998). Larsen, Engles, Wiers, Granic, and Spijkerman (2012) observed participants’ real-time drinking behaviors in an artificially constructed college bar, and determined that group effects accounted for as much as 70% of the variance found in drinking. Further, participants’ drinking patterns were found to emulate the consumption rates of peer confederates – participants consumed up to twice as much alcohol when the confederates drank heavily. Larsen et al. (2012) also found that positive AE are associated with heavier drinking in mock-bar context with peers or friends, and similar studies corroborate these findings (Bot, Engels, & Knibbe, 2005).

Several authors have offered explanations for the link between context and AE from a cognitive perspective. Kairouz, Gilksman, Demers, and Adalf (2002) argue that evidence of context-dependent variations in individuals’ motivations for drinking affirm the position that individuals’ drinking behaviors are determined by outcome expectancies and context (Abrams & Niaura, 1987). Similarly, other authors have noted behavior is guided by memories of previously experienced outcomes, occurring in certain contexts (Reich, Noll, and Goldman, 2005), and that expectancies are likely activated in associated contexts, via neurological pathways (Monk & Heim, 2013; Reder, Park, & Kieffaber, 2009; Wiers, Wood, Darkes, Corbin, Jones, & Sher, 2003). Using a priming manipulation, Reich et al. (2005) found that participants remembered an increased number of AE-related words when given a word list that began with a word related to alcohol (such as beer) as opposed to a non-alcohol (such as milk). The authors suggest that these results demonstrate that words involving alcohol combine with words
involving AE to activate AE, and enhance recall. Roehrich and Goldman (1995) also demonstrated that participants drank significantly more alcohol when primed with a video of a bar, than with a neutral video. Another study demonstrated that participants who were primed with examples of positive AE drank more that those primed with neutral stimuli (Friedman, McCarthy, Pedersen, & Hicks, 2009). These findings support the idea that contexts affect AE, which subsequently mediates drinking (Cox & Klinger, 1990).

The positive or negative valence of AE, and how AE are associated with subsequent alcohol consumption, has been shown to be sensitive to context as well. While positive AE have been linked to significantly higher rates of consumption in contexts such as dates and parties (O’Hare & Sherrer, 2001), negative AE tend to increase in larger, public group contexts, compared to more intimate settings (Mustonen & Makela, 1999). O’Hare (1998) suggests that AE are contextually-dependent, and shift according to social context, by demonstrating that individuals’ who expected to drink more in social contexts exhibited significantly more positive AE. Similarly, Christiansen, Vic, and Jarchow (2002) found that individuals who drank heavily in social contexts report significantly higher positive AE that heavy drinkers who drink alone. In fact, in one study of the social-contextual effect on AE, reported that social facilitation may account for as much as 48% of the variance in AE (Thombs, Beck, & Pleace, 1993). While such studies have been criticized for their reliance on retrospective recall of consumption rates (Kuntsche & Kuendig, 2012), there are data from in vivo research which support their findings. For example, Larsen et al. (2012) observed participants in a staged bar setting, and found that individuals who endorsed positive AE consumed over twice the amount of alcohol, when in the presence of peers who drank, compared to individuals who did not endorse AE as strongly. Results such as these support the idea that social context and AE moderated consumption rates.
Other studies further support the supposition that context can affect AE, and subsequently affect drinking. MacLatchy-Gaudet and Stewart (2001) demonstrated that social, as well as sexual contexts were correlated with increased AE, which predicted consumption in these social contexts. Mulligan, Rauch and Bryant (2000) found that individuals had higher AE related to tension reduction while in the context of an established intimate relationship, as opposed to a blind date. Additionally, with regard to AE related to sexual enhancement Mulligan et al. (2000) found equivalent rates in men in either context (relationship or blind date), while women exhibited significantly sexual enhancement AE in the relationship context compared to the blind date. These results may begin to outline a potentially dangerous constellation of factors related to women’s susceptibility to sexual assault. Given established positive associations between positive AE and alcohol consumption these results suggest that romantic social contexts trigger various AE, which in turn may increase alcohol consumption (particularly if in the presence of a date who is drinking) and may leave women more vulnerable to assaults. Positive sex related alcohol expectancies (SRAE) have also been observed to be more strongly endorsed in the context of college social settings (LaBrie, Grant, & Hummer, 2011). Despite its seemingly obvious importance context is a factor which is often underestimated (Ross & Nisbett, 1991). The majority of AE research has been limited by occurring in a laboratory context. In general, a review of extant literature reveals that expectancies are related to alcohol consumption with an emphasis on the development of interventions aimed at curtailing drinking, and affecting these expectancies.

**Sex-related alcohol expectancies and determinations of sexual assault.**

Among adolescents and young adults risky sexual behaviors have been found to be associated with consumption of alcohol in numerous studies. Results indicate that alcohol and
risky sex are linked on a global level (i.e. engaging in one behavior is predictive of engaging in the other), as well as on a situational level (i.e. both behaviors are likely to occur simultaneously) (White et al., 2009). As Cooper (2002) reports, a review of pertinent literature shows that having a history of alcohol use is a significant predictor of being sexually experienced, and frequency and quantity of alcohol consumption predict frequency of sexual encounters and number of sexual partners. Additionally, drinking alcohol in social situations which may have the potential to lead to sex (e.g. on a date or at a party) is associated with an increased likelihood of sexual intercourse resulting from those situations (Cooper, 2002). Drinking alcohol prior to sex has also been associated with an increased likelihood of risky partner choice (i.e. having sex with an unfamiliar person) (White et al., 2009). Cooper (2002) and other authors have speculated that the association between alcohol and sex may result from the fact that both behaviors are associated with underlying constellations of risk factors (such as association with deviant peer groups, and an appeal to sensation seeking). However, others have asserted that there is a causal relationship between alcohol and sex, and that alcohol moderates sexual behaviors through either direct pathways, indirect pathways, or a synthesis of the two.

Alcohol can directly impact sexual decision making through the psychopharmacological effects associated with acute intoxication. Individuals’ cognitive processing abilities are known to become altered when alcohol is consumed. Steele and Josephs (1990) expounded on the interaction between cognitions and alcohol with their “alcohol myopia” hypothesis. Alcohol myopia describes the process by which acutely intoxicated individuals experience a narrowing of cognitive and perceptual functioning with the result being that more proximal stimuli and considerations become more salient, while more distal cues become less salient. As Patrick and Maggs (2009) summarize, “the acute disinhibitory effects of alcohol reduce the ability to process
complex information (such as long-term goals), thus allowing immediate and salient goals (such as sexual arousal) to influence behavior more strongly” (pp. 472-473). An increasing number of studies have contributed empirical support to the alcohol myopia hypothesis demonstrating that high-risk sexual behaviors become increasingly likely when individuals are intoxicated as opposed to sober (see MacDonald, MacDonald, Zanna, & Fong, 2000; Cooper, 2002; Cooper 2006). Less directly, alcohol use can affect sexual behaviors according to the outcome expectancies which people subscribe to.

