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Body Weight, Sexual History, and Rape: Attitudes of Future Health Care Providers

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Body Weight, Sexual History, and Rape: Attitudes of Future Health Care Providers

by

Sandra Gotovac

A Thesis
Submitted to the Faculty of Graduate Studies
through Psychology
in Partial Fulfillment of the Requirements
for the Degree of Master of Arts
at the University of Windsor

Windsor, Ontario, Canada

2010

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Body Weight, Sexual History, and Rape: Attitudes of Future Health Care Providers

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DECLARATION OF ORIGINALITY

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ABSTRACT

This study examines two specific types of victim blaming: victim blaming for body weight and victim blaming for sexual assault. There is much previous research on these two areas; however, this study aims to bring these two research strands together to examine victim blaming attitudes towards overweight women who have been raped. Weight stigma and victim blaming have been shown to be a significant problem among health care providers, so this study recruited a sample of future health care providers to examine their attitudes towards rape victims depending on their weight (normal weight/overweight) and their sexual history (limited/extensive). Hypothetical patient files were presented, followed by a questionnaire assessing victim blaming attitudes. Results indicated that sexual history still has a strong influence on attitudes towards rape victims and victim blaming (more so for men than women), and that patient weight did not influence participants' attitudes towards patients. A three-way interaction (gender*sexual history*weight) was found which indicated that sexual history did not influence attitudes towards overweight patients, but that men and women had opposite reactions to normal weight patients based on sexual history. Limitations, future directions, and implications of this research are discussed.

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CHAPTER 1 INTRODUCTION AND LITERATURE REVIEW

Introduction

Stigmas come in many different forms, but at their core stigmas are when “a person’s social identity, or membership in some social category calls into question his or her full humanity—the person is devalued, spoiled, or flawed in the eyes of others” (Dovidio, Major & Crocker, 2000, p.1). Goffman (1963) distinguished among three categories of stigma: “abominations of the body” such as physical deformities; “blemishes of individual character” such as mental illness, addiction, or homosexuality; and “tribal identities” such as race, religion, sex, or social class. Individuals who are perceived to have a character blemish are more stigmatized than those with a physical or tribal stigma due to the belief that this stigma is acquired through volition, something the individual chose despite the negative implications (Goffman, 1963).

This greater stigmatization of character stigmas can be attributed to the fact that in our individualist Western culture we tend to ascribe the cause of an outcome to the individual as opposed to the environment or social context (The Fundamental Attribution Error (Ross, 1977)). This often leads to victim blaming for a negative outcome whereby the individual is perceived as being at fault for this outcome they are experiencing. The reason that victim blaming is problematic is that the individual is then seen as being at fault or “deserving it,” and therefore they do not elicit feelings of sympathy and are not seen as deserving of help by others. Victim blaming can be particularly concerning in health care settings, as adequate and fair health care is a fundamental right where no one should be seen as less deserving or denied proper care because they are seen as being “at fault.”

Two specific types of victim blaming are examined in this study: victim blaming for body weight and victim blaming for sexual assault. There has been much research examining attitudes of blame towards those who are overweight as well as towards rape victims; this study aims to bring these two research strands together to examine victim blaming attitudes towards overweight women who have been raped. Given that rape is a crime perpetrated primarily by men against women, many gender stereotypes come into play. Victim blaming attitudes towards rape victims can vary depending on several victim and situational characteristics. Rape victim blaming attitudes are strongly influenced by the woman's sexual history (which is strongly tied to perceptions of her moral character) and her physical attractiveness. In today's Western culture, a woman's body weight is a primary component of her perceived physical attractiveness, sexual desirability, and her moral character. The following literature review will outline the stigmas of sexual activity and body weight that are imposed on women in Western culture, and describe how these cultural beliefs may influence victim blaming attitudes towards overweight rape victims. Specifically, these stigmas will be discussed in the context of health care focusing on how stigmatization by health care providers is a problem faced by many patients. Further, the negative effects that this stigmatization can have on the quality of care these patients receive will be considered.

Stigmatizing sexual activity

Western culture today has been described as a "culture of hooking up," especially for college-age men and women (Bogle, 2004). Sex is much more publicly talked about than it was just a few decades ago, and virginity until marriage is no longer the norm (Bogle, 2004; Fasula, 2005). However, Western culture seems to have ambivalent

attitudes toward sexual activity. In the 21st century, having several sexual partners in a lifetime is acceptable (even expected), and virginity in adulthood is perceived as being rare, yet virginity is also still regarded as a virtue (Bogle, 2004). This ambivalence is also reflected in the different expectations of sexual activity for men and women.

For men, virginity is regarded as “unnatural”; men are expected to be active in their sexual activity, they are the conqueror, they cannot help but be constantly preoccupied with sex, sex is part of being “a man” (Conrad, 2006). For men, virginity is not seen as volitional or desirable (Sprecher & Regan, 1996). In an empirical study investigating the reasons that adults chose to remain virgins, men reported more than women that the main reason for their virginal status was that their current or past partners did not want to have sexual intercourse (Sprecher & Regan, 1996). Male virgins reported lower self-esteem than male non-virgins, and male virgins were less satisfied with and less committed to their virginity than female virgins (Langer, Zimmerman & Katz, 1995; Sprecher & Regan, 1996; Young, 1986). Men reported more than women that they felt social pressure to become sexually active and were much more embarrassed about their virginity (Sprecher & Regan, 1996). Being highly sexually active is much more acceptable for men, and a positive masculine image is associated with high levels of sexual activity (Bunting, 1996).

Women on the other hand are faced with the burden of being dichotomized into the categories of either the “good” or “bad” girl, a Madonna or a Whore (Bunting, 1996; Conrad, 2006; McDermott & Blackstone, 2002; Odone, 2004). The Madonna is an idealized image of a pure, asexual, and nurturing woman, who has little sexual knowledge, and is looking for a serious relationship or marriage (Bogle, 2004; Conrad,

2006; Fasula, 2005). The Whore is a demonized image of a sexually expressive woman, who is open and proactive about sex, sexually knowledgeable, sexually promiscuous, and exudes sexuality (Bogle, 2004; Conrad, 2006; Fasula, 2005). Women are blamed for enticing men, their sexuality is evil and something that needs to be controlled (Bunting, 1996).

For women in Western culture, virginity is still a desired virtue, their sexuality is perceived as passive, and they are expected to submit to the cultural standard of not too much sex, or too often (Conrad, 2006). However, the ambivalence of Western culture's attitudes towards sexual activity arises again here because women are expected to be "good girls" in a "culture of hooking up" where virginity is no longer the norm. In a study of attitudes towards virginity the main reason women cited for remaining virgins was the lack of a committed and loving relationship, and women reported more than men that they felt social pressure to remain virgins (Sprecher & Regan, 1996). Female virgins felt more proud and satisfied with their virginity (compared to male virgins) because they are *choosing* to "wait for the right person" and a woman's virginity is seen as volitional because it is based on morals, religious beliefs, and/or cultural mores (Sprecher & Regan, 1996). It seems that the perception is still that the choice of engaging in sex is dependent upon the woman: all men want to have sex, and the woman must be the one to decide when she is ready to lose her virginity. This choice is not that easy; women must navigate through the mixed and changing cultural messages regarding what level of sexual activity is acceptable (Laner, Laner, & Palmer, 1978).

However, recent research on perceptions of sexual history has found the meaning placed on virginity has begun to change, with studies emerging in the past 10 years

indicating that virginity has lost some of its positive value in Western culture (Baumeister & Vohs, 2004). This research (primarily using students) has shown that in today's society virginity is perceived as an embarrassment, it is something to be lost as soon as possible, and that individuals (men and women) who remain virgins into their late adolescence or early adulthood can be perceived negatively (Bernau, 2007). Teens and young adults report that virginity has more negative than positive consequences, and these negative consequences increase over time (Brady & Halpern-Felsher, 2008). When high school and post-secondary students were asked about their beliefs about sexual activity and virginity, many reported that they believe the majority of their peers are having sex, and those who abstain from sex reported that they feel embarrassed about it and left out (Brady & Halpern-Felsher, 2008; Carpenter, 2001; Denehy, 2007). This was found almost equally among males and females, indicating that the sexual double standard is beginning to change and that abstaining from sex (even for women) is not perceived as virtuous, but as something about which to be embarrassed. Although it appears that the perception of virginity as a virtue for women is beginning to change, this is a recent occurrence, and is almost exclusively among adolescents and young adults. These new findings regarding the perceptions of virginity do indicate that the value placed on sexual activity is changing, but it has not been found to replace the more common perceptions of sexual activity for men and women that were previously discussed (Baumeister & Vohs, 2004; Bernau, 2007; Carpenter, 2001).

The impact of the victim's sexual history on attributions of blame can be amplified or diminished by the perceiver's attitudes towards sexual activity. Attitudes towards sexuality and sexual activity may be classified on a continuum from conservative

to liberal (Hudson, Murphy, & Nurius, 1983). Liberal sexual ideology is defined as the belief that sexual expression should be open, free, and uncontrolled; a conservative sexual ideology is defined as the belief that human sexuality and sexual activity should be controlled, restricted, and monitored (Hudson et al., 1983). Those with a conservative sexual ideology are less accepting of aspects of sexuality like premarital sex, homosexuality, open expressions of sexuality, and pornography (Hudson et al., 1983). In the context of victim blaming, it has been found that, for both men and women, a more conservative sexual ideology is linked to more tolerance of rape, and a greater attribution of blame to the rape victim (Caron & Carter, 1997). However, victim blaming attitudes could be correlated with the perceiver's sexual ideology simply because of the attitudes they hold towards the victim's sexual history (Caron & Carter, 1997).

Stigmatizing sexual assault victims

Sexual assault is a pervasive social problem, and prevalence rates have not declined in the past several decades (Campbell & Wasco, 2005). Both men and women can be sexually assaulted, but the majority of victims are women (Campbell & Wasco, 2005). Sexual assault is a crime of interpersonal violence that is most often committed by men who are trusted and known to the women they attack (Campbell & Wasco, 2005). Rape is not simply a crime of using violence to achieve sexual gratification or fulfill sexual urges; it is an inherently violent act motivated by aggression, anger, the abuse of power, and the need to exert control over others (Becker-Lindow, 2008; Coates & Wade, 2004; DeJong, 1999). Although rape involves the use of sexual organs, it is not sex, but an act of violence in which sex is used as a weapon (Becker-Lindow, 2008). Defining rape as "violence not sex" serves to differentiate between sex (acceptable) and violence

(unacceptable). But it cannot be ignored that coercion and force are integral to male sexuality, and it can be difficult to define rape as distinctly different from intercourse except for the lack of consent (MacKinnon, 1983).

Not only is the actual assault traumatic, but the negative societal attitudes towards women who are raped can be just as distressing (Campbell, 2008; Campbell, Wasco, Ahrens, Sefl & Barnes, 2001). These negative attitudes, or “rape myths,” are “prejudicial, stereotyped, or false beliefs about rape, rape victims, and rapists” (Burt, 1980, p. 217). Rape myths include beliefs such as: "only bad girls get raped; any healthy woman can resist a rapist if she really wants to; women ask for it; women 'cry rape' only when they've been jilted or have something to cover up; rapists are sex-starved, insane, or both” (Burt, 1980, p. 217). Research has consistently shown that these rape myths are more strongly endorsed by men than by women (Ahrens, 2006; Becker-Lindow, 2008; Burt, 1980; Campbell, 2008; Feldman-Summers & Linder, 1976; L'Armand, Pepitone, & Shanmugam, 1981; Macrae & Shepherd, 1980).

The stigma experienced by women who have been raped falls under Goffman's (1963) “blemishes of individual character” stigma category. The devalued status imposed on victims of sexual assault is rationalized by the belief that they committed some volitional behaviour to bring about the attack or took no action to prevent it. These negative and false beliefs have been found to be endorsed by the public, as well as by sexual assault service providers (Best, Dansky & Kilpatrick, 1992).

The reactions of health care professionals and post assault service providers have a substantial impact on victims of sexual assault (Boutcher & Gallop, 1996; Campbell, 2008). Negative social reactions from support providers (including health care

professionals, friends, and family) such as doubt, holding the victim responsible for the attack, or refusing assistance, can be like a “second rape” where victims feel revictimized, a phenomenon that is known as *secondary victimization* (Ahrens, 2006; Campbell, 2008). This secondary victimization serves as a silencing agent to women who have been raped, making them feel guilt or self-blame. Further, their fear of being blamed makes them more reluctant to report the assault or seek help and support (Ahrens, 2006; Renner, Wackett & Ganderton, 1988).

Victim blaming attitudes are influenced by many different victim characteristics that share a perceived relationship with volition. Several supposedly relevant factors that are believed to be under victim control include level of intoxication, provocative dress, whether or not the victim forcefully tried to resist her attacker, and a previous relationship with the attacker (Best, et al., 1992; Cameron & Stritzke, 2003; Hackett, Day & Mohr, 2008; Maurer & Robinson, 2007). Victim blaming is perceived as justified because if she *chose* the behaviour then she *chose* the negative consequences (being at a high risk for rape) that result. Even factors that are perceived as being outside of the victim’s control such as her ethnicity, her attractiveness, and her emotionality after the attack have also been shown to influence victim blaming by way of the character attributions that are associated with those characteristics (Coates & Wade, 2004; George & Martinez, 2002; Maurer & Robinson, 2007).

Victim blaming research has shown that perhaps the most important volitional characteristic is the victim’s sexual history; this potentially has the strongest influence on perceptions of the victim and the resulting secondary victimization (Best, Danksy & Kilpatrick, 1992; Brinson, 1992; Coates & Wade, 2004; Feldman-Summers & Linder,

1976; Hackett et al., 2008). This influence of the victim's sexual history on attributions of blame towards rape victims has been shown in this research to be stronger in men compared to women. Victim respectability influences attributions of responsibility to the victim of a rape, and in our patriarchal culture, a woman's respectability is strongly tied to her sexual history (Simon-Kerr, 2008). Virgins are seen as much more respectable than non-virgins, and in rape trials a woman's credibility as a witness is strongly tied to her perceived sexual virtue (Simon-Kerr, 2008). The belief that chastity is a character trait leads to perceptions that women who are "unchaste" have a questionable character, are more likely to lie, and are more likely to consent to sexual intercourse in any given situation (Becker-Lindow, 2008; Spohn & Horney, 1991). Even though chastity is the exception rather than the rule, the rape is perceived as a less serious crime when the victim is unchaste because the violation of her rights is not as serious since she already "gave up" her virginity (L'Armand & Pepitone, 1982; L'Armand, Pepitone & Shanmugam, 1981). This ambivalence in attitudes towards female sexual activity in Western culture is further evidenced by the contradiction between the supposed acceptability of premarital sex, and the fact that women still report feeling shame and guilt when being scrutinized about their sexual experience (L'Armand et al., 1981).

Studies of jurors' perceptions of rape victims (in hypothetical and real situations) have shown that much less responsibility is attributed to victims who are virgins (or who have a very limited sexual history) than to women who have an extensive sexual history. Women who have a limited sexual history are also assumed to be more traumatized/damaged by the rape and are perceived as more credible in their reports of the rape (Feldman-Summers & Linder, 1976; L'Armand & Pepitone, 1982; Macrae &

Shepherd, 1980). Rape shield laws preventing questioning about a victim's sexual history were enacted because knowledge of prior sexual behaviour has such a profound impact on perceptions of the victim and attributions of responsibility even though it should be irrelevant to judgements of a victim's credibility or whether she gave consent (Spohn & Horney, 1991). However, information regarding prior sexual behaviour can still be admitted into court cases in several states in the United States if it is deemed "relevant," and there are no consistent federal rules regarding what constitutes relevance or irrelevance to the case (Spohn & Horney, 1991).

Outside of the court process, questions about sexual history are often asked by post assault service providers, police officers, peers, and family, and the answers they receive influence their attitudes and reactions towards the victim (Ahrens, 2006; Campbell, 2008; Campbell et al., 2001). Even though professional support providers are supposed to be helpful, many rape survivors have found these interactions quite distressing, reporting negative experiences that leave them feeling blamed and doubted (Ahrens, 2006; Campbell et al., 2001). Throughout the reporting process, the victim is questioned again and again as to the details of the attack, and this questioning often strays to her personal sexual history, what she was wearing, and her personal history with the attacker (Campbell, 2008). This irrelevant questioning can be quite traumatic for victims, leading many to stop disclosing (Ahrens, 2006). Sometimes they are directly told by service providers that they are not credible in their report, and warned of the negative repercussions if their report is found to be false (Ahrens, 2006; Campbell, 2008).