The alcohol use-related sexual expectancies model postulates that beliefs related to alcohol’s ability to enhance sexual behaviors and experiences produce an increased likelihood that individuals will engage in sexual activities while under the influence of alcohol (George, Stoner, Norris, Lopez, & Lehman, 2000). These beliefs about the expected sexual outcomes related to alcohol use, or sex-related alcohol expectancies (SRAE) represent another avenue through which alcohol may influence sexual decision making. Survey research has demonstrated that SRAE are strongly correlated with reasons for drinking alcohol (Leigh, 1990). Additionally, individuals who more strongly endorse SRAE tend to drink more in sexual contexts, and exhibit a stronger association between alcohol consumption and sexual risk taking (compared to those with minimal SRAE endorsement; Dremen & Cooper, 1994; Cooper, Peirce, & Huselid, 1994; Bryan, Ray, & Cooper, 2007). Experimental data have also demonstrated that SRAE can contribute to risky sexual decision making and attitudes (Maistro, Carey, Carey, & Gordon, 2002). In one example, SRAE were found to moderate the sexual responses of individuals in an alcohol-placebo condition (compared to controls); in other words, the strength of an alcohol placebo was associated with strength of participants’ SRAE endorsements (George et al., 2000).
Individuals’ beliefs about how alcohol affects sexuality influence their sexual behaviors and decision making. In accordance with alcohol expectancy theory (Dremen & Cooper, 2000) expectations that alcohol facilitates one’s sexual drive and affect and lowers sexual inhibitions motivate individuals to consume alcohol (Abbey et al., 1999; Kotchick, Shaffer, Forehand, & Miller, 2001). It seems likely that SRAE related to lowering inhibitions may play a role in explaining findings from other studies, such as those demonstrating that women are more likely to engage in casual sex after drinking alcohol (Hendershot, Stoner, George, & Norris, 2007), and that more than half of women have used intoxication instrumentally to increase the likelihood of sex (Taylor, Fulop, & Green, 1999). SRAE related to disinhibition may be especially salient for women who are more likely to be stigmatized for their sexual activities than are men. Alcohol’s perceived instrumental utility with regards to sexual interactions are often guided by SRAE. SRAE which promote drinking in sexual contexts necessarily (and perhaps purposefully) also promote impaired sexual decision making – as discussed previously, alcohol use is often associated with unwanted sexual interactions. However, some authors have suggested that efforts meant to curtail the prevalence of drunken sexual encounters may actually be counterproductive (Dremen, Cooper, & Agocha, 1998). They suggest that public health warnings carrying the message that drinking alcohol leads to sex may actually strengthen sex-related alcohol expectancies (SRAE) and inadvertently promote both drinking and sex by establishing a self-fulfilling prophecy, or “excuse in a bottle” (Coleman & Carter, 2005, p. 75).

As with research regarding general alcohol expectancies (AE), research regarding SRAE has established the importance of positive (as opposed to negative) anticipated outcomes as predictors of behavior. Having positive SRAE, or anticipating rewarding consequences related to drinking alcohol has consistently been associated with increased rates of alcohol use, as well
as increased likelihood of reporting positive experiences related to alcohol (Baer, 2002; Leigh & Stacy, 2004; Park & Grant, 2005). Patrick and Maggs’ (2009) longitudinal study of first-year college students revealed an interaction effect between SRAE and alcohol consumption with regard to sexual activity. Their results also demonstrated that SRAE related to sexual drive were associated with positive consequences of sex, and that participants reported experiencing more positive consequences of sex on days when they drank more heavily. The authors concluded that, “when students perceive more positive sex consequences on days they consume more drinks, compared with days they consume fewer drinks, expectancies about alcohol’s facilitative effects on sex may be reinforced. There is likely a reciprocal association between alcohol use, positive sex consequences, and alcohol-sex expectancies that perpetuates both alcohol use and sexual behaviors” (Patrick & Maggs, 2009, p. 478).

Benson, Gohm, and Gross (2007) investigated the impact of SRAE on college women’s experiences of sexual assault. These authors examined SRAE, drinking habits, sexual histories, via self-report measures from over 350 female college students. They found strong positive correlations between drinking habits and SRAE related to sexual affect, and sexual drive; specifically, women who endorsed beliefs that drinking increased sexual affect and sexual drive drank more. They also found that level of alcohol use was strongly correlated with vulnerability to sexual coercion. Benson and colleagues concluded that “women holding strong beliefs regarding the positive effects of alcohol on sexual behavior may drink heavily in order to give themselves permission to behave in ways they normally wouldn’t” (2007, p. 349). Additionally, these authors noted that women who had histories of sexual assault were significantly more likely to endorse SRAE, relative to women without sexual victimization histories. It appears likely that women high on SRAE and beliefs that alcohol facilitates sexual behaviors drink more
heavily, and are subsequently at an increased risk for being victimized (Benson et al., 2007; Corbin, Bernat, Calhoun, McNair, & Seals, 2001; Pumphrey-Gordon & Gross, 2007).

Pumphrey-Gordon and Gross (2007) investigated the role of SRAE (among other variables, such as prior victimization history) and alcohol consumption in women’s perceptions of risky sexual situations. Female participants were given either alcohol or a placebo and asked to listen to an audio-taped vignette of an increasingly aggressive sexual encounter between a man and woman on a date. The participants were asked to imagine their own behaviors from the perspective of the woman in the vignette, and to stop the tape when they felt as though the male in the vignette had overstepped the bounds of appropriate behavior in the interaction. The authors found that participants who endorsed SRAE exhibited fewer resistance behaviors when they thought they had been given alcohol. The authors concluded that SRAE increased the saliency of disinhibitory sexual cues when women believed they had consumed alcohol, and may serve to normalize experiences of sexual coercion. Women who endorsed SRAE exhibited less resistance to unwanted sexual aggression.

The relationship between SRAE, drinking behaviors, and sexual assaults has also been examined with consideration of males. As with victimization, perpetration of sexual assault within college samples has been strongly linked to alcohol use with as many as 74% of perpetrators reporting consuming alcohol prior to assault (Koss, 1988), and 53% reporting behaviors consistent with alcohol abuse or dependence (Ouimette, 1997). Tuliao and McChargue (2014) extrapolate these and other findings to posit that cognitive affects of alcohol (such as alcohol myopia) likely contribute to males’ misinterpretations of female sexual interests, which ultimately develop and reinforce SRAE leading to subsequent alcohol use in sexual contexts, and that ultimately, in addition to the acute effects of intoxication, SRAE play an
important role in sexual assault. As. Researchers such as Abbey (2002) have noted that SRAE can facilitate male sexual aggression towards women through establishing male beliefs that alcohol leads to decreased sexual inhibitions. In support of this position, research has shown that male reports of arousal, when presented with erotic sexual assault vignettes, were increased by an alcohol placebo (George & Marlatt, 1986; George & Norris, 1991). Results such as these appear to support the idea that SRAE are associated with increased sexual assault, and may distinguish perpetrators who engage in sexual assaults as unique compared to perpetrators who do not use alcohol and non-perpetrators (Tuliao & McChargue, 2014). As with Coleman and Carter’s (2005) assertion of alcohol serving as an “excuse in a bottle,” and research that suggests women use alcohol to engage in potentially stigmatizing sexual behavior (Benson et al., 2007), male perpetrators may also view alcohol (because of its expected impairing effects) as an instrumental agent for rationalizing or excusing sexually aggressive behaviors which are likely to be perceived as socially inappropriate.

Tuliao and McChargue (2014) aimed to more comprehensively describe the complexities of the relationship between SRAE, alcohol use, and sexual assault perpetration by men. Specifically, they investigated whether drinking habits and SRAE should be considered independent predictive factors for sexual assault perpetration, or if SRAE moderate the relationship between drinking and assault. Tuliao and McChargue found that SRAE predicted sexual aggression. They also found that the relationship between level of alcohol consumption and sexual aggression was fully mediated by SRAE. Specifically, they noted that males’ SRAE related to increased sexual attraction, prowess, and enjoyment accounted for the link between alcohol consumption and sexual coercion. They also found that men’s degree of endorsement of SRAE were better predictors of assault perpetration than degree of alcohol consumption.
Perceptions of Sexual Assault

Despite the rich and robust body of literature regarding AE in general, as well as SRAE specifically, there is a distinct paucity within extant literature regarding SRAE and perceptions of sexual assault as they pertain to third-party perspective. Particularly, the relationship between observers’ SRAE and their determinations of assault, as well as attributions of blame within sexual assault scenarios is not well understood.

Studies have demonstrated that alcohol represents an important factor in individuals’ evaluations of sexual interactions. Research has indicated that in cases of sexual assaults involving alcohol, victims are more harshly evaluated and perpetrators are more leniently evaluated compared to cases of non-alcohol involved assaults (Grub & Turner, 2012; Starfelt, Young, White, & Palk, 2015). Findings such as these raise important concerns about victim treatment, disclosure rates, criminal justice, and social perceptions and policy regarding rape and sexual assault cases in which alcohol is involved. This bias in perceptions of sexual violence has been argued by some to be a byproduct of traditional sociocultural beliefs and norms about differentiated expectations regarding gender (Harrison, Howerton, Secarea, & Nguyen, 2008). Some evidence suggests that attitudes regarding these traditional gender roles have a greater influence on perceptions of sexual behaviors than individuals’ genders (Angelone, Mitchell, & Lucente, 2012). Authors such as Pollard (1992) have noted that, among the victim characteristics which influence individual’s attributions of sexual violence (such as using intoxicants, dressing provocatively, and being perceived as sexually promiscuous) may be accurately conceptualized as violations of traditional gender roles related to femininity. Within the literature concerning perceptions of sexual violence there is robust evidence to implicate traditional gender roles, as well as individuals’ acceptance of culturally common rape mythology
(e.g. that women are frequently dishonest about being victimized, or that men are unable to control their sexual urges) as contributing factors of victim blaming and mistreatment (Grubb & Turner, 2012). However, adherence to traditional gender roles and/or rape myth acceptance do not preclude nor fully account for the potentially unique effects of SRAE in evaluations of sexual assault.

Alcohol expectancies have been demonstrated to affect interpretations of alcohol-related cues and information in individuals when they are intoxicated as well as sober (Norris, Davis, George, Martell, & Heiman, 2002; Friedman, McCarthy, Bartholow, & Hicks, 2007). Additionally, as AE are developed and maintained through both social learning processes including vicarious observations, as well as through direct personal experiences (Goldman, Del Boca, & Drakes, 1999), individuals who do not drink alcohol also harbor expectancies related to alcohol use and its effects. These assertions indicate that AE and SRAE may influence individuals’ perceptions whether they are intoxicated or sober, drinker or not. Due to this reasoning it has been posited that SRAE effect perceptions of third-party observers with regards to scenarios which involve alcohol because the scenario itself functions as an alcohol-related priming stimulus (Starfelt et al., 2015).

Although there is relatively little empirical research focused on the role of SRAE in sexual assault-perception and attribution literature, results from several studies evince the importance of SRAE in regards to individual’s perceptions and judgments of sexual assault (Norris et al., 2002; Abbey, Buck, Zawacki, & Saenz, 2003). However, most studies investigating the role of SRAE on such perceptions and judgments focus on individuals’ personal perspectives (by asking participants about their own experiences related to alcohol).
Starfelt and colleagues (2015) conducted an initial investigation into the role of SRAE in attribution of blame in rape. In their study the authors focused on SRAE related to sexual coercion and vulnerability. Citing the paucity of research related to SRAE and rape attribution, Starfelt and colleagues extrapolated findings from contemporaneous sexual assault attribution research to support the focus of these particular SRAE in their study using a sample of Australian college students. They hypothesized that participants with stronger SRAE would evaluate intoxicated sexual assailants as less blameworthy, while evaluating intoxicated sexual assault victims as being more blameworthy. The researches also evaluated participants’ SRAE related to personal alcohol use, SRAE related to alcohol use of members of their same gender, and SRAE related to alcohol use of members of the opposite gender.

Starfelt and Colleagues (2015) assessed participants’ AE and SRAE, adherence to traditional gender roles, rape myth acceptance, as well as alcohol use patterns, and general demographics. Participants were then asked to read a vignette detailing a sexual assault in which alcohol was involved, and evaluate the male and female characters on dimensions of liability, intention, choice, accountability, preventability, and awareness of wrongdoing. The results of their study indicated that individuals high on SRAE related to sexual coercion (the belief that drinking increased their own personal sexually coercive behavior) attributed less blame to the perpetrator. Furthermore, participants who endorsed SRAE related to female sexual coercion (believing that women become more sexually coercive due to alcohol) attributed increased blame to the victim. This result remained with SRAE accounting for a unique portion of variance after controlling for traditional gender roles and rape myth acceptance. Starfelt and colleagues (2015) noted that their results supported their hypotheses that increased SRAE would be associated with increased victim blame and decreased perpetrator blame. The authors further stated that their
results support the position of Littleton (2011), who noted that further considerations beyond rape myth acceptance and traditional gender role adherence need to be evaluated in regards to social evaluations of sexual assault. The authors stated that SRAE “appear to represent an important socio-cognitive concept in explaining why people excuse intoxicated sexual perpetrators while blaming intoxicated victims” (Starfelt et al., 2015, p. 1976).