Weight Stigma

The stigmatization of those who are overweight is one of the few remaining socially acceptable prejudices in Western society (Brochu & Morrison, 2007; Puhl & Brownell, 2001). Research has consistently found over the past several decades that individuals in Western society openly hold and express negative attitudes towards those who are overweight (Blaine & Williams, 2004; Crandall, 1991, 1994; Langlois, Kalakanis, Rubenstein, Larson, Hallam & Smoot, 2000). Overweight individuals experience prejudice and discrimination throughout their lives from childhood to adulthood (Langlois et al., 2000; Musher-Eizenman, Holub, Miller, Goldstein, & Edwards-Leeper, 2004; Puhl, Moss-Racusin, Schwartz & Brownell, 2008), and in many areas of their lives including employment, health care, and education (Brochu & Morrison, 2007).

Furthermore, it appears that this difference in our perceptions of the desirability of weight applies particularly to women. Although the research findings have not been entirely consistent, much research evidence suggests that overweight women are more stigmatized than overweight men (Blaine & Williams, 2004; Brochu & Morrison, 2007; Eagly, Ashmore, Makhijani & Longo, 1991; Rice, 2007). Cultural standards of beauty and thinness for women differ from those applied to men. Women are primarily evaluated (and self-evaluate) on the basis of physical appearance, with body size and shape being a principal component of attractiveness, and their sense of body and femininity is shaped through cultural meanings and social experiences (Blaine & Williams, 2004; Rice, 2007). In contemporary Western society overweight is almost universally interpreted as unattractive (Bordo, 1993; Sisssem & Heckert, 2002), and being thin is inextricably linked

to attractiveness (Young & Powell, 1985). When holding facial characteristics constant, photographs of women that are manipulated by computer to appear overweight are perceived as much less attractive, sexually desirable, and feminine than the same photos at normal weight (Harris, 1990; Regan, 1996). Body image disturbance and unhappiness with one's appearance are most commonly tied to dissatisfaction with one's weight, which can be attributed to the Western standards of attractiveness purveyed by the culture that communicate that being thin is analogous to being beautiful (Sissem & Heckert, 2002; Thompson & Stice, 2001).

Human ideals of female beauty are a social construct, and in non-Western cultures such as Fiji and Thailand, a more robust and larger figure is the ideal and is actually interpreted as a sign of both wealth and health (Becker, Burwell, Gilman, Herzog & Hamburg, 2002; Craven & Hawks, 2006). Even in Western society, the idea that "one can never be too rich or too thin" is a relatively recent one (Levin, 2008). Examination of the historical record indicates that, although it fluctuated somewhat, the Western ideal for women up to the 20th century was more robust and curvy rather than slim and lean (Firestone & Dozois, 2007). However, when women began to move out of the domestic sphere in the 1920s, the ideal changed, and wealth and health were increasingly associated with less body mass. The ideal North American body size, especially for women, has continued to decrease over the past several decades (Firestone & Dozois, 2007). Marilyn Monroe, the icon of sexuality in the 1950s and 60s, was a size 14, but in the 21st century anything above a size 10 is considered "plus sized" and sizes 2 to 4 are considered ideal (Firestone & Dozois, 2007). However, this beauty ideal is not universally applied to, or internalized by, all women in Western culture. White women

have been shown to be much more rigid in their concepts of what the ideal body size is and express considerably more body shape dissatisfaction compared to women of colour (Parker, Nichter, Nichter, Vockovic, Sims, & Ritenbaugh, 1995). African American perceptions of beauty are more flexible, with African American women being less preoccupied with weight and dieting than White women (Parker et al., 1995). Women of colour seem to not compare their appearance to the dominant White ideal in the media, which is much smaller than what is considered an ideal body size for women of colour (Allan, 1993).

Not only is beauty a social construct, but what is considered “overweight” is also a social construction reflecting the cultural belief of what the ideal body size is. The meaning of “fat” or “fatness” has changed over time (Boero, 2006). Pre-1900s “fat” was conceptualized as a moral issue stemming from gluttony and excess, with the focus being on people’s diets, not their body size. In the early 20th century this focus changed, with a devaluation of any kind of fleshiness or softness of the body, primarily for women, and the increase of the value of “natural thinness” with the decline of the corset. In post-war times (post 1950s) came the medicalization of obesity; fat is conceptualized as a medical as well as a moral issue, with the introduction of weight/height charts (such as the BMI and height/weight tables of the insurance industry), and measurement of excess weight became significant in health care and determining an individual’s health. Recently the construction of “fat” has again changed: beginning in the late 20th century overweight has moved from being an individual health and moral problem to an “epidemic,” a construction reflecting the belief that “fat” is a social problem, affecting society as a whole regardless of individual weight status (Boero, 2006; Scott-Dixon, 2008). This

conceptualization of overweight is found in the general public as well as in health care, with measurement of body weight a compulsory part of health exams, even though the tools used by health care professionals are often overly simplistic and inaccurate in determining the health of an individual based on their weight (Ode, Pivarnik, Reeves & Knous, 2007; Scott-Dixon, 2008).

The most common tool used by health professionals for categorizing individuals' weight is Body Mass Index (BMI), which is calculated by dividing the individual's body weight by the square of his or her height (World Health Organization [WHO], 2006). This tool is widely used due to its simplicity, though it may not very useful in evaluating individual health because the categories were developed using general population information without taking into account gender, age, ethnicity, body fat percentage, and lean muscle mass (Ode et al., 2007; Romero-Corral et al., 2008; Scott-Dixon, 2008; WHO, 2006). The BMI was developed in the 1830s and was not intended to be considered a measurement of health, but a measure of averages to classify people on the basis of weight (Boero, 2006). According to WHO's classification, those with a BMI < 18.5 are underweight, BMI between 18.5 and 24.99 is normal weight, BMI between 25 and 29.99 is overweight, and BMI > 30 is obese, with these categories applied to both men and women regardless of age. Prior to 1998 a BMI greater than 27.8 in men and 27 in women was considered overweight; this change to lower the threshold for what is classified as "overweight" causes approximately 60% of the American population to be classified as overweight or obese even though the average weights of Americans do not appear to be rising (Boero, 2006; Hubbard, 2000).

In public health discourse in current North American society, obesity has been conceptualized as an epidemic, and fat as a disease that is linked to an unhealthy body and mind (Rice, 2007). Furthermore, unlike some other diseases, research suggests that obesity is perceived as being under the individual's control. According to attribution theory (Weiner, 1988), observers conduct an attributional analysis of an actor's outcome (especially for negative events). Observers search for the cause of the particular outcome, and the perceived cause determines their affective reaction and subsequent behavioural response to the actor (Weiner, 1988). The perception that a negative outcome is under the actor's control elicits negative emotions such as disgust and anger, which then lead to avoidance, neglect, and discriminatory behaviours (Weiner, 1988). On the other hand, the perception of a negative outcome as outside the actor's control elicits feelings of pity and intentions to provide help (Weiner, 1988).

In this context, stigmatized traits (physical, character, or tribal) are seen as negative outcomes, and certain stigmas are already associated with certain attributions so a further search is not needed (e.g., addiction is attributed to moral weakness, sexually transmitted infections are attributed to promiscuous and unsafe sexual behaviours) (Weiner, 1988). With regard to weight, the default perception appears to be that body weight is under the individual's control because they *choose* to eat too much, and they could lose weight if they only had more willpower and were less lazy (Blaine & Williams, 2004; Perez-Lopez, Lewis & Bash, 2001; Sisseem & Heckert, 2002).

The research appears to support this interpretation. Individuals who are seen to have acquired their deviant status through volitional behaviours are regarded as having character blemishes, and this stigma category is associated with harsher and more explicit

derogation than tribal or physical stigmas (DeJong, 1980; Sisseem & Heckert, 2002). Our belief that the cause of a negative outcome is under an individual's control leads to devaluing and stigmatization (Blaine & Williams, 2004; Musher-Eizenmann et al., 2004). DeJong (1980) gave each participant in his study a folder containing a photograph and description of an overweight adolescent girl. The description either contained no information regarding the cause of the excess weight, or indicated that the girl's weight was due to a thyroid condition. Results showed that participants in the thyroid condition rated the overweight girls much less negatively than no information control condition participants (DeJong, 1980). Subsequent research has also found a strong link between antifat attitudes and attributions of responsibility. In two cross-cultural studies, Crandall and Martinez (1996) and Crandall et al. (2001) measured and compared antifat attitudes, attributions of control, and individualistic ideology (ranked using Hofstede's analysis of individualism in 50 nations) in the United States, Mexico, Australia, India, Poland, Turkey, and Venezuela. The very individualistic cultures of the U.S. and Australia are characterized by the belief that individuals are responsible for their own outcomes, whereas Mexico, Turkey, India and Venezuela have a much more collectivistic cultural ideology (Hofstede, 1980). In both studies, the U.S. sample scored highest on the Antifat Attitudes (AFA) questionnaire, and they also scored much higher on items attributing overweight to a lack of will power and to personal fault (Crandall & Martinez, 1996; Crandall et al., 2001). The U.S. sample also scored highest on three social ideological variables: Belief in a Just World (BJW), political conservatism, and the belief that negative outcomes are controllable (Crandall & Martinez, 1996). Overall it was found that antifat attitudes and the attribution of excess weight to personal responsibility were

much more pronounced in the more individualistic countries including the U.S. (Crandall & Martinez, 1996; Crandall et al., 2001). Crandall and Biernat (1990) found that antifat attitudes were strongly correlated with political conservatism, which is often used as a proxy for an individualistic ideology. This pattern of research indicates that, in the absence of external explanations, the attribution is that weight is under the individual's control, which elicits affective reactions of disgust and anger, and leads to avoidance and discriminatory behaviours (Blaine & Williams, 2004; DeJong, 1980; Sisseem & Heckert, 2002; Swami et al., 2008; Weiner, 1988).

Unfortunately, these negative attitudes towards the overweight appear to be held not only by the general public, but also by health care providers and mental health professionals. Blumberg and Mellis (1985) examined the attitudes held by University of Illinois medical students towards their normal, overweight and obese patients before and after their internship. Before their internship, the students had neutral or positive attitudes towards normal weight patients, neutral or negative attitudes toward overweight patients (defined as 20% to 30% overweight), and consistently negative attitudes towards morbidly obese (30% or more overweight) patients. Unfortunately, interacting with overweight and obese patients during internship made no difference in the medical students' negative attitudes towards these patients (Blumberg & Mellis, 1985). In England, Harvey and Hill (2001) found that the top two perceived causes of obesity reported by the general practitioners and clinical psychologists in their sample were physical inactivity and overeating (stemming from food addiction or stress); their participants shared a general perception that for overweight patients to be able to lose

weight they needed to recognize their weight as a problem and take personal responsibility.

Weight bias by psychotherapists has been shown to affect clinical judgements and treatment planning for overweight female patients. Young and Powell (1985) found that when all other patient characteristics were held constant, mental health workers were much more likely to assign negative symptoms to obese patients (30% or more overweight), as compared to overweight (20% overweight) or normal weight patients. Obese patients were judged to exhibit more agitation, emotional behaviour, inadequate hygiene, self-injurious behaviour, and other inappropriate behaviours than non-obese patients. It was found that respondents' age and gender had a significant effect, such that female mental health workers were harsher in their judgements of the obese patients than male mental health workers, and younger workers were more likely to assign negative symptoms to overweight or obese patients than older workers. Unfortunately it seems that not much has changed in the past 20 years, and this weight bias is still found among mental health professionals. A more recent empirical study examining the impact of female clients' weight found that clinical psychologists rated the overweight target patient more negatively than the average weight patient (Davis-Coelho, Waltz & Davis-Coelho, 2000). Younger as compared to older psychologists predicted that the overweight client would display less effort and have a poorer prognosis than the normal weight client, and female psychologists predicted a poorer prognosis for overweight clients than male psychologists.

Overweight patients are not unaware of the negative attitudes held by health care providers. As compared to normal weight patients, overweight patients report that

physicians show less comfort and warmth and increased hostility and attribute their excess weight to laziness (Hebl, Xu & Mason, 2003). Even though physicians should have a superior knowledge of obesity and its various causes, studies have shown that they still commonly resort to the use of stereotypes (Hebl et al., 2003). Interviews with overweight female patients reveal that they are nervous and anxious when going to the doctor, knowing that the appointment requires the physician to touch and physically examine them (Hebl et al., 2003). Patients also report that doctors' offices and hospitals do not supply size-appropriate equipment (e.g., gowns, blood pressure cuffs, chairs, examination tables) (Kaminsky & Gadaleta, 2002).

These negative health care provider attitudes and behaviours can have serious implications for overweight patients' quality of care. Their care is compromised not only by the health care providers' behaviours, but by their own attempts to avoid interactions in which they feel they may be treated negatively, which can lead overweight patients to avoid seeing their doctors when needed (Hebl et al., 2003). Female patients also reported expecting harsher judgements from male health care providers, and reported more anxiety and more frequent avoidance of seeing their health care provider if he was a male (Hebl et al., 2003)

Attractiveness, body weight, and sexual activity

A critical factor in perceptions of attractiveness and sexual desirability is an individual's body weight. Overweight individuals are believed to not have as much personal control as normal weight individuals in their level of sexual activity. "Even if fat people want to have sex, who would want to have sex with them?" Research has consistently found that the most important predictor of judgements of social appeal and

social competence is attractiveness, with the effect being found more strongly in males (Langlois et al., 2000). With weight being a principal component in perceptions of attractiveness it comes as no surprise that judgements of social appeal and social competence are also very strongly tied to individuals' weight (Eagly et al., 1991), and this is especially true for women (Swami et al., 2008). Swami and colleagues (2008) investigated participants' perceptions of loneliness, laziness and being teased in a series of photos of men and women ranging in BMI from underweight to obese. They found that as BMI increasingly deviated from the normal range, women were judged as being lonelier and more teased (Swami et al., 2008). The same pattern was found for male targets; however mean ratings were much lower (Swami et al., 2008).

Furthermore, judgements of romantic relationships and romantic history (by laypersons and by health care professionals) are significantly dependent on the targets' weight. Perceptions of how love is experienced by overweight individuals are much different compared to perceptions about normal weight individuals, and are not necessarily accurate (Harris, 1990). Compared to overweight targets, normal weight targets are seen as much more likely to be currently dating either one person or several people, and more likely to have been in love (Harris, 1990). Overweight targets were assumed to not be currently dating anyone, much less likely to have experienced erotic and ludic (game-playing) love, and more likely to have experienced manic (controlling/obsessive) love (Harris, 1990). "These findings are consistent with the theory that obese people are seen as having fewer resources to contribute to a romantic relationship and thus as experiencing such a relationship less passionately, less playfully, and more desperately than a normal weight person would" (Harris, 1990, p. 1220).

However, even though observers' judgements of social and romantic relationships are heavily dependent on the target's weight, research does not support this perception; the quality of interpersonal relationships does not appear to be related to BMI (Carr & Friedman, 2006).

Not surprisingly, the perceptions of sexual characteristics and sexual experience have been found to be different for overweight men as compared to overweight women. Perceptions of the sexuality of normal weight and overweight adult men have been found to be very similar; however, compared to normal weight women, overweight women are seen as much less sexually attractive, desirable, skilled, responsive, and more likely to be virgins and not have current partners (Regan, 1996). Health care providers hold similar negative attitudes regarding the sexuality of overweight women, believing them to be less sexually attractive, and less likely to have a current partner than normal weight women (Harvey & Hill, 2001), and with all other characteristics of the patient being equal, treatment goals are significantly more likely to include "increase body image" and "increase sexual satisfaction" (Davis-Coelho et al., 2000). Researchers investigating the impact of weight loss surgery (WLS) on patients often state that the weight can be a barrier to sexual activity and satisfaction, and patients can expect their libido to increase and improvements in their romantic relationships after WLS. No consistent empirical support can be found for these propositions (Applegate & Friedman, 2008). These attributions reflect the belief that an overweight woman's limited sexual experience is nonvolitional because she is sexually undesirable to potential partners.