The purpose of this present investigation is to build upon the extensive literature related to sexual assault, AE, and SRAE, with a particular emphasis on the newly burgeoning sub-field related to SRAE, blame attribution, and third-party perceptions and evaluations of sexual assault. Specifically, this study will evaluate the relationship between AE, SRAE and determinations of sexual assault using an audio vignette depicting a sexual assault scenario (Marx & Gross, 1995), one prefaced as an encounter involving alcohol and the other not involving alcohol. Participants completed measures assessing demographic factors, alcohol consumption patterns, AE and SRAE. Participants listened to the audio vignette depicting a sexual assault either involving alcohol or not involving alcohol, and were instructed to indicate when during the vignette the male should stop his sexual advances. They subsequently completed measures assessing blame attribution related to the vignette. It was expected that SRAE would account for unique variance in predicting response latency after controlling for demographic factors, drinking habits, and alcohol context. It was also expected that SRAE scores would be positively associated with victim blame, and account for unique variance in predicting the degree of victim blame, after controlling for demographic factors, drinking habit, and alcohol context.
CHAPTER II

METHODS

Participants

A large sample of male and female college students were recruited from a public university located in the Southeastern United States, as well as through the online message board community, Reddit. Participants were recruited via email and via postings to Reddit message boards (/r/samplesize, /r/research, and /r/college). Participants ranged in age from 18-55, and exhibited ethnic characteristics which approximated United States postsecondary enrollment demographic patterns (National Center for Educational Statistics [NCES], 2016). Specifically, the sample was comprised of 77.7% Caucasian, 12.7% African-American, 2.5% Hispanic, 2.5% Asian, 0.6% Native American, 1.9% multiracial, and 1.9% “other.” Participation was incentivized through enrolling participants in a lottery for a $100 cash prize. In order to obtain power of .80 a minimum final sample size of $N = 110$ was needed for this study, in accordance with power analysis calculations (Faul, Erdfelder, Buchner, & Lang, 2009). Overall, 483 individuals participated, to some degree, in the study; of that number, a final, usable sample size of 157 remained after screening for validity concerns and outliers.
Measures

Demographics Questionnaire

Demographic information regarding participant age, gender, race/ethnicity, and sexual orientation was collected. Participants were also asked to indicate their current relationship status, fraternity or sorority affiliation status, age of first sexual intercourse, and lifetime number of sexual intercourse partners.

Alcohol Consumption Habits

A modified version of the Daily Drinking Questionnaire (DDQ; Norris et al., 1996) was used as a self-report measure alcohol consumption patterns during the prior 30 days. The DDQ is a three-item self-report questionnaire in which items assess quantity, volume, and frequency of alcohol consumption and allow for tabulation of average daily and weekly consumption patterns. Items assess participants’ typical consumption patterns with a series of open-ended questions which ask participants to estimate average daily and weekly consumption rates. The DDQ has been shown to provide adequate reliability and construct validity (Benson et al., 2007).

Alcohol Expectancies

The Alcohol Expectancy Questionnaire (AEQ; Brown, Christiansen, & Goldman, 1987) is a self-report measure consisting of 120 statements from men and women ages 16 to 60 years (with diverse ethnic and alcohol use backgrounds) regarding their expected effects of using alcohol. Each item on the AEQ is presented as a true/false choice through which respondents indicate their agreement or disagreement with each of the 120 statements related to beliefs about
alcohol. Responses are then summed to produce subscale scores and a total score. The AEQ yields a total score, as well as scores on each of its six, factor-analytically derived subscales, which include: positive global changes in experience, sexual enhancement, social and physical pleasure, assertiveness, relaxation and tension reduction, and arousal/interpersonal power.

Psychometric evaluation of the AEQ has demonstrated its reliability (test-retest and internal consistency) and validity (content, criterion [predictive, concurrent, and postdictive], and construct) in clinical and research samples (see Goldman, Darkes, & Del Boca, 1999; McCarthy, Kroll, & Smith, 2001; and McCarthy, Miller, Smith, & Smith, 2001). Literature regarding the utility of the AEQ in research has demonstrated that AEQ scores mediate the influence of numerous alcohol-use risk factors (such as family history and personality variables), and that changes in AEQ scores have been predictive of changes in drinking patterns and future alcohol use (Brown, Christiansen, & Goldman, 1987).

Scenario and Character Evaluations

The Perceptions of Blame Questionnaire (PBQ; Rusinko, Bradley, & Miller, 2010) is a 4-item, face-valid self-report questionnaire assessing attributions of blame related to sexual assault scenarios. The original PBQ (Rusinko, Bradley, & Miller, 2010) was developed for use with video depicted vignettes; the PBQ has been slightly modified by replacing “video” with “recording”, and “watched” with “listened to” on each of the four items. Participants are asked to rate each of the four items on a scale of 0 to 100 (where 0 = none, and 100 = all), relating to attributions of perpetrator and victim blame for the scenario. The PBQ used for this study was comprised of the following questions: (1) How responsible is the woman for what happened in the recording you just listened to? (b) How responsible is the man for what happened in the
recording you just listened to? (c) How much did the woman’s behavior lead to the man’s behavior in the recording you just listened to? and (d) How much did the man’s behavior lead to the woman’s behavior in the recording you just listened to?

Response Latency

Response latency (RL) will be determined by length of time for participants to identify an audiotaped vignette depicting a date rape as a sexual assault. Response latencies will be recorded as the amount of time (in seconds) between the beginning of the audio vignette, and the time at which participants signal that the encounter has become inappropriate. Bernat, Stolp, Calhoun, and Adams (1997) found that using the audio taped vignette (Marx & Gross, 1995) as part of a response-latency procedure produced results with good construct, convergent, and divergent validity, as well as test-retest reliability.

Stimulus Materials

Participants will be exposed to an audio recording depicting a man and woman engaging in consensual and non-consensual sexual contact, developed by Marx and Gross (1995). The 6-minute audio vignette begins with the couple engaging in cordial conversation and consensual kissing, which gradually escalates, by degrees, to a forcible rape depiction. The authenticity of the scenario along several dimensions was supported by male and female (N = 43) college student ratings (Marx & Gross, 1995). The recording to be implemented in the current study was rerecorded by Winslett and Gross (2008).

Participants were informed that the couple is returning to the man’s apartment after a date at the movie. Participants were further prefaced to the vignette depending on to which condition they were assigned. In the alcohol-involved condition, participants were told that the couple
went on a date to see a movie on a Saturday night, stopped by a bar on the way home, and each consumed alcohol. In the non-alcohol condition, participants were prefaced by being told that the couple is returning from a date to a movie on a weeknight, specifying that they are both sober.

**Procedure**

Participants were recruited via email announcement and posts to Reddit message boards (/r/samplesize, /r/research, and /r/college). Participation was solicited by entering participants into a drawing for a $100 cash prize. Interested participants were provided a link to Qualtrics where all data were collected anonymously. Recruiting announcements informed participants that involvement would include listening to a recording of a dating interaction and completing several anonymous surveys regarding alcohol use and dating behaviors. Participants were presented with informed consent, and then completed the demographic survey, DDQ, and AEQ. Upon completion of pre-test measures, participants were randomly assigned to either the alcohol-involved, or no-alcohol condition, and asked to read preface material for their assigned condition. Participants were then asked to listen to the vignette and to stop playback (recording the time) of the recording as soon as they feel as though the interaction is no longer appropriate. Participants were informed that they could continue listening to the vignette, after they indicate a stopping point, to reduce the likelihood of participants delaying stopping of the recording due to curiosity.

After stopping the vignette, participants were asked to complete the remaining PBQ. To assure anonymity all questionnaires were completed via computer administration using a university sponsored online survey program (*Qualtrics*). Participant data was stored automatically to the
software program’s secure server without identifiers, until being downloaded by the principal investigator. After the final questionnaire, participants were debriefed, and offered local counseling referrals if they desired.
CHAPTER III

RESULTS

Prior to conducting primary analyses, data were screened for completeness, univariate and multivariate outliers, and adherence to relevant assumptions of planned analyses (multiple hierarchical regressions). A total sample size of 483 survey responses were recorded in Qualtrics. Of this total, 112 responses indicated that they did not agree to the terms of informed consent, and no further responses were recorded in these cases; these cases were removed from the data set. Of the remaining responses, 1 additional case indicated that he or she was below the age of 18 and was removed. Of these remaining responses, 44 cases were observed to have duplicate IP addresses (suggesting the likelihood that a single participant had taken the survey multiple times) and were summarily removed from further analysis. Of the remaining responses, 141 were incomplete in ways which would diminish their utility for ultimate hypothesis testing (leaving blank one or all items related to dependent variables), and they were removed. A further 4 failed to attend correctly to an attentional/validity check (Blue Dot) and were subsequently removed.

Data were then screened for multivariate outliers using Mahalanobis distance. Of the remaining cases, 24 were identified as being multivariate outliers and removed from subsequent
analyses. Following removal of outliers and unusable cases, the total remaining sample size was 157.

**Summary Statistics**

Analyses of demographic variables indicate the following sample characteristics. In regards to gender, 108 (68.8%) respondents identified as female, 48 (30.6%) identified as male, and 1 (0.6%) identified as transgender. Seventy one (45.1%) reported to be between the ages of 18 and 21, 42 (26.7%) reported to be between the ages of 22 and 25, and 44 (28.28%) reported to be 26 or older. The mean age of the sample was 24.43, and the modal age was 19. The majority of respondents (122 [77.7%]) identified as “White/Caucasian/Non-Hispanic;” remaining respondents identified as “Black/African American” (20 [12.7%]), “Asian” (4 [2.5%]), “Hispanic/Latino” (4 [2.5%]), “Multiracial” (3 [1.9%]), “Other” (3 [1.9%]), and Native American Indian (1 [0.6%]). With regard to nationality, 144 (91.7%) lived in the United States, while the remaining respondents (13 [8.3%]) lived in the following countries: United Kingdom (4), Canada (2), Australia (1), Germany (1), Portugal (1), Serbia (1), Singapore (1), South Africa (1), and Sweden (1). Regarding sexual orientation, 138 (87.9%) identified as “Heterosexual/Straight,” 6 (3.8%) identified as “Homosexual/Gay or Lesbian,” 10 (6.4%) identified as “Bisexual,” and 3 (1.9%) identified as “Other.” The majority of participants (60 [38.2%]) reported that they were “Single/Not Currently in a Relationship; 52 (33.1%) reported they were monogamously dating, 11 (7%) reported dating multiple people, 6 (3.8%) reported they were engaged, 24 (15.3%) reported they were married, 1 (0.6%) reported to be divorced, and 3 (1.9%) reported to be “Other.” The majority of participants, 128 (81.5%) indicated a history of sexual intercourse, and the mean number of sexual partners for the entire sample was 5.46.
With regard to academic standing, the majority of participants reported that they were currently college Freshmen (46 [29.3%]); remaining participants reported to be Sophomores (12 [7.6%]), Juniors (34 [21.7%]), Seniors (29 [18.5%]), graduate students (22 [14%]), and non-degree seeking (14 [8.9%]). For the total sample, the mean number of years since beginning college was 3.4 years. The number of participants who indicated that they were members of a fraternity or sorority was 46 (29.3%), while 111 (70.7%) indicated they were not affiliated with a Greek organization. Of the total sample, 11 (7%) indicated that they were a member of an athletic team associated with their school.

Hierarchical Multiple Regressions

**Response Latency**

Hierarchical multiple regression (HMR) was used to test the hypothesis that SRAE accounted for unique variance in predicting response latency after controlling for demographic factors, drinking habits, alcohol context, and AE scores. Prior to HMR, relevant assumptions of this procedure were assessed. To begin with, the sample size of 157 was deemed to be adequate for the procedure, given the number of independent variables and steps in the final regression model (Tabachnick & Fidell, 2001). The assumption of singularity was met for all independent variables, with the exception of AE total scores and SRAE subscale scores as both were calculated from the AEQ. Pearson product-moment correlation matrix (see Table 3 in the Appendix) revealed that no independent variables were highly correlated, with the exception of AE total scores and SRAE subscale scores ($r = 0.756$). However, collinearity statistics (VIF and Tolerance) were observed to be within acceptable limits, indicating that multicollinearity was not
violated (Coakes, 2005). Univariate and multivariate outliers were identified and removed as described above. Examinations of residual and scatter plots indicated no violations of normality (skew and kurtosis), linearity, or homoscedasticity assumptions. All predictor variables were centered prior to principle regression analyses.

A five-stage HMR was conducted with response latency as the dependent variable. Demographic variables (age, gender, ethnicity, sexual orientation, relationship status, current academic classification, number of years enrolled in college, past history of sexual intercourse, lifetime number of sexual partners, fraternity/sorority membership, and membership of an athletic team) were entered at stage one of the regression model to control for the influence of such factors on subsequent variables’ ability to predict response latency. In stage two of the regression, drinking habits (assessed via the DDQ) were entered as estimated average number of drinks per month. The vignette prompt condition (alcohol versus no alcohol) was entered in step three of the regression to control for the context in which the assault (vignette) occurred. Controlling for the alcohol context of the assault, a factor which has been demonstrated to be closely associated with perceptions of sexual assault (Pumphrey-Gordon & Gross, 2007) is important for further isolating the unique predictive abilities of AE and SRAE with regard to response latency. In step four of the regression, AE were entered in to the model in the form of AEQ total scores. SRAE were entered in to the regression in the fifth and final step. SRAE scores were comprised of AEQ SRAE subscale scores. Coefficient statistics for this regression model can be found in Table 1 of the Appendix.

The rationale for the order in which independent variables were entered into the regression model was to incrementally control for factors which would contribute to predicting response latency. Starting from broader factors (e.g. demographic factors), and then including
variables which were thought to account for increasing predictive variance until all relevant variables contained within this study were controlled, allowing the unique contribution of SRAE to be isolated and analyzed.