However, other research contradicts these attributions, and suggests that sexual experience is within the control of the overweight individual. These studies have shown

that overweight women are perceived to be less sexually responsive and as having less sexual desire (Regan, 1996), therefore not wanting or enjoying sex as much as normal weight women. Clinicians often explain binge eating as a compensatory behaviour for sexual inactivity, whereby overweight women replace sex with food (Adolfsson, Elofsson, Rossner & Unden, 2004; Kinzel et al., 2001). Other psychologists see obesity as serving a self-limiting and adaptive function for overweight women as a rationale for avoiding sexual activity (Wiederman, Sansone & Sansone, 1999). The reality suggests that neither the perception of internal or external locus of control for sexual inactivity is accurate. Many studies have found an inconsistent or nonexistent relationship between body size and sexual activity and/or sexual satisfaction (Adolfsson et al., 2004; Carr & Friedman, 2006; Harris, 1990).

Body weight, sexual activity, and sexual assault

Body size not only influences perceptions of the individual's attractiveness and sexual activity, it can be a primary cue in observers' perceptions of rape victims (Ryckman, Graham, Gold & Lindnera, 1998). As previously described, rape is still largely assumed by many to be an act of sexual gratification, motivated primarily by the man's inability to restrain himself from acting on natural sexual urges, an assumption that leads to the belief that an attractive woman is a more likely and desirable rape victim than an unattractive woman (Coates & Wade, 2004; DeJong, 1999; Tieger, 1981).

Unattractive women are seen as unlikely rape victims because they are seen as sexually undesirable and unlikely to trigger those overwhelming sexual urges (Deitz, Littman & Bentley, 1984; Thornton & Ryckman, 1983).

DeJong (1999) gave participants a series of photos of women who varied in terms

of facial attractiveness and told them that half of these women had previously been raped and half had not. Participants categorized the photos of attractive women more often as victims of rape, and the photos of unattractive women more often as not being victims of rape (DeJong, 1999). Research comparing participants' judgements of rape cases in which the rape victims varied in attractiveness, with attractiveness defined in terms of facial attractiveness, found that participants believed the rape was more likely to have actually occurred if the victim was attractive (Jacobson & Popovich, 1983; Thornton & Ryckman, 1983). Experimental studies manipulating the attractiveness of the (hypothetical) rape victim's photo have consistently showed that people feel less positively about an unattractive as compared to an attractive victim and attribute more responsibility for the attack to the unattractive victim (Deitz et al., 1984; Jacobson & Popovich, 1983; Thornton & Ryckman, 1983; Tieger, 1981). This attribution of increased responsibility to unattractive victims is based on the belief that if she was actually raped she must have acted provocatively or seductively to provoke the attack; otherwise the rapist could not have been sexually aroused and would not have wanted to rape her (Deitz, Littman & Bentley, 1984; Thornton & Ryckman, 1983; Tieger, 1981).

In the current literature on overweight stigma there is a library of research on the attributions about women's character, sexuality, and level of sexual activity, yet research tying these attributions to rape victim blaming attitudes is absent. Since weight and attractiveness are inextricably linked in Western culture the ample research base examining victim attractiveness and victim blaming can greatly inform this area of research. There is also a plethora of research examining the victim's sexual history and victim blaming; however, the sexual activity (or lack thereof) has different meanings for

overweight and normal weight women. This previous research on sexual history and victim blaming does not necessarily extend to explain victim blaming of overweight rape victims.

Secondary victimization by health care providers

Women who are overweight are already burdened with a negative character stigma, which, coupled with the character stigma imposed on rape victims may make overweight women who have been raped extremely vulnerable to secondary victimization. This can then have serious implications on the quality of their post assault care and support from the health care providers from whom they seek help. The stigma that overweight women face causes them to be perceived as flawed in character and moral standing, and consistent with the definition of stigma their humanity is devalued. This character stigma can cause these women to be perceived as non-credible so their claim of rape is not taken seriously, and they can be believed to not be deserving of help. As previous research has shown, weight stigma is prevalent in health care settings, and health care professionals' antifat attitudes can influence how they perceive and treat patients simply due to the fact that the patient is overweight. Even though weight bias is prevalent in health care, these negative attitudes would not be tapped into when health care professionals are treating normal weight patients, therefore even if the health care professional has strong antifat attitudes it would not influence interactions with normal weight patients.

As previously mentioned, the literature has consistently shown that rape is believed to be an act of sexual gratification, which leads to the belief that unattractive women are unlikely rape victims. Since weight and attractiveness are so closely linked in

Western ideals of beauty, many of the findings from the literature on victim attractiveness and victim blaming can contribute to understanding the relationship between victim weight and victim blaming. As in the case with unattractive rape victims, more responsibility may be attributed to overweight rape victims because these women can be believed to be unlikely rape victims since they are “unattractive” and are not sexually desirable.

The consensus in the rape literature is that victims who were virgins (or had a very limited sexual history) garner much more sympathy than victims who have had an extensive sexual history. Rape victims who were virgins are assumed to be much more traumatized by the assault, and much less responsibility is attributed to these women. It could be assumed that since overweight women are believed to be less sexually active and more likely to be virgins, people would have more sympathy for overweight rape victims and they would be blamed less for the attack. However, other research has found that volitional and non-volitional virginity do not hold the same value. Virginity that is non-volitional due to the fact that the individual is not sexually desirable is not as virtuous as virginity that is volitional based on moral or religious reasons. Research on attributions of sexual activity for overweight women has shown that these women are not believed to be virgins by choice, but are less sexually active because they are unattractive, undesirable, and socially incompetent.

Current study

The purpose of the current study was to investigate the influence of the attributions of obesity, sexual activity, and rape on the victim blaming attitudes of future health care professionals. This study examined the interaction of the attributions

associated with the stigmas of obesity and sexual assault, and how this influences the secondary victimization of overweight rape victims. If women choose to report their rape a health care professional is most often the person these women will seek out for help. The reaction of the health care provider can have a tremendous impact on the victim. She may feel supported and want to follow through in her reporting (which can have positive political and social implications for violence against women), or she may feel doubted and stigmatized (which can silence her and can have severe negative psychological implications). Given that health care professionals can be key post-assault service providers it is crucial that they do not endorse the victim blaming attitudes that are so commonplace in our culture. The prejudice of health care providers can be a significant barrier for overweight women to seek out health care and receive fair treatment.

The large majority of this research was conducted using samples of laypersons or undergraduate students, and although the attitudes of health care professionals have been found to mirror those of the general public it cannot be assumed that these outcomes can be universally applied to other populations. By using a sample of future health care professionals we can investigate the attitudes of the next generation of service providers and how they perceive overweight patients and patients who report being raped.

Hypotheses

Bringing together these previously outlined streams of research, it is predicted that overweight women compared to normal weight women will be judged as more responsible for a rape. Furthermore, although the research indicates that the sexual history of the victim also strongly influences attributions of blame, it is predicted that this effect will not be found for overweight women. Based on the literature, it is predicted that

less blame will be attributed to normal weight women with a limited sexual history than to normal weight women with an extensive sexual history because their limited sexual history is perceived as a virtue. Even though overweight women are believed to have a limited sexual history, it is predicted that they will not be given credit for their limited sexual history because it is perceived as nonvolitional; therefore, attributions of blame for sexually inexperienced overweight women will not differ significantly from attributions of blame for sexually experienced overweight women, and will differ significantly from attributions of blame for normal weight women with a limited sexual history.

The hypotheses are as follows:

H1: For overweight victims of rape stronger antifat attitudes will be correlated with:

- greater attributions of blame to the victim
- less positive feelings toward the victim
- less responsibility attributed to the attacker
- greater minimization of the seriousness of the rape

H2: More conservative participant sexual ideology will be positively correlated with:

- greater attributions of blame to the victim
- less positive feelings toward the victim
- less responsibility attributed to the attacker
- greater minimization of the seriousness of the rape

H3: As compared to female participants, male participants will:

- have less positive feelings toward the victim
- attribute more responsibility to the victim
- attribute less responsibility to the attacker

- will evaluate the rape as less serious

H4: As compared to participants evaluating normal weight victims, participants evaluating overweight victims will:

- have less positive feelings toward the victim
- attribute more responsibility to the victim
- attribute less responsibility to the attacker
- and will evaluate the rape as less serious

H5: As compared to participants evaluating normal weight victims with an extensive sexual history, or overweight victims with either limited or extensive sexual history, participants evaluating normal weight victims with a limited sexual history will:

- attribute less responsibility to the victim
- have more positive feelings toward the victim
- attribute more responsibility to the attacker
- will evaluate the rape as more serious

CHAPTER II DESIGN AND METHODOLOGY

Experimental Design

The experiment was a 2 (limited/extensive sexual history) x 2 (average/overweight) x 2 (participant gender) between-subjects factorial design with sexual ideology (as measured by SAS) included as a covariate.

Participants

91 participants were recruited for this study. For the 89 participants who completed the demographic questionnaire there were 53 females and 36 males. Participants were enrolled in programs that trained them to work in the health care field: 26 in the Faculty of Nursing (20 female, 6 male), 14 in the School of Social Work (all female), 38 in the Faculty of Human Kinetics (19 female, 19 male), and 11 in the Schulich School of Medicine (all male). The participant demographics are presented in Table 1.

Table 1
Sample Demographics (N=89)

Variable	Statistics
Gender	60% female, 40% male
Age	18-51 ($M=23.7$, $SD=7.26$)
Ethnicity	71% Caucasian, 8% East Asian, 6% Middle Eastern, 4% Black, 4% mixed, 1% Hispanic, 1% South Asian, 5% unidentified
Program of Study by Gender	43% Human Kinetics (50% male, 50% female) 29% Nursing (77% female, 23% male) 16% Social Work (100% female) 12% Medical School (100% male)
Year of Study	28% first year, 24% second year, 18% third year, 23% fourth year, 7% graduate students

Procedure

Faculty members in the Faculty of Nursing, Faculty of Human Kinetics, School of Social Work, and the Schulich School of Medicine were contacted via e-mail. The email contained information describing the general objective of the study and a request for permission to speak to the students in their class for a few minutes to advertise the study and hand out flyers. Flyers advertising the study with the researcher's contact information were posted in common areas in the participating faculties/schools, and an email was sent to all potential participants by the faculty/school secretary identifying the general objective of the study and providing the researcher's contact information. The email indicated that participation in the study was voluntary, that participants could withdraw from the study at any time without penalty, that all collected information was anonymous, and that all participants could enter their name in a draw for one of five \$100 prizes. Reminder emails were sent out periodically throughout the Winter and Summer 2010 semesters. The recruitment materials can be found in Appendix A.

Students were instructed to contact the researcher by phone or email if they wished to participate in this study. Sessions for participants to complete the survey were scheduled several times a week throughout the Winter and Summer 2010 semesters, with groups ranging in size from 1 to 11.

When participants entered the room to participate they were given a ballot to fill out and place in the ballot box for the gift certificate draw. Participants then read the informed consent form (Appendix B) and signed it if they agreed to participate. Once this form was signed and returned to the researcher, participants were given the survey package containing all other materials. The researcher verbally instructed participants to

carefully read and complete all the materials and to then return the package to her.

All participants read three vignettes that were presented as hospital emergency room patient file reports¹, with the relevant information described as the result of the interview conducted by the ER intake nurse. The experimental vignette described a young woman who had been raped (Appendix C). For the limited sexual history condition the woman was described as having had one previous sexual partner, for the extensive sexual history condition the woman was described as having several previous sexual partners. For the average weight condition the woman was 5'7"(5'5")²/170cm tall and weighed 121lbs/55kg, and for the overweight condition the woman was 5'7"/170cm tall and weighed 250lbs/114kg³.

There were two distracter vignettes that described a man who had been mugged and a young girl who was in a school yard fight. Participants were randomly assigned to one of the four experimental conditions, with the order of the experimental and distracter vignettes presented in a counterbalanced order to control for possible order effects.

After each patient file, participants completed the manipulation check and dependent measures. They completed antifat attitude, sexual ideology and demographic measures after they had completed reading all three patient vignettes.

Following completion of the questionnaires, participants were debriefed (Appendix D) regarding the true purpose of the study and allowed to voice any concerns or ask any questions. During the debriefing participants were probed to as to what they

¹ From this point forward, the rape victim will be referred to as "patient" given that in the context of this study, the rape victim is a patient at an ER.

² The height of the normal weight patient with a limited sexual history was inadvertently recorded as 5'5" instead of 5'7"; however, the manipulation checks indicated that all participants perceived the patient who was 121lbs/55kg as normal weight regardless of her height.

³ Weight manipulations were chosen based on subjective judgements of what would be the perceptions of normal weight and overweight, not based on BMI or other medical classifications. The weight manipulations were corroborated by colleagues and peers.

thought this study was investigating. No participants indicated that they thought this study was specifically investigating victim blaming of rape victims; the majority of participants believed that this study was investigating the differences in victim blaming attitudes depending on the type of incident that required the patient to seek medical care. Many participants indicated that they thought that the weight of the patient was a variable due to the inclusion of the antifat attitudes scale. Participants were also reminded of their right to remove their data from the study, provided with a debriefing handout (Appendix E) containing a research summary and the researcher's contact information if any questions or concerns arose, thanked for their participation and asked not to discuss the experiment with other potential participants. No participants chose to withdraw their data from the study after being debriefed.

Experimental Measures

Demographic Questionnaire. Participants were asked to indicate their gender, age, ethnicity, year of study, and program of study. The demographic questionnaire is included in Appendix F.

Manipulation Checks. After reading each vignette, participants completed three forced choice items, including their recall of the victim's weight, height, and sexual experience. Participants also responded to filler items asking about the patient's arrival time, method of arrival and treatment given. These filler items were included to disguise the specific variables of interest in this study to maintain the deception of the purpose of the study. The manipulation check items can be found in Appendix G.

Sexual Attitude Scale. Sexual ideology was measured using Hudson, Murphy, and Nurius' (1983) Sexual Attitude Scale (SAS). Sexual ideology refers to beliefs and

attitudes regarding sexual regulation and expression. Scores on the SAS indicate whether the individual has a liberal or conservative orientation toward human sexuality. This scale consists of 25 items scored on 5-point Likert scales ranging from 1 (strongly disagree) to 5 (strongly agree), with items 21 and 22 reverse scored. Scores on the SAS range from 0 to 100 with higher scores indicating a more conservative sexual ideology. This scale has been shown to have good psychometric properties with a Cronbach's alpha of .94, and good criterion and discriminant validity (Hudson et al., 1983; Troiden & Jendrek, 1985). The SAS is included in Appendix H.

Antifat Attitudes Test (AFAT). Attitudes towards overweight individuals were measured using Lewis, Cash, Jacobi and Bubb-Lewis' (1997) Antifat Attitudes Test (AFAT). This questionnaire assesses cognitive, affective, and behavioural dispositions towards overweight individuals, with no items concerning individual's judgements of their own body weight. The AFAT consists of 47 items that yields an overall mean score as well as scores on three subscales: social/character disparagement (15 items), physical/romantic unattractiveness (10 items), and weight control/blame (9 items). Each item is answered using a 5-point Likert scale ranging from 1 (strongly disagree) to 5 (strongly agree), higher scores reflecting stronger endorsement of antifat attitudes. Items 2, 21, 31, 37, 40, 42, 45, and 47 are reverse scored. Lewis et al. (1997) reported that the AFAT has good psychometric properties, with coefficient alphas of the overall scores and subscale scores ranging from .82 to .95. The AFAT scale is included in Appendix I.