The HMR revealed that at stage 1, demographic variables did not significantly contribute to the regression model, \( F (10,146) = 1.262, p = 0.257 \), but accounted for 8% of the variation in response latency. Introducing alcohol use patterns (drinks per month) explained only an additional 0.7% of variation in response latency, and was not a significant change in \( R^2 \), \( F (1,145) = 1.143, p = 0.287 \) (\( R^2 \) change = 0.07, \( B = 0.272, \beta = 0.097; p = 0.287 \)). Adding the alcohol context of the vignette (alcohol involved versus no alcohol involved) to the regression model explained an additional 3.6% of variation in response latency and this \( R^2 \) change approached significance, \( F (1,144) = 3.850, p = 0.062 \) (\( R^2 \) change = 0.24, \( B = -10.364, \beta = -0.159; p = 0.064 \)). The addition of AE (AEQ total scores) significantly contributed to the regression model, \( F (1,143) = 4.372, p = 0.038 \), and accounted for an additional 2.8% of the variance in predicting response latency (\( R^2 \) change = 0.026, \( B = 0.594, \beta = 0.188; p = 0.038 \)). Finally, the addition of SRAE (AEQ SRAE subscale scores) explained only an additional 0.3% of the variance (\( R^2 \) change = 0.003, \( B = -3.696, \beta = -0.087; p = 0.500 \)) in predicting response latency, and the \( R^2 \) in this step was not significant, \( F (1,141) = 0.458, p = 0.500 \). As a whole, in the final step of the regression model, all independent variables included accounted for a total of 14% of the variance in response latency.

**Blame Attribution**

Hierarchical multiple regression was used to test the hypothesis that SREA accounted for unique variance in predicting the degree of victim responsibility for the assault, after controlling
for demographic factors, drinking habit, alcohol context, and AE scores. Prior to HMR, relevant assumptions of this procedure were assessed, as discussed in the previous section.

Similarly to the response latency model, a five-stage HMR was conducted with the degree of victim responsibility for the assault (PBQ) as the dependent variable. The same independent variables and HMR steps as the response latency model were used for this model as well. Demographic variables were entered at stage one of the regression model. In stage two of the regression, drinking habits were entered. The vignette prompt condition was entered in step three to control for the alcohol-context of the assault vignette. In step four of the regression, AE were entered in to the model in the form of AEQ total scores. Finally, as before, SRAE were entered in to the regression in the fifth and final step. Coefficient statistics for this regression model can be found in Table 2 of the Appendix.

The rationale for the order in which independent variables were entered into the regression model was identical to that of the previous HMR model, to incrementally control for factors which would contribute to predicting victim blaming. Starting from broader factors and then including variables which were thought to account for increasing predictive variance until all relevant variables contained within this study were controlled, allowing the unique contribution of SRAE to victim blaming to be isolated and analyzed.

The HMR revealed that at stage 1, demographic variables significantly contributed to the regression model, $F (10,146) = 4.441, p = 0.000$, and accounted for 23.3% of the variation in how participants ranked the female character’s degree of responsibility for the encounter. Introducing alcohol use patterns (drinks per month) explained only an additional 1.5% of variation ($R^2$ change = 0.015, $B = 0.202, \beta = 140; p = 0.090$) in victim blaming, and was not a
significant change in $R^2$, $F(1,145) = 2.917, p = 0.090$. Adding the alcohol context of the vignette to the regression model explained an additional 3.2% of variation ($R^2$ change = 0.032, $B$ = 6.167, $\beta = 0.186; p = 0.012$) in victim blaming and produced a significant $R^2$ change, $F(1,144) = 6.476, p = 0.012$. The addition of AE (AEQ total scores) significantly contributed to the regression model as well, $F(1,143) = 6.019, p = 0.015$, and accounted for an additional 2.9% of the variance ($R^2$ change = 0.029, $B = -0.319, \beta = -0.197; p = 0.015$) in predicting victim blaming. Finally, the addition of SRAE (AEQ SRAE subscale scores) explained only an additional 0.4% of the variance ($R^2$ change = 0.004, $B = 2.150, \beta = 0.099; p = 0.390$) in predicting victim blaming, and the $R^2$ in this step was not significant, $F(1,142) = 0.743, p = 0.390$. As a whole, in the final step of the regression model, all independent variables included accounted for a total of 31.3% of the variance in response latency.

**Exploratory Analyses**

In order to rule out potential moderator effects between predictor variables, two additional regression models were conducted for both RL and VB. When SRAE were replaced by an alcohol-context-by-alcohol-expectancies interaction term was entered in the final step of the model, the results were not significant for both RL ($F(1, 142) = 2.565, p = 0.112$) and VB ($F(1, 142) = 0.371, p = 0.544$), indicating that this interaction term did not account for any additional unique variance. An interaction term of drinking-habits-by-alcohol-expectancies was also analyzed in the same fashion, and results indicated that this term did not account for additional unique variance for RL ($F(1, 142) = 0.026, p = 0.872$) or VB ($F(1, 142) = 1.049, p = 0.308$).
CHAPTER IV

DISCUSSION

The purpose of this research was to investigate how AE and SRAE were associated with individuals’ evaluations of a sexual assault scenario. Despite a robust body of research pertaining to alcohol use behaviors and beliefs, and their association with sexual violence, relatively few studies have focused explicitly on sex-related beliefs about alcohol (SRAE) and even fewer have examined the associations between SRAE and perceptions of sexual violence form a third-party perspective. This study proposed that AE, and SRAE in particular, would account for unique variance in both how long it took for individuals to identify a sexual assault as being such, and the degree of responsibility placed upon the victim of the assault. These propositions were partially supported, in that AE were shown to account for unique variance in both models (RL and victim blame), whereas SRAE did not account for unique variance in either model.

**Response Latency (RL)**

Alcohol expectancies (AE) are defined as individuals’ beliefs about likely outcomes of drinking alcohol (Reich, Below, & Goldman, 2010). Results indicate that increased endorsement of AE was a unique predictor for how late in the audio vignette participants indicated that it had become inappropriate. This suggests that as individuals’ AE increase, so do their tolerance for
sexually assaultive behavior. This finding corroborates other research that has linked higher degrees of AE endorsement with more permissive views towards risky, dangerous, and assaultive sexual behaviors (e.g. Corbin, Bernat, Calhoun, & McNair, 2001; Palmer, McMahon, Rounsaville, & Ball, 2009).

While the precise mechanism for the association between AE and increased permissiveness towards sexually assaultive behaviors is not completely understood, it seems reasonably likely that higher endorsements of AE are indicative of underlying patterns related to cultural context, learning histories, and a number of other factors which are known to be linked with sexual violence. For example, individuals who have higher endorsements of AE have been shown to drink more heavily and regularly (e.g. Anderson et al., 2011; Larsen et al., 2012) which has been repeatedly linked with instances of sexual violence (White et al., 2009). In other words, AE are catalysts for drinking and drinking is a catalyst for sexual assaults; thus, those who subscribe to AE are more likely to have encountered elements or instances of sexual violence, and are more likely to view such behaviors as normative, or at least less aberrant. This pattern replicates the “reciprocal feedback loop” described by Patrick and Maggs (2009) by which AE are often reinforced or confirmed by direct observations. It may also be that individuals who more highly endorse AE are more likely to endorse other commonly held beliefs and expectancies which are characteristic of their cultural context. As Starfelt and colleagues (2015) point out, the cultural contexts of individuals who highly endorse AE are often those that are also more likely to accept rape mythology and ideas about traditional gender roles.

Current literature concerning individuals’ beliefs about how drinking influences sexual behaviors and outcomes (SRAE) has shown that increased endorsements of SRAE are associated with a number of risky behaviors related to drinking and sex. For example, such individuals are
more likely to drink in sexual contexts (e.g. Park & Grant, 2005), which is known to increase the risk of sexual assault. SRAE have also been linked with promiscuity and more casual attitudes towards selecting sexual partners, and more permissive attitudes regarding a higher degree of sexual activities (Hendershot et al., 2007; Coleman & Carter, 2005). Given these findings, it seemed reasonable to expect that higher endorsements of SRAE would be associated with more permissiveness towards the sexual activities portrayed in the acquaintance rape vignette, and thus SRAE would account for unique variance in RL. However, contrary to this expectation, SRAE was not found to be a unique predictor of RL. It may be that the AEQ SRAE subscale lacks the specificity needed for such investigations. For example, Starfelt and colleagues (2015), used measures which specified SRAE related to coercion and vulnerability, rather than a more general SRAE measure, such as the AEQ subscale used in this current study. It may be that assessing for such specific domains of SRAE, especially those which appear to be more closely related to sexual assault, would allow for more productive analyses of the link between SRAE and perceptions of sexual violence.

Victim Blame (VB)

As opposed to RL, the regression model for ascription of victim blame (VB) revealed unique predictors in 3 out of 5 of the steps. Demographic variables accounted for a significant portion of the variance in VB. The alcohol-context in which the assault occurred (whether the two actors had been drinking prior to returning home or not) accounted for unique variance in how individuals placed responsibility for the assault on the female victim in the vignette. This finding is consistent with previous studies that have shown associations between alcohol use and victim blaming (see Grub & Turner, 2012; Pollard, 1992; Angelone, Mitchell, & Lecente, 2012).
As with RL, the regression model for VB found that AE was a unique predictor. As individuals’ endorsements of general beliefs about alcohol and the outcomes of drinking alcohol increased, so did their tendency to ascribe blame to the female victim in the assault vignette. This finding suggests that AE play an important role in judgments of rape and sexual violence (such as Quigley & Leonard, 2006; Abbey, Buck, Zawacki, & Saenz, 2003; and Norris et al., 2002). This result is consistent with that of Starfelt and colleagues (2015) who found AE to be associated with VB. As these authors concluded, it seems that this is accounted for by the fact that AE “appear to be intertwined with a larger and more complex networks of beliefs and attitudes that, at large, are problematic” (Starfelt et al., 2015, p. 1976). That is, as mentioned earlier, individuals with higher endorsements of AE are more likely to endorse other problematic beliefs, such as rape mythologies which tend to portray victims as sharing a higher degree of blame for sexual assaults.

As a number of researchers have pointed out, the role of AE in VB has a number of potentially dire consequences. As populations which exhibit higher AE as well as higher risk for sexual violence are particularly in peril, as this likely promotes an environment where victims are deemed as responsible for their own victimization. This tendency to blame victims likely leads to suppressed rates of reported assaults as well as further traumatizing victims and, potentially allowing perpetrators to continue assaultive behaviors.

With VB as well, however, SRAE was again found not to be a significant unique predictor. As discussed above, reasons for this finding are only speculative, but may be rooted in the personal nature the sexual component of SRAE as opposed to general AE. However, again, this position is not supported by the findings of Starfelt and colleagues. Also similarly, the
complete regression model accounted for 31% of the total variance in VB. So, as with RL, there remains a large portion of total variance unaccounted for by even the complete model.

**Limitations and Suggestions for Future Research**

Several limitations of this study should be noted. Firstly, due to demographics of the sample, generalizability of the results to other populations cannot be determined. Replications of this study with samples of greater diversity and community samples would help bolster the current findings. Secondly, results may be influenced by artifacts produced by the measures and procedures used to assess AE, SRAE, and RL. Finally, this study used self-report measures and may be subject to social desirability. This study raised several important and unanswered questions about the relationship between AE and SRAE, and the discrepant predictive ability of each in regard to sexual violence. Replications and further investigations along similar lines would be informative.

Implications of these findings highlight the importance of further understanding AE and developing streamlined methods for evaluating AE endorsement in populations which are at increased risk for sexual assault, such as college students. Development of programs to address AE and their association with assaultive behaviors may help to reduce tolerance for what may otherwise be seen as permissible sexual behaviors. From this study’s results, one could imagine how lowering AE among college students may result in an increase of reported, witnessed sexually assaultive behaviors. It seems likely that a population of college students who were better able to accurately distinguish from assaultive and consensual sexual behaviors would be at an increased likelihood for intervening observed sexual assaults, such at large parties for example.
LIST OF REFERENCES
REFERENCES


Benson, B. J., Gohm, C. L., & Gross, A. M. (2007). College women and sexual assault: The role


LaBrie, J. W., Grant, S., & Hummer, J. F. (2011). This would be better drunk”: Alcohol expectancies become more positive while drinking in the college social environment. *Addictive Behaviors, 36*, 890–893.


Maisto, S. A., Carey, M. P., Carey, K. B., & Gordon, C. M. (2002). The effects of alcohol and
expectancies on risk perception and behavioral skills relevant to safer sex among heterosexual young adult women. *Journal of Studies on Alcohol, 63*, 476-485.


Table 1.

Summary of Hierarchical Multiple Regression Analysis for Variables Predicting Response Latency

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* *p < .05. **p < .01
Table 2.

Summary of Hierarchical Multiple Regression Analysis for Variables Predicting Victim Blame

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\*p < .05. \**p < .01
Table 3.

*Pearson Correlation Matrix of Predictor Variables for Response Latency and Victim Blame HMR Models*

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*p < .05. **p < .01
VITA

Walter Thomas Rueff Jr.

Contact Information:  4860 Corning Drive
                      Nashville, TN 37211
                      601.278.5711
                      rueffwt@gmail.com

Education

University of Mississippi, Oxford, MS
Ph.D. Candidate, January 2014 – Present
Major: Clinical Psychology

University of Mississippi, Oxford, MS
Master of Arts, December 2013
Major: Clinical Psychology

Millsaps College, Jackson, MS
Bachelor of Science, May 2007
Major: Psychology, Minor: Human Services
Distinction: Cum Laude

Relevant Professional Experience

Psychology Intern, Adult Psychiatry (Pre-Doctoral Internship)  July 2016 – June 2017
Vanderbilt Psychiatric Hospital, Nashville, TN
Therapist  
Region II (Communicare) Community Mental Health, Sardis, MS  
August 2015 – June 2016

Provided individual psychotherapy with a caseload of approximately 70 adult and pediatric clients with a variety of diagnoses and demographic backgrounds. Utilized evidence-based assessments and treatment protocols as necessary.
Supervisor: Dixie Church, M.A., LCSW

Research Assistant, Dept. of Education and Research  
The Baddour Memorial Center, Senatobia, MS  
August 2014 – June 2016

Oversee the regular neuropsychological assessment of residents campus wide. Orient, educate, and assist current psychology interns and Education & Research support staff.
Supervisor: Shannon Hill, Ph.D.