Rape Responsibility Questionnaire Revised. Participants completed a revised version of the Rape Responsibility Questionnaire (RRQ) (Deitz & Byrnes, 1981). The RRQ consists of 12 items divided into four subscales that constituted the four dependent

variables in this study: feelings toward the rape victim (3 items), responsibility of the rape victim (5 items), responsibility of the attacker (2 items), and perceived seriousness of the attack (2 items) rated on 5-point Likert scales. Two items from the Victim Culpability Scale (George & Martinez, 2002) were added to the RRQ to better gauge perceptions of victim responsibility: “How much did the victim have the capacity to stop/prevent the attack?” and “How much choice did the victim have in this situation”, to create the RRQR used in the present study. For each item the word “victim” was replaced with “patient” to allow for consistent wording of items across the experimental and distracter scenarios. Becker-Lindow (2008) reported that scores on the RRQ are correlated with scores on the Rape Empathy Scale, the Attitudes Towards Women Scale, and the Rape Myth Acceptance Scale, however reliability data for the RRQ are not available. Participants completed the RRQR after they had read each patient file and completed the manipulation check. The RRQR used in this study can be found in Appendix J.

CHAPTER III RESULTS

Preliminary Analyses

Manipulation Checks

Examination of the manipulation check data indicated that all participants ($N=91$) accurately recalled the patient's weight and sexual history as provided in their patient files. A small number of participants ($n=8$) did not accurately recall the patient's time of arrival or the treatment given to the patient, but since this information was not relevant to the experimental manipulations no data were excluded from the analyses based on the manipulation checks.

Demographic Questionnaire

Two participants did not complete any of the demographic questionnaire items, including gender and program of study, so their data were excluded from subsequent analyses ($N=89$). Four participants who completed other demographic questionnaire items did not indicate ethnicity, and one participant did not indicate year of study, but as this information was not used in the analyses conducted for the present study, these participants were not excluded.

Antifat Attitudes Test (AFAT)

Responses on the AFAT were analysed for outliers and missing data. In examining the z-scores of AFAT no outliers were detected, and there was no missing data for this scale. The means, standard deviations, and reliability coefficients for AFAT are displayed in Table 3. Reliability analyses of the AFAT indicated that this scale has very good reliability with reliability coefficients comparable to those reported by Lewis, Cash, Jacobi and Bubb-Lewis (1997). For the whole AFAT scale there is a Cronbach's α of .95,

an α of .85 for the subscale of social/character disparagement, an α of .82 for the subscale of physical/romantic unattractiveness, and an α of .82 for the subscale of weight control/blame.

Sexual Attitudes Scale (SAS)

The formula for the calculation of the total SAS score compensates for missing items so it was not necessary to conduct analyses on missing items. Responses on the SAS were examined for outliers, with one case exceeding the cut-off (cut-off of $z = \pm 3.29$, Tabachnick & Fidell, 2001), and two cases in which the SAS was not completed. These three cases were removed from the analyses ($N=86$).

Reliability analyses of the SAS indicated that this scale has a very good reliability with a Cronbach's α of .92, which is comparable to reliability coefficients found in previous research. Scores on the SAS range from 0 (liberal) to 100 (conservative), and the mean SAS score was 38.42 with a standard deviation of 8.76, which indicates that this sample has a liberal sexual ideology with little variance.

Although preliminary analyses indicated that the SAS did not have a linear relationship with the dependent variables, thus violating covariate assumptions, the covariance analysis is robust with regard to this violation, so the covariance analysis was conducted. However, the covariance analysis revealed that the SAS was not a significantly covariate. (The correlations between the SAS and the RRQR subscales are presented in Table 2.) As a result, the SAS was removed from subsequent analyses, and the statistical test used was a MANOVA rather than a MANCOVA. Since the SAS was not included in the analyses, the three cases that were previously removed during data screening as SAS outliers were included in the main analyses, for a total $N=89$.

Table 2
Correlations Between SAS and the RRQR subscales

	Feelings Toward Patient	Patient Blame	Attacker Blame	Perceived Seriousness of Rape
Sexual Attitudes Scale	-.04	.05	-.08	.07

**all correlations non-significant*

This indicates that there was no support for the hypothesis that more conservative sexual ideology would be associated with less positive feelings toward the patient, more patient blame, less attacker blame and less perceived seriousness of the attack. Further, there was no support even when the data were examined separately for males and female and for students in different programs.

Rape Responsibility Questionnaire Revised

All 89 respondents completed all items on all four RRQR subscales. The boxplots and z-scores of the RRQR subscales were examined to identify outliers, defined as those with data exceeding $z = \pm 3.29$ (Tabachnick & Fidell, 2001). RRQR subscale data were also examined for multivariate and influential outliers, using Mahalanobis' distance and Cook's values (cut-off of >1), but none were found. Therefore no data were removed based on data screening of the RRQR subscales.

Inter-item correlations and Cronbach's α were used to examine the reliability of the four RRQR subscales. Table 3 displays the inter-item correlations for the 14 items constituting the four subscales, and Table 4 displays the means, standard deviations, and reliability coefficients for each of the subscales.

Table 3
Inter-item Correlation Matrix of Rape Responsibility Scale

Variable Name		1					2					3			4	
	Item	1	2	7	3	4	5	8	9	10	12	11	14	6	13	
1. Feelings towards patient	1	-	.46*	.48*	.14	-.31*	-.32*	-.07	.02	-.20	-.07	.23	.04	.24	.30	
	2		-	.50*	.03	-.15	-.06	-.17	.08	-.11	-.06	.24	.03	.15	.15	
	7			-	.01	-.23	-.31	-.19	-.22*	-.12	-.20	.21	.10	.20	.12	
2. Patient responsibility	3				-	-.01	-.05	.17	.01	.01	-.22	.05	-.21	.01	.04	
	4					-	.43*	.42*	.46*	.31*	.40*	-.21	-.15	-.23	-.33*	
	5						-	.48*	.59*	.41*	.41*	-.43*	-.10	-.22	-.33*	
	8							-	.43*	.41*	.41*	-.28*	.21	-.16	-.09	
	9								-	.37*	.38*	-.31*	-.21	-.03	-.06	
3. Attacker responsibility	11											-	.10	.13	.10	
	14												-	-.04	-.05	
	6													-	.52*	
4. Perceived seriousness of the attack	13														-	

* $p < .05$

Table 4
Means, Standard Deviations, and Reliability Coefficients of AFAT, SAS, and RRQR

Scale	<i>M</i>	<i>SD</i>	Cronbach's <i>a</i>
Antifat Attitudes Test (social/character disparagement)	1.61	.49	.85
Antifat Attitudes Test (physical/romantic unattractiveness)	2.69	.65	.82
Antifat Attitudes Test (weight control/blame)	2.81	.71	.82
Sexual Attitudes Scale	38.42	8.76	.92
Feelings Toward Patient	3.48	.51	.62
Patient Blame	1.74	.79	.75
Attacker Blame	4.80	.45	+
Perceived Seriousness of the Rape	4.76	.47	.68

+not available for a one item scale

For Feelings Toward the Patient (items 1, 2, 7), Cronbach's α was .62, and item-total analyses indicated that deleting any of these items would not increase reliability. Although a Cronbach's α of .70 is generally regarded as the minimal acceptable reliability (Field, 2005), the inter-item correlations were quite high and positive, so this scale was deemed acceptable.

The Patient Responsibility subscale (items 3, 4, 5, 8, 9, 10, 12) had a Cronbach's α of .63, with the analysis indicating that deleting item 3 would increase reliability to $\alpha=.75$. Item 3 ("To what extent was the patient's involvement in the incident due to chance?") did not correlate significantly with any of the other items on the Patient Responsibility subscale or with any of the items on the other subscales. Therefore, item 3 was removed from the Patient Responsibility subscale and not included in subsequent analyses.

The Attacker Responsibility subscale (items 11, 14) reliability was quite low at $\alpha=.21$, with these items having a very low and non-significant correlation. Examination of inter-item correlations for the entire RRQR scale indicated that item 11 ("How responsible is the attacker for what happened?") correlated significantly and negatively with Patient Responsibility subscale items. However, item 14 ("How certain are you of the attacker's guilt for committing the attack?") did not correlate significantly with any of the other items on any of the other subscales. Therefore, item 11 was retained as a measure of Attacker Responsibility, and item 14 was excluded from subsequent analyses.

The Perceived Seriousness of the Rape subscale (6, 13) had a marginally acceptable Cronbach's α of .68, but these two items were highly correlated so this scale was deemed to have acceptable reliability for the analyses.

Reliability analyses were also conducted on the male and female samples separately to examine if there were different patterns of responding among male and female participants. These analyses revealed no differences in reliability or inter-item correlations for the male and female samples.

Assumptions of MANOVA

Since the four RRQR subscales are correlated with each other, a Multivariate Analysis of Variance is the most appropriate statistical test as it takes into account the relationship between the dependent measures and controls for Type I error compared to conducting several ANOVAs. The correlations among the four subscales are displayed in Table 4. Since the four subscales are not correlated too highly with one another, it can be said that there is not a problem with multisphericity for the outcome measures.

Table 5
Correlations Between the RRQR Subscales

Variable	1	2	3	4
1. Attacker Blame	-	.19	-.41**	.21*
2. Feelings Toward Patient		-	-.11	.35**
3. Patient Blame			-	-.30**
4. Perceived Seriousness of the Rape				-

* $p < .05$
** $p < .01$

It is assumed that the independence of observations assumption is met as participants were randomly assigned to the four experimental conditions and this was not a repeated measures design. As there is no specific test for multivariate normality, univariate and bivariate normality were assessed. Examination of the Shapiro-Wilk's statistics indicates that the data did not meet the assumption of univariate normality. Further, the scatterplots of all the pairs of dependent variables indicated that these data did not meet bivariate normality assumptions. Given these findings it can be said that the assumption of multivariate normality was violated; however, MANOVA is fairly robust

to violations of normality, especially if homogeneity of variance is not also violated (Field, 2005).

Box's M was used to assess homogeneity of covariance matrices and was found to be non-significant ($F(42, 4042) = 1.35, ns$) which indicates that there is homogeneity of covariance matrices; however, this test is very susceptible to violations of multivariate normality so the results of this test may not be accurate in indicating whether the assumption of homogeneity of covariance matrices is met. Since the normality and homogeneity assumptions may not be tenable the Pillai-Bartlett trace is the most appropriate test statistic as it is the most robust to violations of assumptions (Field, 2005).

Main Analyses

Antifat Attitudes and Rape Responsibility

To test Hypothesis one, which predicted that antifat attitudes would be related to attributions of rape responsibility for participants in the overweight patient conditions, a correlation matrix was generated for the four AFAT scores and the four RRQR scale scores. Examination of the correlations in Table 6 for the 43 participants who were assigned to read the files of the overweight patients reveals several significant moderate to high correlations that confirm the hypothesis for two of the four AFAT subscales: Attacker blame and perceived seriousness of the rape. Attacker blame was significantly correlated with overall AFAT scores, physical/romantic unattractiveness subscale scores, and weight control/blame subscale scores. Perceived seriousness of the rape was significantly correlated with overall antifat attitudes scores, character disparagement subscale scores, and weight control/blame subscale scores.

Examination of the pattern of correlations by participant gender revealed that for the female sample ($n = 29$), only the character disparagement subscale and perceived seriousness of the rape correlated significantly. For the male sample ($n = 14$), the dependent variables of attacker blame and perceived seriousness of the rape had moderate to strong negative correlations with all four AFAT scores.

Table 6
Correlations Between Antifat Attitudes and the Rape Responsibility Subscales for the Overweight Condition

Antifat Attitude Scores	Rape Responsibility Subscale			
	Feelings Toward Patient	Patient Blame	Attacker Blame	Perceived Seriousness of Rape
Total ($n = 43$)				
Antifat Attitudes	-.21	.10	-.39**	-.33*
Character Disparagement	-.13	.04	-.28	-.42**
Physical/Romantic Unattractiveness	-.18	.03	-.31*	-.21
Weight Control/Blame	-.23	.17	-.46**	-.28
Females ($n = 29$)				
Antifat Attitudes	-.14	.02	.03	-.27
Character Disparagement	-.04	.03	.19	-.45*
Physical/Romantic Unattractiveness	-.10	-.10	.08	-.10
Weight Control/Blame	-.13	.07	-.10	-.13
Males ($n = 14$)				
Antifat Attitudes	-.11	.31	-.62*	-.52*
Character Disparagement	-.08	.11	-.53*	-.39*
Physical/Romantic Unattractiveness	-.08	.34	-.58*	-.49*
Weight Control/Blame	-.20	.45	-.68**	-.68**

* $p < .05$

** $p < .01$

Males also had significantly higher overall antifat attitudes than females ($F(1, 81) = 5.33, p < .05, d = 0.5$, power = .63), as well as significantly higher scores on the physical/romantic unattractiveness subscale ($F(1, 81) = 4.7, p < .05, d = .47$, power = .57). Males also had higher scores on the character disparagement subscale ($F(1, 81) = 3.28, p = .07$) and the weight blame/control subscale ($F(1, 81) = 3.18, p = .07$) that were marginally significant. (See Figure 1). Participants also differed on their antifat attitudes by their program of study. Participants from Social Work had significantly lower antifat

attitudes than all other programs of study (for all four AFAT scores), with the other three programs of study not differing significantly on their antifat attitudes except for the medical school students, who had significantly higher scores on the Weight Control/Blame subscale than the three other programs of study (See Figure 2). Table 7 displays the means and standard deviations of anti-fat attitudes by gender and program.

Figure 1
Anti-Fat Attitudes by Participant Gender

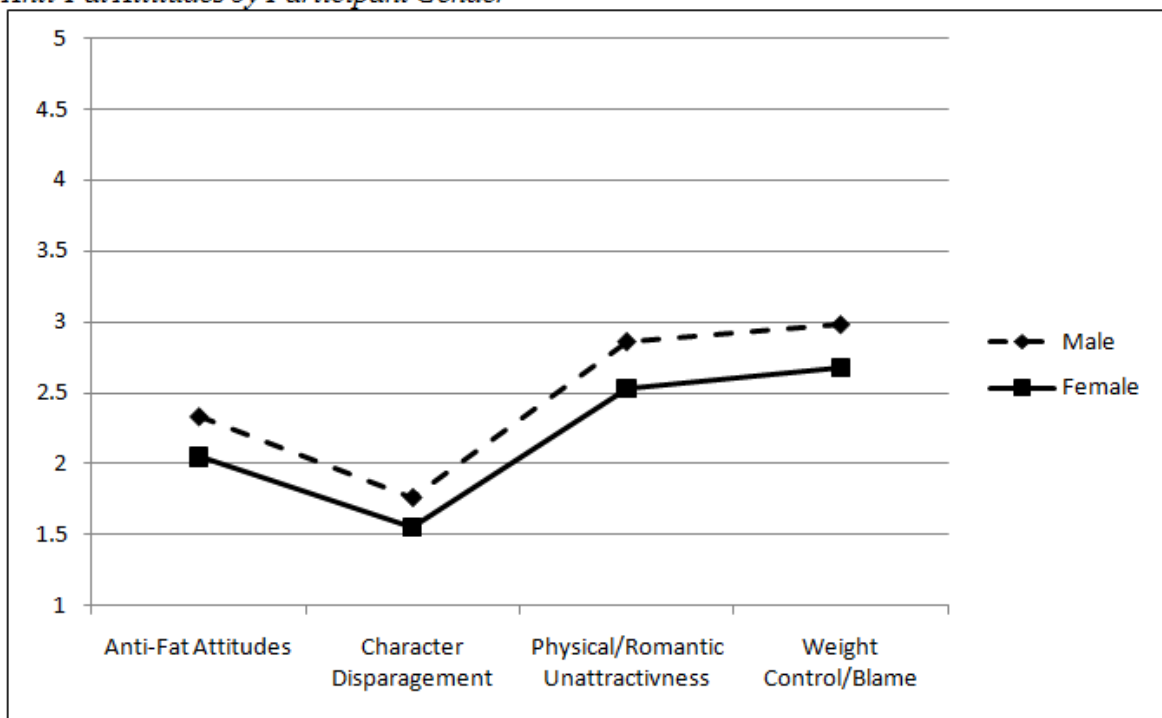


Figure 2
Anti-Fat Attitudes by Participant Program of Study

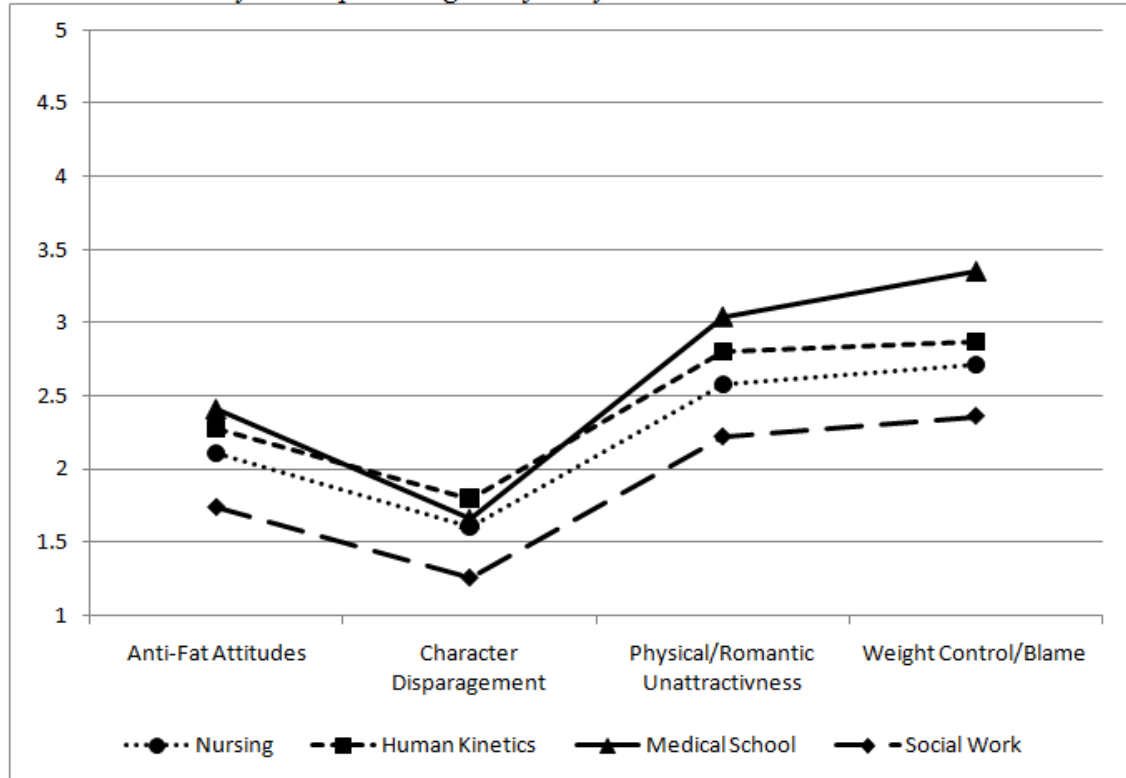


Table 7
Means and Standard Deviations of Antifat Attitudes by Participant Gender and Program of Study

	Males		Females		Nursing		Human Kinetics		Medical School		Social Work	
	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD
Antifat Attitudes	2.33	.09	2.05	.08	2.11	.12	2.28	.13	2.41	.15	1.74	.14
Character Disparagement	1.76	.08	1.55	.08	1.61	.11	1.8	.12	1.66	.14	1.26	.13
Physical/Romantic Unattractiveness	2.86	.11	2.54	.10	2.58	.15	2.8	.17	3.04	.19	2.22	.17
Weight Control/Blame	2.97	.12	2.68	.11	2.71	.16	2.87	.18	3.35	.21	2.36	.18

Gender, Weight, Sexual History and Rape Responsibility

It will be recalled that it was expected that male participants would be less sympathetic to the patient than female participants across all conditions (Hypothesis 3),

that participants evaluating overweight patients would be less sympathetic than those evaluating normal weight patients (Hypothesis 4) and that normal weight patients with little sexual experience would be regarded significantly more sympathetically than the other three categories of patient (Hypothesis 5). Support was provided for the differential evaluation of patients based on participant gender, patient weight and patient sexual experience, but not in the ways predicted.

Examination of the results of the 2 x 2 x 2 MANOVA indicated a significant effect for sexual history ($F(4, 78) = 2.96, p < .05, d = 0.40, \text{power} = .76$), and a significant three-way interaction for gender x weight x sexual history ($F(4, 78) = 3.10, p < .05, d = 0.41, \text{power} = .78$). No other significant multivariate effects were found.

The univariate tests for the effect of sexual history indicated a significant effect for one of the four subscales: feelings toward the patient ($F(1, 88) = 10.08, p < .01, d = .68, \text{power} = .87$). Examination of the mean differences indicated that participants had significantly more positive feelings towards patients with a limited sexual history ($M = 3.12, SD = .08$) than patients with an extensive sexual history ($M = 2.77, SD = .07$) (See Figure 3).

In examining the univariate tests, the significant gender x sexual history interaction for attacker blame ($F(1, 81) = 4.58, \text{power} = .57$) revealed that male and female participants did not differ in their attributions of blame to the attacker for patients with a limited sexual history. However, for patients with an extensive sexual history, female participants ($M = 4.89, SD = .09$) attributed significantly more blame to the attacker than did male participants ($M = 4.52, SD = .11$). (See Figure 4.)

Figure 3
Feelings Towards the Patient by Sexual History

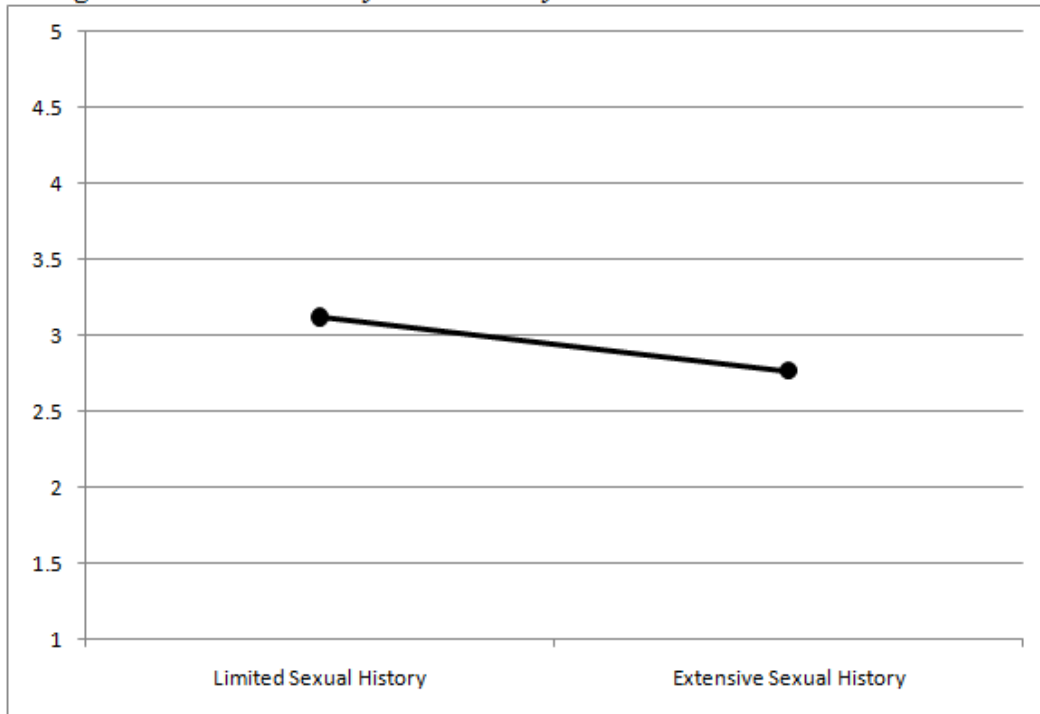
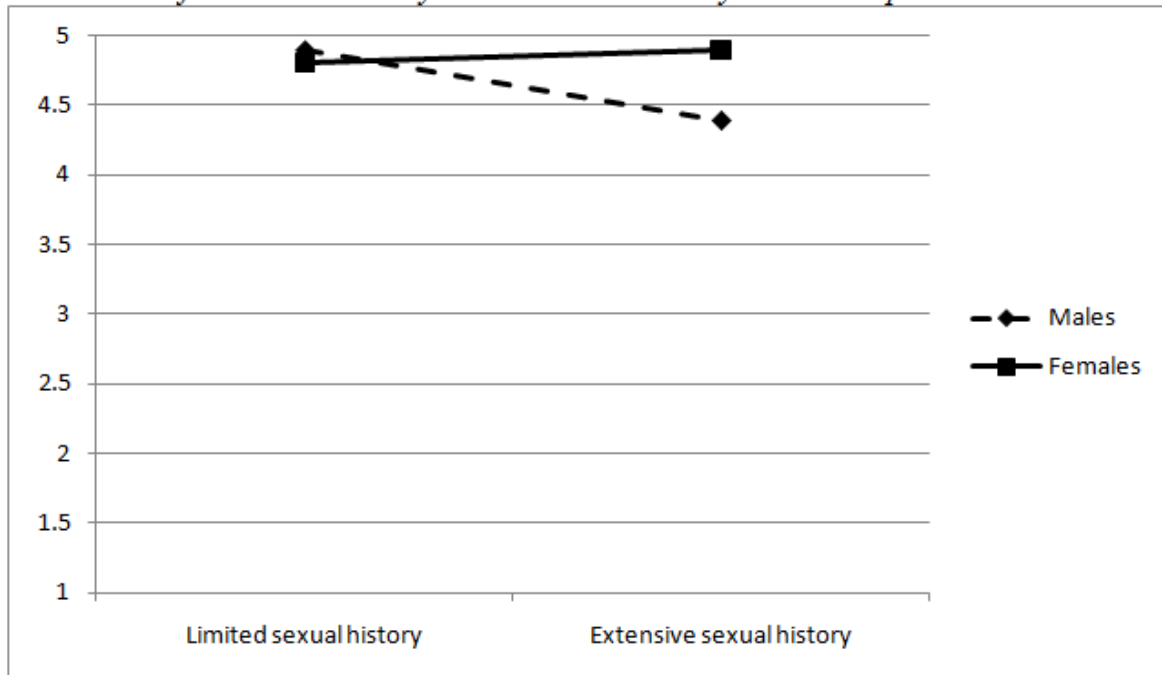


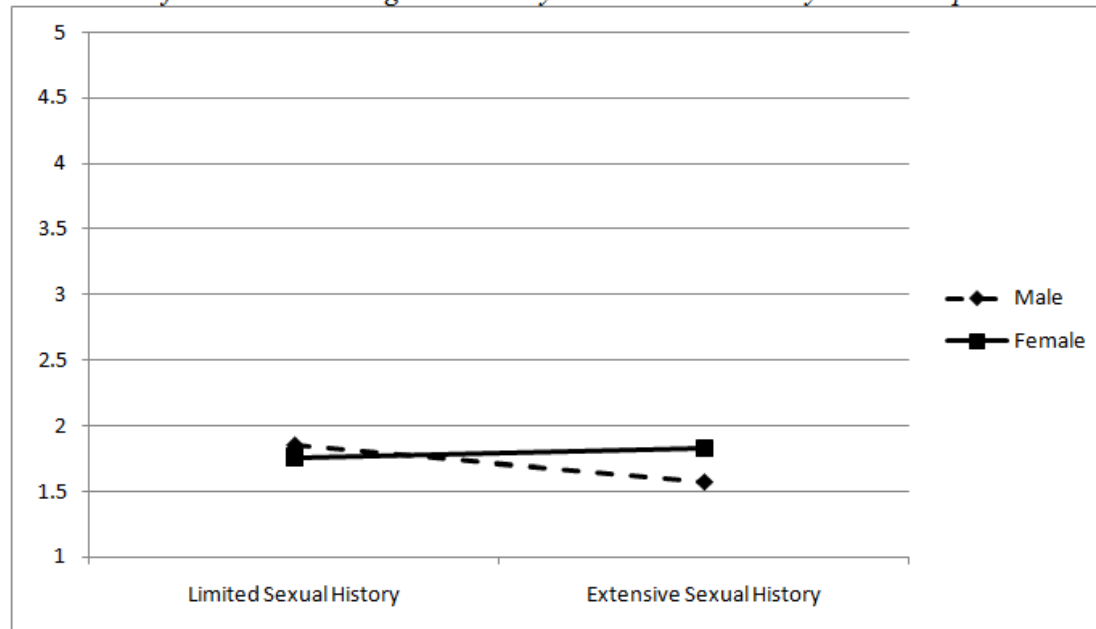
Figure 4
Attributions of Attacker Blame by Patient Sexual History and Participant Gender



An examination of the univariate tests for the three way interaction of gender x weight x sexual history indicated a significant effect for attributions of blame to the patient. Male ($F(1, 80)=.99, ns$) and female ($F(1, 80)=.14, ns$) participants did not differ significantly in their ratings of blame for overweight patients regardless of whether the patients had a limited or extensive sexual history (See Figure 5).

Figure 5

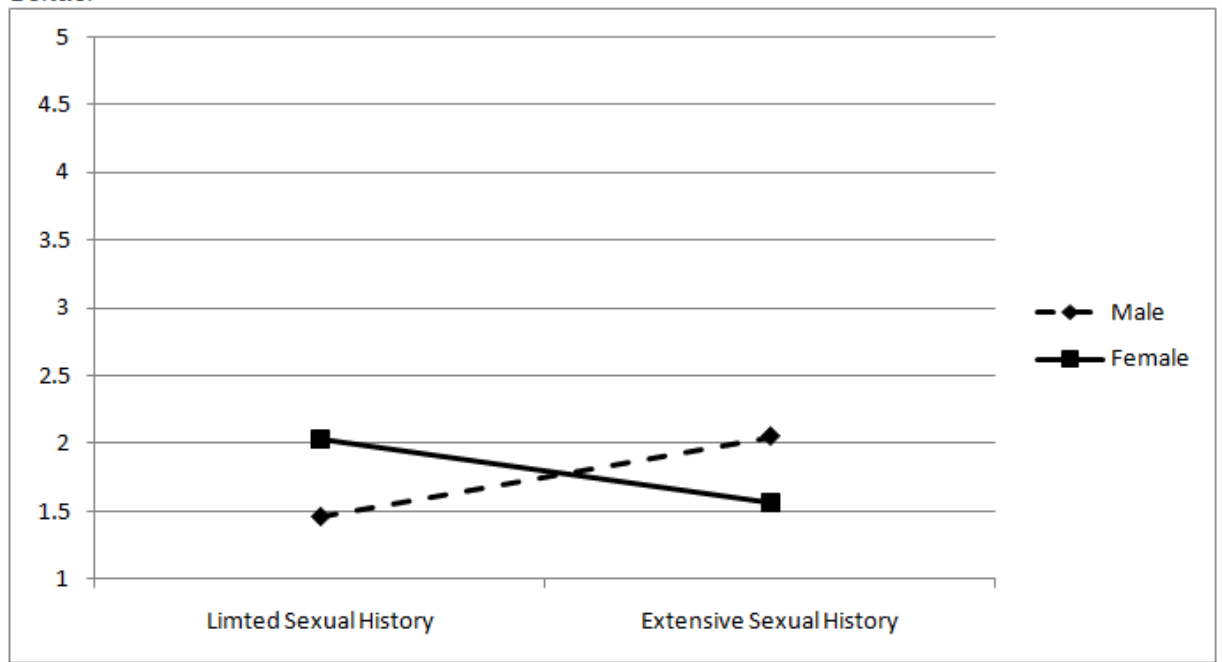
Attributions of Blame to Overweight Patients by Patient Sexual History and Participant Gender



However, male and female participants had opposite patterns of responding to normal weight patients in their attributions of patient blame. Male participants blamed patients with an extensive sexual history ($M = 2.05 SD = .16$) significantly more than patients with a limited sexual history ($M = 1.45 SD = .15$) ($F(1, 80) = 7.46, p < .01, d = .31, power = .77$), while female participants blamed patients with a limited sexual history ($M = 2.03 SD = .15$) significantly more than patients with an extensive sexual history ($M = 1.55 SD = .15$) ($F(1, 80) = 4.99, p < .05, d = .20, power = .60$). Female participants also attributed significantly more blame ($M = 2.03 SD = .15$) to normal weight patients with a

limited sexual history than did male participants ($M = 1.45$ $SD = .15$) ($F(1, 80) = 7.20, p < .01, d = .15$, power = .75), and male participants attributed significantly more blame ($M = 2.05$ $SD = .16$) to normal weight patients with an extensive sexual history than did female participants ($M = 1.55$ $SD = .15$) ($F(1, 80) = 5.20, p < .05, d = .15$, power = .62). (See Figure 6).