Therapist (Practicum)  
Region II (Communicare) Community Mental Health, Holly Springs, MS  

Provided individual psychotherapy with a caseload of approximately 60 adult and pediatric clients with a variety of diagnoses and demographic backgrounds. Utilized evidence-based assessments and treatment protocols as necessary.
Supervisor: Dixie Church, M.A., LCSW

Intern, Dept. of Education and Research (Practicum)  
The Baddour Memorial Center, Senatobia, MS  
July 2013 – July 2014

Maintained a caseload of approximately 30 residents, conducted psychological evaluations, group therapy, functional assessments, and individual psychotherapy. Provided behavioral support and intervention as needed.
Supervisor: Shannon Hill, Ph.D.

Graduate Assessor  
Psychological Assessment Clinic, University of Mississippi  
July 2012 – Present

Worked as a paid assessment contractor, administering and scoring assessments, and writing assessment reports with a variety of applications, including: full-battery psychoeducational assessments with adults, adolescents, and children; ADHD-Specific assessment batteries; and Fitness for Duty Assessments for the University of Mississippi Police Department.
Assessment and report count at present: 42
Supervisor: Scott Gustafson, Ph.D.

Manager/Coordinator (Practicum)  
Psychological Assessment Clinic, University of Mississippi  
July 2012 – July 2013

Assisted with University of Mississippi graduate assessment practicum. Coordinated all in-clinic assessment services, oversaw clinic resources, and supervised assessment practicum students. Worked as a verification specialist for the Office of Student Disability Services.
Supervisor: Scott Gustafson, Ph.D.
**Graduate Research Assistant (Practicum)**  
*Social Science Research Center, Mississippi State University*  
January 2012 – August 2012

Recruited participants from various drug court programs in the state (Indianola, Greenwood, Greenville, Batesville, Oxford, West Point, and Hattiesburg) and conducted experimental group therapy protocol (Real Men Are Safe; REMAS) aimed at reducing risky sexual behaviors in males.  
 Supervisors: Angela Robertson, Ph.D.; Janet St. Lawrence, Ph.D.

**Therapist, Adult Services (Practicum)**  
*Region IV (Timber Hills) Community Mental Health, Hernando, MS*  
July 2011 – December 2011

Provided individual psychotherapy with a caseload of approximately 40 clients with a variety of diagnoses and demographic backgrounds. Utilized evidence-based assessments and treatment protocols as necessary.  
 Supervisor: Priscilla Roth-Wall, Ph.D.

**Graduate Therapist (On-Site Practicum Training)**  
*Psychological Services Center, University of Mississippi*  
August 2010 – present

Provided evidence-based outpatient psychological services to adults and children with various diagnoses and needs. Utilized evidence based assessment procedures to monitor treatment effectiveness.  
 Supervisors: Alan Gross, Ph.D.; John Young, Ph.D.; Tom Lombardo, Ph.D.

**Psychology Intern (Practicum)**  
*North Mississippi Regional Center, Oxford, MS*  
June 2010 – June 2011

Conducted individual and group therapy with residential clients with Intellectual Disabilities. Developed and wrote behavioral programs, functional assessments, and annual reports. Conducted assessment batteries for Diagnostic Services Dept. as well as residential clients.  
 Supervisor: Scott Bethay, Ph.D.

**Polysomnographic Technologist**  
*Sleep Disorders Center, University of Mississippi Medical Center, Jackson, MS*  
January 2008 – July 2009

Prepped patients for nocturnal polysomnography – applying EEG, EMG, EOC, and EKG leads. Recorded and interpreted nocturnal polysomnograph sleep evaluations, and daytime Multiple Sleep Latency studies. Conducted CPAP pressure titrations to alleviate sleep disordered breathing.  
 Supervisor: Andrew Westphal, B.S., RPSGT (Manager)  
Alp S. Baran, M.D. (Director)

**Undergraduate Psychological Assessment Intern**  
*Behavioral Health Associates, St. Dominic Hospital Counseling Center, Jackson, MS*  
August 2006 – May 2007

Administered, scored, and created computerized reports of various psychometric assessments, observed psychotherapy via CCTV, edited assessment reports, and participated in weekly case discussions with staff therapists.  
 Supervisor: Criss Lott, Ph.D.
Undergraduate Research Assistant May 2006 – August, 2006

Department of Psychology, Millsaps College, Jackson, MS

Maintained the upkeep of laboratory animals and facilities, conducted surgery on laboratory animals, collected and analyzed data, paid position.

Supervisor: Kurt Thaw, Ph.D.

Selected Research

Thesis
Title: Discrepant Self-Reporting in Men and Women’s Accounts of Sexual Assault: An Analysis of Survey Item Wording.
Defended: December, 2013

Dissertation
Title: Sex-Related Alcohol Expectancies and Perceptions of Sexual Assault: Recognition Response Latency and Blame Attribution
Defended: July, 2017

Publications


Selected Presentations


Rueff, W. T. (2014, September). Assessment of Specific Learning Disorder in a College-Age Male: Case Conceptualization and Clinical Diagnostic Practice. Presented as part of the Symposium on Case Conceptualization at the University of Mississippi; Oxford, MS.


Young, J.C., Rueff, W. T., Campbell, S.W., & Gross, A.M. (2010 August). Detection of Response Bias and Adult ADHD. Presented at the annual meeting of the American Psychological Association (APA); San Diego, CA


Rueff, W.T., Corkrin, C.A., Mckorkle, P., & Herman, C. (2006, April). The Effects of Swimming-Induced Stress on Anorexic Behaviors in Rats. Presented at the Department of Psychology’s Annual Student Research Fair, Millsaps College; Jackson, MS.

Selected Achievements and Awards

- Earned a scaled score of 626 on the Examination for Professional Practice in Psychology (EPPP); surpassing the Association for State and Provincial Psychology Boards (ASPPB) recommended score (500) for unsupervised clinical practice. (July, 2014)
- Certified Forensic Evaluator in the State of Tennessee (September, 2016)
- Gordon Allport Award for the Application of Psychology (Spring, 2007)
- Excellence Overall in Writing, Psychology Comprehensive Examinations, Millsaps College (Spring, 2007)
- Excellence in Psychology Comprehensive Examinations, Millsaps College (Spring, 2007)
- Faculty Choice Award for Paper and Presentation in the 3rd Annual Millsaps Arts and Letters Research Symposium (Spring, 2007)
Professional References

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Professor and Director of Clinical Training
Department of Psychology
University of Mississippi
Peabody Hall, 302
University, MS 38677
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pygross@olemiss.edu

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Director, Psychological Services Center
Department of Psychology
University of Mississippi
Kinard Hall, Suite G-382
University, MS 38677
(662) 915-5272
sagustaf@olemiss.edu

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Whitney N. Pierce, PsyD, RN, BCB
Board Certified in Biofeedback
Clinical Pain Psychologist
VA Tennessee Valley Healthcare System
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Murfreesboro, TN 37129
(615) 225-3776
whitney.pierce@va.gov