Figure 6
Attributions of Blame to Normal Weight Patients by Patient Sexual History and Participant Gender



CHAPTER IV DISCUSSION

Discussion of Results

The present study was designed to investigate the attitudes of future health care providers towards overweight patients reporting a rape. Weight stigma is pervasive in our culture, especially towards women, given the incorporation of thinness into cultural definitions and perceptions of beauty. Not surprisingly, the antifat attitudes of health care professionals have been found to be similar to those of the general public, even for those who are specifically trained and educated in issues of body weight and obesity (Schwartz, Chambliss, Brownell, Blair, & Billington, 2003). The blaming of sexual assault victims by health care providers is also problematic given that they are key post-assault service providers, and their reactions to patients who report being raped can have a tremendous impact (Boutcher & Gallop, 1996; Campbell, 2008). The present study sought to investigate the attitudes of future health care professionals as they will be the next generation of service providers, and the attitudes that they hold about weight and rape can be revealing in terms of what stereotypes and biases health care education should be targeting.

Hypothesis 1 predicted that participant's antifat attitudes (as indicated by higher scores on the AFAT) would be positively correlated with greater attributions of blame to the patient, less positive feelings toward the patient, less responsibility attributed to the attacker, and greater minimization of the seriousness of the rape for the overweight patients. Consistent with the hypothesis, antifat attitudes were moderately to strongly related with attacker blame and perceived seriousness of the rape, and when analyzed separately by participant gender this pattern was stronger for males and weaker for

females. Women's antifat attitudes regarding character disparagement were found to be related to perceived seriousness of the crime, in that the women who believed that being overweight is a character flaw also perceived the rape as being a less serious crime and having less of a psychological impact on the victim. This can be related to previous research that indicates when a woman is believed to have be flawed in character (i.e., being unchaste, being a bad mother, or in this case being fat), her rape is perceived as less serious because the violation is not considered to be as serious (Masser, Lee, & McKimmie, 2009). Research indicates that women empathize with female rape victims more than men do by virtue of their shared gender (Coller & Resick, 1987). By believing the victim to have a character flaw (being fat), they can separate themselves from the victim, which makes them feel less personally threatened and more likely to perceive the rape as less serious (Maes, 1994; Van Prooihen & Van Den Bos, 2009).

Not only were men found to have higher antifat attitudes than women, all four AFAT scores were found to be strongly negatively related to attributions of blame to the attacker and perceived seriousness of the rape. Therefore, for overweight patients the attacker was blamed less and the rape was perceived as less serious among males who had stronger antifat attitudes, believed being overweight was a character flaw, believed those who are overweight are physically and romantically unattractive, and believed that being overweight is under the individual's control. This pattern indicates that not only do men have a stronger bias against overweight individuals than women, but there is a stronger relation for men as compared to women between these negative attitudes and their perceptions of an overweight rape victim and her rape. Given this male bias against overweight women, the lack of significant gender x weight interactions is most likely

attributable to inadequate power. There were only 14 men, but 29 women, in the overweight rape victim conditions, and a post-hoc power analysis corroborates this assumption as power was approximately .43 for the analyses of weight effects.

The finding that participants from the Social Work program had significantly lower scores on all four AFAT scores and that participants from the medical school had higher weight control/blame scores may be confounded with participant gender. All participants from the Social Work program were women, and all participants from the medical school were men; therefore, it is unclear whether differences in antifat attitudes may be more appropriately attributed to participant gender or to the training program. However, it is not surprising that Social Work participants were all female given that only about 18% of Social Work students for the 2010-2011 school year were male. It is more surprising that all participants from the Medical School were male given that the gender distribution of students are more equal with approximately 46% of students being female. Possible reasons for this discrepancy are addressed in subsequent sections of this discussion.

Hypothesis 2 predicted that a more conservative ideology (indicated by higher SAS scores) would be positively correlated with greater attributions of blame to the patient, less positive feelings toward the patient, less responsibility attributed to the attacker, and greater minimization of the seriousness of the rape. This hypothesis was not confirmed; SAS was not related to the dependent variables, and the multivariate analysis of covariance indicated that it was not a significant covariate. Although scores on the SAS have been found to be correlated with a higher tolerance of rape and less acceptance of premarital sex, this scale was developed in 1983 and the cultural ideology about

acceptable sexual activity has changed dramatically in the past two decades (Bogle, 2004). An extensive literature search revealed that there has been no scale developed recently that measures sexual ideology on a conservative to liberal dimension. Given the outdated nature of many of the questions on the SAS it is not surprising that the mean was very liberal and there was little variance in participants' scores. Although this scale was selected as it was the best available to measure liberal to conservative sexual ideology, what is deemed conservative or liberal in terms of sexual attitudes is relative in nature, beliefs that would be considered liberal two decades ago may now be considered conservative beliefs. This scale will be further discussed with the limitation and future directions of this research.

Hypothesis 3 predicted that, as compared to female participants, male participants would have less positive feelings toward the patient, attribute more responsibility to the patient, attribute less responsibility to the attacker, and will evaluate the rape as less serious. Much previous research has shown that overall women have lower rape victim blaming attitudes than men, which is attributed to factors such as increased empathy and identification by females with rape victims, as well as the findings that rape myths are found to be more highly endorsed by males (Maurer & Robinson, 2007). Contrary to expectations, no main effects were found for gender; male and female participants did not significantly differ on their feelings towards the patient, attributions of blame to the patient, attributions of blame to the attacker, and perceived seriousness of the rape. This pattern of findings suggests that the victim blaming attitudes of men and women may be more similar than expected.

However, a significant gender x sexual history interaction was found for feelings towards the patient as well as attributions of blame to the attacker. Patients with an extensive sexual history elicited less positive feelings from male participants than female participants, and the attacker was blamed significantly less by male participants than female participants. This indicates that victim sexual history has a stronger effect on males' attitudes towards the patient and rape than females' attitudes, consistent with previous research (Bunting, 1996; Conrad, 2006; McDermott & Blackstone, 2002; Odone, 2004). Even though it seems that men and women are not that different in terms of their rape victim blaming attitudes, sexual history still has a strong and negative influence on victim blaming attitudes of males.

When thinking about this unexpected similarity between male and female victim blaming attitudes, it is important to take into consideration the context of the study as the format the scenarios were presented in is considerably different than most attribution research in which scenarios are presented as a paragraph(s) describing a rape/report. The use of medical charts may make the victim more "real" to participants and the fact that the victim is in an emergency room may increase the perceived seriousness, which could have decreased the victim blaming attitudes of men. Attribution research that uses scenarios can be quite artificial and participants' responses to the manipulations do not accurately reflect how they would feel towards a real person (Lucas, Collins, & Langdon, 2009). The conclusions drawn from this research may then be inflating gender differences as it has been found that attributional responses and helping behaviour to real incidents as compared to vignettes are more positive (Lucas, Collins, & Langdon, 2009).

Hypothesis 4 predicted that a main effect for weight would be found, in that normal weight patients will elicit more positive feelings from participants, lower attributions of blame, higher blame would be attributed to the attacker, and their rape will be perceived as more serious than overweight patients. No significant effects were found for weight. Participants did not report any more negative feelings towards the overweight patients than the normal weight patients. Given that it was mostly in males that antifat attitudes were found to be related to attitudes towards the overweight patient and her rape, but a significant gender x weight interaction was not found, it seems that males' weight bias did not have a strong enough influence on their reported attitudes towards the patients to cause a meaningful difference between the attitudes towards normal weight and overweight patients. As previously outlined, the lack of significant effects for weight may be due to not enough males in the sample as it seems that any weight effect would be attributed to male participants.

Hypothesis 5 predicted that there would be a weight x sexual history interaction in that normal weight patients with limited sexual experience would elicit more positive feelings from participants, participants would attribute less responsibility to the patient, attribute more responsibility to the attacker, and will evaluate the rape as more serious compared to the normal weight patients with extensive sexual experience or overweight women with either limited or extensive sexual experience. Overall this hypothesis was not found to be true; however, in terms of attributions of blame to the patient it was found that for overweight women, their sexual history did not influence attributions of blame. This finding supports the prediction that an overweight woman is not given credit for her

limited sexual history as it is not perceived as a virtue because it may be perceived as being nonvolitional.

The interesting finding is that for normal weight patients, their sexual history had the opposite influence on male and female participants' attributions of blame to the patient. Attributions of blame by male participants were congruent with what was hypothesized: the normal weight patient with a limited sexual history was blamed less than the normal weight patient with an extensive sexual history, and there were no significant differences in the attributions of blame to overweight patients regardless of sexual history. Conversely, women actually blamed the normal weight patient with a limited sexual history *more* than the normal weight patient with an extensive sexual history. An extensive research of differential effects of gender on victim blaming and did not reveal any findings consistent with what was found in this study. This is a peculiar finding that cannot be readily explained given the results that were found and the research literature in this area; however, one possible explanation for this unanticipated finding is the effect of social desirability bias.

Given the recent research on perceptions of sexual history indicating that virginity has lost some of its positive value for women in Western culture (Baumeister & Vohs, 2004) it could be expected that the patient with the limited sexual history could be perceived more negatively than the patient with an extensive sexual history; however, this was not found except in regards to patient blame by female participants, which makes it unlikely that female participants perceived the patient with a limited sexual history more negatively than the patient with an extensive sexual history (otherwise this pattern would be expected to be found for feelings towards the patient and the other

dependent variables). Since this pattern was not found, it is improbable that women with a limited sexual history are perceived more negatively than women with a extensive sexual history.

During the debriefing process, many of the female participants talked about how they are aware that popular public perception is that a woman who has had many previous sexual partners is perceived more negatively and blamed more, but they know that a woman's sexual history should not influence the perceptions of her or her rape, and that they *do not endorse these sexist attitudes*. If this was the case, and that sexual history truly did not influence female participants' attributions of blame, it would be expected that no significant difference would be found between patients with a limited or extensive sexual history. Given that it was found that normal weight patients with an extensive sexual history were blamed *less* than those with a limited sexual history, it is possible that this difference is due to a reactionary response of female participants to the inclusion of the patient's extensive sexual history. By being directly asked about blame and responsibility of the patient, Feminist theory would posit that these participants may have been overcompensating in their positive responses because they were trying to compensate for the negative societal attitudes towards rape victims and female sexual activity (Figart, 1997).

Finally, it is important to interpret the victim blaming attitudes in the context of the range of responses. Although significant differences were found for attacker blame and patient blame, all means were still contained within a small range on the non-blame side of the scale. So, although it can be said that attackers were blamed significantly less in certain contexts and patients were blamed significantly more in certain contexts,

overall it cannot be said that the attacker was *not* blamed or that the patient *was* blamed as none of the means fell below/above the midpoint. These differences are still important though, as they indicate that rape victims are still somewhat doubted and blamed, and that rape is still perceived as something that the victim can influence. Although these negative beliefs have diminished over the past three decades since Burt (1980) first started researching rape victim blaming, it is still problematic that rape victims are doubted or blamed even a little bit, or that attackers are not completely blamed regardless of the circumstances or victim characteristics.

Limitations and Future Directions

The two main limitations of this study worked in combination with each other which limited the ability of this study to detect significant differences between the different experimental manipulations. First, the small sample size in this study limited the statistical analyses that were planned. Comparisons by participant program of study, as well as differences across the different years of study were not possible due to an inadequate sample size. Given that a focus of this study was the attitudes of different types of future health care professionals and how their education can reinforce or discourage these stigmas, future research with a larger sample will address these variables. By comparing the attitudes of students in these programs across the different years of study, results could indicate if certain stereotypes or biases may be reinforced or discouraged by the education they receive. A larger sample would also increase the power of the analyses, which was a limitation in terms of detecting significant effects for weight and gender. Visual inspection of the profile plots of weight and gender seem to

indicate that the hypotheses may be supported, but there was inadequate power to detect a significant effect.

The second limitation of this study was the RRQR used to measure victim blaming attitudes. This measure used a 5-point Likert scale, but a 9- or 11-point scale would have been better for this study in terms of maximizing the possible variance in responses. Even with the use of deception to conceal the true purpose of the study, social desirability bias in responding suggests that participants will tend to respond on the extreme ends of the scale, which limits the variance in responses. The self-report nature of the scale also limits the ability to accurately measure participants' true attitudes, and self-reported attitudes do not necessarily predict their behaviour towards these patients. This scale was also problematic in terms of the items it contained. The reliability analyses revealed that two items needed to be removed, which meant that attacker blame was only measured by one item. Although attacker blame in this context was not a complex construct since there was very limited information provided about the attacker, additional items tapping into participants' perceptions of the attacker's motivations would have been valuable in terms of examining differences in perceptions of the attacker depending on the patient's weight. If the other three subscales of the RRQR had contained more items and were more reliable, this could have influenced the results that were found for these constructs, and may have aided in the interpretation of results, especially the unanticipated results. Given that the patient blame subscale contained the most items and was found to be most reliable, it is possible that the pattern of results could have been influenced by the inadequate subscales that assessed feelings towards the patient, attacker blame, and perceived seriousness of the rape.

Additional items asking about the perceptions of the patient's sexual history would also be valuable in confirming that not only does sexual activity have different meanings for normal weight and overweight women, but also that this difference can be attributed to the perception that an overweight woman's limited sexual history is nonvolitional. Given the changing meaning of virginity in Western culture, and the differential effect of weight on sexual activity, future research should attempt to elucidate how virginity and sexual activity are conceptualized in our contemporary culture.

In the current study, antifat attitudes were analysed separately as a variable hypothesized to be related to the dependent variables. Given the limited sample size of this study, including additional independent variables would reduce already limited power and make it less likely to detect any significant effects. However, future research should include antifat attitudes as an independent variable, enabling the generation of causal attributions about antifat attitudes' effect on future health care providers' attitudes towards patients based on weight.

Another limitation of this study was that the SAS used in this study is an outdated scale; however there is no other more recent scale available that assesses sexual ideology on a continuum from liberal to conservative. Given that it was found that according to the SAS this sample had a very liberal sexual ideology with little variance it seems that this scale does not accurately assess contemporary liberal and conservative attitudes towards sexuality. What is defined as liberal or conservative sexual ideology is relative to the time and culture; future research should focus on updating and adding items to the SAS so that liberal and conservative sexual ideology can be assessed more accurately for the current time. A scale that assesses a construct that changes with the ideology of the time should

be attempted to be updated approximately every 10-15 years to ensure that the liberal/conservative dimensions are accurate.

Limitations regarding the generalizability of these results are also important to note. Given the specific sample that was recruited for this study, and the small number of participants from each of the different programs of study, these results may not be generalizable to other institutions that train health care providers or to health care providers in general. These results are also not necessarily generalizable to other student populations, or non-student populations. Although the aim of this research was to investigate future health care providers' attitudes, the results that were found may be specific to this sample from this specific institution and programs of study. Future research in this area needs to expand the recruitment of future health care providers, so that results can be analysed in terms of differences not only between programs, but even by institution given that education on diversity and gender issues are not consistent across institutions.

Implications

In spite of the limitations, the findings of this study can have implications for the training of health care professionals and the possibility of gender bias in their education. Although women comprise the majority of health care providers, they are still underrepresented in positions of leadership and authority, and it is the individuals in these positions who develop the curriculum for these students (Zimmerman, 2000). Health care education is fragmented, with women's health being conceptualized and taught as a speciality or subspecialty; therefore students who do not choose to pursue this speciality receive little education on these issues (Zimmerman, 2000). The findings from this study

serve to confirm that gender bias is still an issue in health care training, and issues of stereotypical gender attitudes must be made a larger part of this education and not separated into a speciality.

However, before students can change, the teachers must change. Gender bias among health care professionals is maintained through the education they receive. By being aware of the stereotypical beliefs that are present among health care students, the curriculum can be changed to better address these issues for *all students*, not just the students who choose to become educated in issues of gender and women's health. Part of the problem is that the content of the curriculum across the different types of health care training programs is inconsistent, with no standards or policies for training in issues of diversity (Wallis, 1993). This line of research can have positive implications for the content and structure of health care training programs to eliminate the cycle of gender bias that is obviously still an issue today.

The effect of weight is absent from research on victim blaming, although no significant effects were found for this particular study, this line of research can have implications for expanding this area of research and including variables that are important to consider. Given that the influence on weight of perceptions of women is so strong in Western culture, research needs to include body weight as a contributing factor to attitudes towards rape victims and how it can change the meaning of many of the factors that influence victim blaming attitudes (such as sexual history, the clothing of the victim, victim ethnicity, the relationship with her rapist, etc.).

Finally, the use of medical charts as the stimulus materials and the way in which the study was advertised has implications on the validity of the findings of this research.

Using medical charts to describe the victim made the situation more real to participants, and many participants indicated that they believed that the files were actual files from the local hospital. Therefore the results found most likely are more accurate in terms of reflecting participants' true attitudes compared to using vignettes or scenarios (Lucas, Collins, & Langdon, 2009). Studies of sexuality and/or violence are also significantly influenced by self-selection bias. Research has found that significant differences between volunteers and non-volunteers for sexuality and violence research can have a substantial influence on the results found and thus the validity of these results (Gaither, Sellbom, & Meier, 2003; Trivedi & Sabini, 1998; Weiderman, 1999). Given that this study was advertised as "investigating future health care providers' attitudes towards patients" with no mention of sexuality or violence, the self-selection bias was likely avoided. The combination of the heightened realism of the victims and the limited self-selection bias of participants in this study increases the validity of the findings of the present study which translates into increased possible generalizability of the results.

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APPENDIX A
Recruitment Materials

Subject Line: Sign Up for a Health-Related Study and a Chance to Win \$100

Hi (program) Students:

My name is Sandra Gotovac, a Master's student in the Applied Social Psychology program at the University of Windsor.

For my Master's thesis, I am looking for (program) students in all years of the program to participate in a study about future health care professionals' perceptions of patients entitled "Health Care in the Emergency Room: File Information and Perceptions of Patients". Participation should take between 20 and 30 minutes, and all participants will be eligible to enter their names in a draw to win one of 5 \$100 prizes.

If you are interested in participating in this study, please contact the researcher at gotovac@uwindsor.ca to schedule a time.

Your participation in this study will be completely confidential. If you have any questions about the study, feel free to contact Sandra Gotovac (gotovac@uwindsor.ca, 519-253-3000 ext, 2185) or the research supervisor, Dr. Shelagh Towson (towson@uwindsor.ca, 519-253-3000 ext.2223).

Your participation in this study is completely voluntary, and you may choose to withdraw from the study at any time.

Your participation in this research would be greatly appreciated!

Thank you very much,

Sandra Gotovac

Sandra Gotovac, B.A. (Hons.)
Department of Psychology
University of Windsor

Dr. Shelagh Towson
Applied Social Psychology
University of Windsor



You can WIN \$100!!!

Participate in a health-related study
and enter a draw to win one of 5 \$100
prizes!

I'm Sandra Gotovac, and I'm recruiting students to
participate in my MA thesis project examining future
health care providers' perceptions of patients.

If you'd like to participate, contact me, Sandra
Gotovac (gotovac@uwindsor.ca, 519-253-3000, ext.
2185)

to schedule a time.

Participation should take about 20-30 minutes.
Your participation will be completely confidential. If
you have any questions, feel free to contact me or my
faculty supervisor, Dr. Shelagh Towson
(towson@uwindsor.ca, 519-253-3000, ext.2223).

*This study has received clearance from the University of
Windsor REB*

APPENDIX B



CONSENT TO PARTICIPATE IN RESEARCH

Title of Study: Health Care in the Emergency Room: File Information and Perceptions of Patients

You are asked to participate in a research study conducted by Sandra Gotovac and Dr. Shelagh Towson from the Department of Psychology at the University of Windsor. The University of Windsor Research Ethics Board has reviewed and cleared this study. Results of this study will contribute to the completion of Sandra Gotovac's MA degree with Dr. Shelagh Towson serving as her faculty supervisor.

If you have any questions or concerns about the research, please feel to contact Sandra Gotovac by phone at (519)253-3000 ext. 2185 or email at gotovac@uwindsor.ca. You can also contact Dr. Shelagh Towson by phone at (519)253-3000 ext. 2223 or email at towson@uwindsor.ca.

PURPOSE OF THE STUDY

The purpose of this study is to understand future health care professionals' perceptions of patients in an emergency room setting based on patient files.

PROCEDURES

If you volunteer to participate in this study we will ask you to read three patient files and answer questions about your perceptions of the patient based on information contained in the patient file, and then fill out two attitude surveys. You will complete this study in a research lab with about 15 other students during a scheduled session that will take about 20-30 minutes. At the end of the study you will have the opportunity to fill out a ballot to be entered in a draw for one of 5 \$100 prizes.

POTENTIAL RISKS AND DISCOMFORTS

There are no known risks associated with participating in this research. Potential risks may be mild anxiety or discomfort reading patient files describing injuries. If any questions make you uncomfortable, you can leave them blank. The researcher's contact information will be given to you at the end of the study so that you can ask questions or raise concerns regarding your participation or about the study itself.

POTENTIAL BENEFITS TO SUBJECTS AND/OR TO SOCIETY

Participating in this study may increase your awareness of the issues involved in assessing patient needs. The results of this study will provide useful information regarding the interaction between health care providers' perceptions and patient treatment.

PAYMENT FOR PARTICIPATION

At the beginning of the study, you have the option of including your name in a draw for one of 5 \$100 prizes. The draw will be held after data collection is complete.

CONFIDENTIALITY

Any information that is obtained in connection with this study and that can be identified with you will remain confidential to the researcher and will be disclosed only with your permission. The consent forms are not anonymous as they have your name on it, but they will be kept separate from your responses to ensure anonymity of the data. In order to make sure your responses are anonymous, you will be asked NOT to put your name or student number on any of the study materials. The completed study materials will be stored securely in a locked cabinet in the researcher's office in the psychology department. Also, when reporting on the results of the study, the information will be presented in a way that no one will be able to infer any individual participant's responses.

PARTICIPATION AND WITHDRAWAL

You can choose whether to be in this study or not. If you volunteer to be in this study, you may withdraw at any time without consequences of any kind. You may also refuse to answer any questions you don't want to answer and still remain in the study. The investigator may withdraw you from this research if circumstances arise which warrant doing so.

FEEDBACK OF THE RESULTS OF THIS STUDY TO THE SUBJECTS

The results of this study will be available by Fall 2010. If you are interested in learning about the results once the study is complete, please visit the University of Windsor Research Ethics Board website at www.uwindsor.ca/reb or contact Sandra Gotovac (gotovac@uwindsor.ca).

SUBSEQUENT USE OF DATA

The information collected in this study may be used in future studies.

RIGHTS OF RESEARCH SUBJECTS

You may withdraw your consent at any time and discontinue participation without penalty. If you have questions regarding your rights as a research subject, contact: Research Ethics Coordinator, University of Windsor, Windsor, Ontario N9B 3P4; Telephone: 519-253-3000, ext. 3948; e mail: ethics@uwindsor.ca

SIGNATURE OF RESEARCH SUBJECT/LEGAL REPRESENTATIVE

I understand the information provided for the study “Health Care in the Emergency Room: File Information and Perceptions of Patients” as described herein. My questions have been answered to my satisfaction, and I agree to participate in this study. I have been given a copy of this form.

Name of Subject

Signature of Subject

Date

SIGNATURE OF INVESTIGATOR

These are the terms under which I will conduct research.

Signature of Investigator

Date

APPENDIX C

Patient Files and Experiment Deception

Many studies investigating the health care profession have shown that patients are treated by several different health care workers during one visit. We want to investigate how accurately health care workers read patient files. Imagine that you are a health care professional working in a hospital emergency room and need to treat the following patients. These reports are the intake assessments taken when the patients first presented to the emergency room. Please read the reports carefully and answer the questions that follow based on each patient file.

UNIVERSITY MEDICAL CENTER
EMERGENCY DEPARTMENT
INITIAL ASSESSMENT



Address/graph

Name: Brenda S [redacted] Date 06/04/08 Arrival Time: 7:15 pm
Age: 24 Weight: 250 lbs / 114 kg Height: 5'7" / 170 cm

PATIENT STATEMENT

Patient was walking to bus stop across the street from her college with her classmate. They were at the library late studying for an exam, while en route he forced her behind a building and raped her. Patient has bruising around vagina + inner thighs with no other visible injuries/bruises. Patient is unsure if he used a condom. Patient has had several previous sexual partners, but not ever tested positive for an STI.

ER VISIT WITHIN 72 HRS.: YES NO

ARRIVED VIA: Ambulance/Mobile ICU Provider Wheelchair
 Other private vehicle

Treat & Release Acute Trauma

CLASSIFICATION: Emergent Urgent Non-Urgent

TIME				
TEMP				
BP				
PULSE				
RESP				
O2SAT				

ASSESSMENT/TREATMENT

- HIV/AIDS test
- STI screen
- pregnancy test
- vaginal swabs
- referred to law enforcement and rape counselor

ALLERGIES:

peanuts

Pregnancy within last year: Yes Date _____ No

Medications

Name / Purpose	Dose/Route/Frequency	Name / Purpose	Dose/Route/Frequency
<u>NONE</u>			

PAST MEDICAL HISTORY:

Nurse's Signature: _____

Print: _____

UNIVERSITY MEDICAL CENTER
EMERGENCY DEPARTMENT
INITIAL ASSESSMENT



Addressograph

Name: Brenda S [redacted] Date 06/04/06 Arrival Time: 7:15pm
Age: 24 Weight: 250lbs/114kg Height: 5'7"/170cm

PATIENT STATEMENT

Patient was walking to bus stop across the street from her college with her classmate. They were at the library late studying for an exam. While en route he forced her behind a building where he raped her. Patient has bruising around vagina + inner thighs with no other visible wounds/injuries. Patient is unsure if he used a condom. Patient has only had one previous sexual partner and never tested positive for an STI.

ER VISIT WITHIN 72 HRS.: YES NO

ARRIVED VIA: Ambulance/Mobile ICU Provider Wheelchair
 Other private vehicle

Treat & Release Acute Trauma

CLASSIFICATION: Emergent Urgent Non-Urgent

TIME				
TEMP				
BP				
PULSE				
RESP				
O2SAT				

ASSESSMENT/TREATMENT

- HIV/AIDS test
- STI screen
- pregnancy test
- vaginal swab
- referred to law enforcement
- rape counsellor

ALLERGIES:

peanuts

Pregnancy within last year: Yes Date _____ No

Medications

Name / Purpose	Dose/Route/Frequency	Name / Purpose	Dose/Route/Frequency
<u>none</u>			

PAST MEDICAL HISTORY:

Nurse's Signature: [redacted]

Print: [redacted]

UNIVERSITY MEDICAL CENTER EMERGENCY DEPT. INITIAL ASSESSMENT

MEDICAL RECORDS COPY

REV 10/5/00

UNIVERSITY MEDICAL CENTER
EMERGENCY DEPARTMENT
INITIAL ASSESSMENT



Address/graph

Name: Brenda [Redacted] Date: 06/02/06 Arrival Time: 7:15pm
Age: 24 Weight: 121 lbs/55 kg Height: 5'5 / 165cm

PATIENT STATEMENT
Patient was walking to bus stop across the street from her college with her classmate. They were at the library late studying for an exam. While en route he forced her behind a building where he raped her. Patient has bruising around vagina + inner thighs with no other visible wounds/injuries. Patient is unsure if she used a condom. Patient has only had one previous sexual partner and never previously tested positive for an STI.

ER VISIT WITHIN 72 HRS.: YES NO
ARRIVED VIA: Ambulance/Mobile ICU Provider Wheelchair
 Other private vehicle
 Treat & Release Acute Trauma
CLASSIFICATION: Emergent Urgent Non-Urgent

TIME				
TEMP				
BP				
PULSE				
RESP				
O2SAT				

ASSESSMENT/TREATMENT
- HIV/AIDS test
- STI screen
- pregnancy test
- vaginal swab
- referred to law enforcement + rape counsellor

ALLERGIES:
peanuts
Pregnancy within last year: Yes Date: 2/10

Medications

Name / Purpose	Dose/Route/Frequency	Name / Purpose	Dose/Route/Frequency
<u>none</u>			

PAST MEDICAL HISTORY:

Nurse's Signature: [Redacted]
Print: [Redacted]



UNIVERSITY MEDICAL CENTER
EMERGENCY DEPARTMENT
INITIAL ASSESSMENT



Addressograph

Name: Brenda S. [Redacted] Date 06/07/08 Arrival Time: 7:15 pm
Age: 24 Weight: 121 lbs/55 kg Height: 5'7" / 170cm

PATIENT STATEMENT

Patient was walking to bus stop across the street from her college with her classmates. They were at the library late studying for an exam. While en route he forced her behind a building and raped her. Patient has bruising around vagina + inner thighs but no other visible wounds/injuries. Patient is unsure if he used a condom. Patient has had several previous sexual partners but never tested positive for an STI.

ER VISIT WITHIN 72 HRS.: YES NO

ARRIVED VIA: Ambulance/Mobile ICU Provider Wheelchair
 Other private vehicle

Treat & Release Acute Trauma

CLASSIFICATION: Emergent Urgent Non-Urgent

TIME					
TEMP					
BP					
PULSE					
RESP					
O2SAT					

ASSESSMENT/TREATMENT

- HIV/AIDS test
- STI screen
- pregnancy test
- vaginal swab
- referred to law enforcement + rape counselor

ALLERGIES:

peanuts

Pregnancy within last year: Yes Date _____ No

Medications


Name / Purpose	Dose/Route/Frequency	Name / Purpose	Dose/Route/Frequency
<u>None</u>			

PAST MEDICAL HISTORY:

Nurse's Signature: _____

Print: _____

**UNIVERSITY MEDICAL CENTER
EMERGENCY DEPARTMENT
INITIAL ASSESSMENT**

Addressograph


Name: Lisa G [Redacted] Date 10/04/08 Arrival Time: 1:50pm
 Age: 17 Weight: 118 lbs/54kg Height: 5'6"/168cm

PATIENT STATEMENT
 Patient was involved in an altercation during lunch hour on her high school campus. Angry words were exchanged back + forth between her friend group and another group of student's which resulted in a physical fight. Confrontation lasted some time before being broken up. Severe bruising of face, torso; broken finger on right hand; patient reports throbbing pain in left knee.

ER VISIT WITHIN 72 HRS.: YES NO
 ARRIVED VIA: Ambulance/Mobile ICU Provider Wheelchair
 Other police escort
 Treat & Release Acute Trauma
 CLASSIFICATION: Emergent Urgent Non-Urgent

TIME				
TEMP				
BP				
PULSE				
RESP				
O2SAT				

ASSESSMENT/TREATMENT
 Axa's: chest, arms, right hand, left leg
 Sutures above eye
 Splint on broken finger

ALLERGIES: None
 Pregnancy within last year: Yes Date _____ No

Medications

Name / Purpose	Dose/Route/Frequency	Name / Purpose	Dose/Route/Frequency
<u>None</u>			

PAST MEDICAL HISTORY: _____

Nurse's Signature: [Redacted]
 Print: [Redacted]



**UNIVERSITY MEDICAL CENTER
EMERGENCY DEPARTMENT
INITIAL ASSESSMENT**



Addressograph

Name: Mark K [REDACTED] Date 9/29/08 Arrival Time: 8:05pm
Age: 26 Weight: 180lbs/82kg Height: 5'7"/170cm

PATIENT STATEMENT

Patient was walking through parking lot of the local shopping center on the way to his car earlier this evening. A man stepped out from behind truck, held out a large knife and physically forced him to the ground. Attacker took patient's wallet, personal electronics and shopping bags. Bruising and scratches on face, arms, torso and knees. Deep cut along patient's cheek and hand. No other pain reported.

ER VISIT WITHIN 72 HRS.: YES NO

ARRIVED VIA: Ambulance/Mobile ICU Provider Wheelchair
 Other private vehicle

Treat & Release Acute Trauma

CLASSIFICATION: Emergent Urgent Non-Urgent

TIME					
TEMP					
BP					
PULSE					
RESP					
O2SAT					

ASSESSMENT/TREATMENT

Sutures, ice, bacitracin applied to wounds. Notified law enforcement so patient can file a report.

ALLERGIES:

animal dander

Pregnancy within last year: Yes Date _____ No

Medications

Name / Purpose	Dose/Route/Frequency	Name / Purpose	Dose/Route/Frequency
<u>None</u>			

PAST MEDICAL HISTORY: _____

Nurse's Signature: _____

Print: _____

APPENDIX D Verbal Debriefing

Thank you for participating in this study. As you may have guessed, There is more to this study than I have told you about so far. I do have hypotheses about people's perceptions of patients based on the kind of information I provided you with. But before I tell you exactly what my hypotheses are, I would like your feedback on what you thought the study was about. (Participants respond.) Thank you. Your feedback is very helpful.

Now I would like to explain exactly what we are trying to find in this study. You were told that the purpose of the study was to understand future health care professionals' perceptions of patients based on the information provided in emergency room patient files. Although this general statement is somewhat true, this study was designed to investigate whether a patient's weight and sexual history might influence health care professionals' attitudes towards them. You all read three patient files; however, we were really interested only in your responses to the patient who had been sexually assaulted. Research has shown that weight stigma is a large problem in the health care field, especially for overweight women. As well, attitudes toward sexual assault victims are greatly influenced by the victim's individual characteristics, such as attractiveness, weight, and sexual history. My major hypothesis in this study is that overweight rape victims will be blamed more for the sexual assault than normal weight victims, even if they were virgins. So, all of you read about a woman who had been sexually assaulted. However, some of you read about an average weight woman, and some of you read about an overweight woman. Some of you read about a woman with little sexual experience and some of you read about a woman with somewhat more sexual experience. If we had told you exactly what we were studying, you would have paid closer attention to those details in the reports, and even if you had tried to be as objective as possible, you wouldn't have been answering naturally, in the way you would respond in a real life situation. I hope you can understand why we could not completely inform you about the purpose of this study. Are there any questions? [pause and address any questions or comments]

As in most psychological research, we are not interested in your individual responses. In fact, it is not possible for us to draw any conclusions from the responses of one particular person. What we are trying to figure out is how the average person reacts in these situations which is only possible if we get a large number of people and combine their results. This means that we will be combining your data with the data that we collect from all the other participants so that we have enough responses to draw conclusions. What this means is that it is going to be necessary to ask you to not say anything about this study to anyone else. If you talk to someone else about this study and tell them what I just told you, it could invalidate their responses. If that happened, all the time and effort put into this study would be wasted since the results would not reflect honest responses and would not help to answer our research question. So I hope you can see why it is

extremely important that I have to ask you to not to say anything about this study to anyone. Even if they are not eligible to participate or are not planning to participate, they may talk to someone who will participate. So, I would like to ask you to not say anything about the study except that you have been asked to not talk about it (without making a huge secret or mystery about it) until the end of the semester when data collection will be complete. Will you promise not to tell others about the study until it is over?

I realize that the more I tell you about this study the more you can tell someone else, so it is quite a risky move. However, in general people are more willing to cooperate and not talk about the experiment if they receive a through explanation of why it was necessary. We do also want people to get an educational value out of participating, and if we didn't explain to you what exactly we are trying to do you wouldn't really learn much from your participation. I hope you feel that you have learned something from participating in this study and how research is conducted.

Your participation in this research is very important. In a study like this where you were not fully informed at the beginning we want to make sure that you are satisfied with your participation and that you wish to keep your data in the study. However, if you do not want your data to be used, that is completely within your rights and we will remove it from the data pool. Please let us know if you wish to have your data removed or if you have any questions about anything I've said.

I have a handout with some resources if you are interested in learning more about this research, or wish to contact the researchers. Results of this study will be posted on the ethics website, the link is on the resource sheet, but if you would like results emailed to you, you can add your email address to the list. You can also take one ballot to fill out and place in the ballot box just outside the room. I want to assure you that the email list is kept completely separate from the data so that your anonymity and confidentiality are protected.

Thank you very much for your participation.

APPENDIX E Debriefing Handout

Your participation in this study is greatly appreciated, and if you wish to pursue further information on this topic, you can look at the following references:

- Campbell, R. C., Wasco, S. M., Ahrens, C. E., Sefl, T. & Barnes, H. E. (2001). Preventing the “second rape”: Rape survivors’ experiences with community service providers. *Journal of Interpersonal violence*, 16, 1239-1259.
- Puhl, R. M., Moss-Racusin, C. A., Schwartz, M. B. & Brownell, K. D. (2008). Weight stigmatization and bias reduction: Perspectives of overweight and obese adults. *Health Education Research*, 23, 347-358.
- Thornton, B. & Ryckman, R. M. (1983). The influence of a rape victim’s physical attractiveness on observers’ attributions of responsibility. *Human Relations*, 36, 5549-562.
- Weiner, B., Perry, R. P. & Magnusson, J. (1988). An attributional analysis of reactions to stigmas. *Journal of Personality and Social Psychology*, 55, 738-748.

If you have questions about your participation in the study please feel to contact Sandra Gotovac by phone at (519)253-3000 ext. 2185 or email at gotovac@uwindsor.ca, or Dr. Shelagh Towson by phone at (519)253-3000 ext. 2223 or email at towson@uwindsor.ca. If you have questions about your rights as a research participant, you may contact the Research Ethics Coordinator at the University of Windsor, Windsor, Ontario N9B 3P4; Telephone: 519-253-3000, ext. 3948; email: ethics@uwindsor.ca

It is often very helpful to speak to someone about any difficulties or problems you may be having, and there are several community resources available that can help:

Student Counselling Centre at the University of Windsor

Room 293 2nd Floor CAW Student Centre
(519) 253-3000 Ext. 4616
Email: scc@uwindsor.ca
Website: www.uwindsor.ca/scc

Bulimia Anorexia Nervosa Association (BANA)

2109 Ottawa Street, Suite 400, Windsor, ON
(519) 969-2112
Email: info@bana.ca
Website: www.bana.ca

Sexual Assault Crisis Centre of Essex County

Crisis Line: (519) 253-9667
Phone: (519) 253-3100
Email: sacc@wincom.net
Website: www.wincom.net/~sacc

A brief user friendly summary of the initial findings of this study will be posted on the University of Windsor ethics webpage at www.uwindsor.ca/reb. Click on “Study results” then click on “Participants/Visitors”. Scroll down to Sandra Gotovac and click on the title to see the results.

Thank you again for your participation in this research.

APPENDIX F
Demographic Questionnaire

Age: _____

Gender: _____

- Ethnicity: Caucasian
 Black/African-Canadian
 Hispanic/Latino
 South Asian
 East Asian
 Middle Eastern
 Native American
 Other (Please specify) _____
 Not known

- Program: Nursing
 Human Kinetics (undeclared)
 Human Kinetics Movement Science
 Social Work
 Schulich School of Medicine

Year of study: 1 2 3 4 Grad student

Part-time student Full-time student

APPENDIX G
Manipulation Checks

Please check your answers to the following questions regarding the information contained in the previous patient file.

1. How did the patient arrive at the hospital?

Ambulance Walking Personal vehicle Police car

2. When did the patient arrive at the hospital?

Early morning Late afternoon Early evening Late evening

3. What was the patient's approximate height?

Below average Average Above average

4. What was the patient's approximate weight?

Underweight Average Weight Overweight

5. What was the patient's sexual history prior to the attack?

Virgin One partner A few partners Many partners

6. What treatment was given to the patient? (check all that apply)

<input type="checkbox"/> No treatment given yet	<input type="checkbox"/> Referred to counseling	<input type="checkbox"/> Cast
<input type="checkbox"/> STI tests	<input type="checkbox"/> Sutures	<input type="checkbox"/> Pregnancy test
<input type="checkbox"/> HIV/AIDS test	<input type="checkbox"/> Referred to police	<input type="checkbox"/> Pain medication
<input type="checkbox"/> Splint	<input type="checkbox"/> X-rays	<input type="checkbox"/> Other

Please check your answers to the following questions regarding the information contained in the previous patient file.

1. How did the patient arrive at the hospital?

Ambulance Walking Personal vehicle Police car

2. When did the patient arrive at the hospital?

Early afternoon Late afternoon Early evening Late evening

3. What was the patient's approximate height?

Below average Average Above average

4. What was the patient's approximate weight?

Underweight Average Weight Overweight

5. What was the patient's criminal record prior to the fight?

No criminal record One charge of assault Minor criminal record Extensive criminal record

6. What treatment was given to the patient? (check all that apply)

<input type="checkbox"/> No treatment given yet	<input type="checkbox"/> Referred to counselling	<input type="checkbox"/> Cast
<input type="checkbox"/> STI tests	<input type="checkbox"/> Sutures	<input type="checkbox"/> Pregnancy test
<input type="checkbox"/> HIV/AIDS test	<input type="checkbox"/> Referred to police	<input type="checkbox"/> Pain medication
<input type="checkbox"/> Splint	<input type="checkbox"/> X-rays	<input type="checkbox"/> Other

Please check your answers to the following questions regarding the information contained in the previous patient file.

1. How did the patient arrive at the hospital?

Ambulance Walking Personal vehicle Police car

2. When did the patient arrive at the hospital?

Early morning Late afternoon Early evening Late evening

3. What was the patient's approximate height?

Below average Average Above average

4. What was the patient's approximate weight?

Underweight Average Weight Overweight

5. Where was the patient attacked?

Parking lot Back alley Public bathroom Enclosed parking garage

6. What treatment was given to the patient? (check all that apply)

<input type="checkbox"/> No treatment given yet	<input type="checkbox"/> Referred to counseling	<input type="checkbox"/> Cast
<input type="checkbox"/> STI tests	<input type="checkbox"/> Sutures	<input type="checkbox"/> Pregnancy test
<input type="checkbox"/> HIV/AIDS test	<input type="checkbox"/> Referred to police	<input type="checkbox"/> Pain medication
<input type="checkbox"/> Splint	<input type="checkbox"/> X-rays	<input type="checkbox"/> Other

APPENDIX H
Sexual Attitudes Scale (SAS)

This questionnaire is designed to measure the way you feel about sexual behaviour. It is not a test, so ***there are no right or wrong answers***. Respond to each statement as carefully and accurately as you can by bubbling in the appropriate number on the scantron form for each statement as follows:

- A Strongly disagree
- B Disagree
- C Neither agree nor disagree
- D Agree
- E Strongly agree

1. I think there is too much sexual freedom given to adults these days.
2. I think that the increased sexual freedom seen in the past several years has done much to undermine the family.
3. I think that young people have been given too much information about sex.
4. Sex education should be restricted to the home.
5. Older people do not need to have sex.
6. Sex education should be given only when people are ready for marriage.
7. Premarital sex may be a sign of decaying social order.
8. Extramarital sex is never excusable.
9. I think there is too much sexual freedom given to teenagers these days.
10. I think there is not enough sexual restraint among young people.
11. I think people indulge in sex too much.
12. I think the only proper way to have sex is through intercourse.
13. I think sex should be reserved for marriage.
14. Sex should be only for the young.
15. Too much social approval has been given to homosexuals.
16. Sex should be devoted to the business of procreation.
17. People should not masturbate.
18. Heavy sexual petting should be discouraged.
19. People should not discuss their sexual affairs or business with others.
20. Severely handicapped (physically or mentally) people should not have sex.
21. There should be no laws prohibiting sexual acts between consenting adults.
22. What two consenting adults do together sexually is their own business.
23. There is too much sex on television.
24. Movies today are too explicit.
25. Pornography should be totally banned from our bookstores.

APPENDIX I
Antifat Attitudes Test (AFAT)

The following pages contain a series of statements or opinions about fat people. On this questionnaire you are asked to indicate your own personal opinions. In other words, you should indicate *honestly* how much you agree or disagree with each of the opinion statements listed below.

In order to complete the questionnaire, read each statement carefully and decide how much you personally disagree or agree. Using the scale below, bubble in your answer on the scantron form provided.

There are no right or wrong answers—only opinions. Just give the answer that most accurately states your opinion. Remember, your responses are anonymous, so please be completely honest. Please give an answer to all of the statements.

A	B	C	D	E
Definitely Disagree	Mostly Disagree	Neither Agree Nor Disagree	Mostly Agree	Definitely Agree

1. There's no excuse for being fat.
2. If I were single, I would date a fat person.
3. Jokes about fat people are funny.
4. Most fat people buy too much junk food.
5. Fat people are physically unattractive.
6. Fat people shouldn't wear revealing clothing in public.
7. If someone in my family were fat, I'd be ashamed of him or her.
8. I can't stand to look at fat people.
9. If fat people don't get hired, it's their own fault.
10. Fat people are disgusting.
11. If I have the choice, I'd rather not sit next to a fat person.
12. Fat people don't care about anything except eating.
13. I'd lose respect for a friend who started getting fat.
14. Most fat people are boring.
15. I can't believe someone of average weight would marry a fat person.
16. Society is too tolerant of fat people.
17. When fat people exercise, they look ridiculous.
18. I hate it when fat people take up more room than they should in a theatre, or on a bus or plane.
19. Most fat people are lazy.
20. Most fat people don't care about anyone but themselves.

21. Fat people are just as competent in their work as anyone.
22. If fat people really wanted to lose weight they could.
23. Being fat is sinful.
24. It's disgusting to see fat people eating.
25. Fat people have no will power.
26. I prefer not to associate with fat people.
27. Fat people don't care about their appearance.
28. Most fat people are moody and hard to get along with.
29. If bad things happen to fat people, they deserve it.
30. Most fat people don't keep their surroundings neat and clean.
31. Society should respect the rights of fat people.
32. It's hard not to stare at fat people because they are so unattractive.
33. If I owned a business, I would not hire fat people because of the way they look.
34. I'd feel self-conscious being seen in public with a fat person.
35. The idea that genetics cause people to be fat is just an excuse.
36. I would not want to continue in a romantic relationship if my partner became fat.
37. The existence of organizations to lobby for the rights of fat people in our society is a good idea.
38. I don't understand how someone could be sexually attracted to a fat person.
39. If fat people knew how bad they looked, they would lose weight.
40. People who are fat have as much physical coordination as anyone.
41. Fat people are unclean.
42. Fat people should be encouraged to accept themselves the way they are.
43. Most fat people will latch onto almost any excuse for being fat.
44. It's hard to take fat people seriously.
45. Fat people do not necessarily eat more than other people.
46. Fat people obviously have a character flaw, otherwise they wouldn't become fat.
47. It makes me angry to hear anybody say insulting things about people because they are fat.

APPENDIX J
Rape Responsibility Questionnaire Revised

Having read the preceding patient file please read the following questions carefully and circle your answers for each question on the scale provided. There are no right or wrong answers, just give the answer that most accurately reflects your opinion. Remember, your responses are anonymous, so please try to be completely honest.

1. What are your personal feelings towards the patient?

1	2	3	4	5
Very negative				Very positive

2. How much identification do you feel with the patient?

1	2	3	4	5
No identification				High identification

3. To what extent was the patient's involvement in the incident due to chance?

1	2	3	4	5
Not due to chance at all				Completely due to chance

4. What is the likelihood that the patient did something to encourage the incident?

1	2	3	4	5
Not at all likely				Extremely likely

5. How responsible is the patient for what happened?

1	2	3	4	5
Not at all responsible				Completely responsible

6. How severe is the psychological impact of the attack on the patient?

1	2	3	4	5
Not at all severe				Extremely severe

7. How certain are you that the patient's report is truthful?

1	2	3	4	5
Not at all certain				Extremely certain

8. How much did the patient have the capacity to prevent/stop the attack?

1	2	3	4	5
Not at all				Completely

9. To what extent did the patient cause the attack?

1	2	3	4	5
Not at all				Completely

VITA AUCTORIS

Sandra Gotovac was born in Mississauga, Ontario, Canada in 1984. She moved with her family to London, Ontario at the age of five where she attended St. Joseph's French Immersion Elementary School and continued her French Immersion education at Catholic Central High School. After high school she went on to earn her B.A. in Psychology from King's College at the University of Western Ontario in 2006. Sandra is currently a Master's student in Applied Social Psychology at the University of Windsor with plans to continue her education to pursue her Ph.D. in the Fall of 2010.