Spring 2025

Perceived Credibility of Allegations of Sexual Assault Across Victim Race and Mental Health History

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PERCEIVED CREDIBILITY OF ALLEGATIONS OF SEXUAL ASSAULT ACROSS VICTIM RACE AND MENTAL HEALTH HISTORY

by

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(Under the Direction of Dorthie Cross)

ABSTRACT

Previous research examined the effect of victim gender and rape myth acceptance (RMA) on perceptions of victim credibility; however, little attention has been given to the impact of victim race and mental health history, and even fewer studies have explored the intersection of these two identities. The primary purpose of the current study was to identify factors affecting understanding of perceived credibility of victims of sexual assault, specifically in terms of victim race and mental health history. The study also examined the role of RMA on perceptions of credibility and explored participant attitudes related to color-blind racial attitudes and mental illness stigma, as well as religiousness and rurality. 689 college students participated in an anonymous online study in which they (1) read and evaluated a fictional news article describing testimony of woman who had been sexual assaulted and (2) completed questionnaires related to RMA, color-blind racial attitudes, mental illness stigma, religiousness, and rurality. Only 199 participants demonstrated sufficient effort in the first section (vignette), but 545 demonstrated sufficient effort in the second (questionnaires). A planned 2 (Victim Race: Black, White) x 3 [Victim Diagnosis: Asthma (Control), Depression, Schizophrenia] between-subjects ANOVA was conducted and revealed no significant effects on perceived victim credibility. Another planned 2 (Victim Race) x 3 (Victim Diagnosis) x 3 (Participant RMA: Low vs. High) between-subjects ANOVA was conducted and showed that participants with high RMA perceived the victim as less credible compared to participants with low RMA. Victim race and diagnosis were again not significant. Both analyses were limited by the large volume of insufficient effort leading to greater-than-expected exclusions. Several exploratory analyses were conducted, including comparing participants who grew up in rural and non-rural areas on self-reported RMA, color-blind racial attitudes, ableist attitudes, and religiousness. No differences were found.

Correlations revealed RMA, racist attitudes, and ableist attitudes significantly positively correlated, and religiousness positively correlated with RMA and racist attitudes, but not ableist attitudes. These findings and others are discussed. Understanding factors contributing to victim credibility may help clinicians and educators create effective interventions, particularly for survivors from marginalized communities.

INDEX WORDS*:* Sexual assault, Victim credibility, Victim race, Victim mental health, Rape myth acceptance, Victim gender, Rurality

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by

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B.S., Georgia Southern University, 2020

M.S., Georgia Southern University, 2022

A Dissertation Submitted to the Graduate Faculty of Georgia Southern University

in partial Fulfillment of the Requirements for the Degree

DOCTOR OF PSYCHOLOGY

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Electronic Version Approved:

May 2024

DEDICATION

In honor of those who are more than their experiences and continue to survive and thrive.

ACKNOWLEDGMENTS

First, I want to thank my dissertation chair, Dr. Dorthie Cross, for her guidance, support, kind words and hard work in mentoring me through this project. This project could not have been developed without you. I am grateful to have you Dorthie and hope you continue to shine bright. Secondly, I want to thank my committee members, Dr. Ryan Couillou and Dr. Thresa Yancey, for their assistance, patience, encouragement, and expertise.

To my family and friends, thank you! Without your love, support, jokes, and knowledge, I would not be where I am now. I am especially grateful for my mother, father, grandparents, siblings, and partner who all, in their own way, have encouraged me every step of the way through the turmoil and celebration of this doctoral program. Additionally, I am grateful for my friends who kept the good times flowing and filled my life with joy. To the "Silo" —your friendship has shown me the true meaning of community.

Lastly, I would like to thank all the Black women and girls who influenced my professional journey and helped motivate this dissertation. Through your stories, I have learned what it means to thrive, love, and heal.

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Prevalence of Sexual Violence

Sexual violence in the United States has been known for numerous years to be a silent epidemic, especially in vulnerable populations such as children and individuals with marginalized identities (Deer, 2003; Gilbert, 1991; Miller, 2017; Russell & Bolen, 2000; Sigurdsson, 2018; Stipek, 2021). However, sexual violence is notably difficult to measure due to multiple factors such as underreporting to law enforcement, the context in which data are collected, target populations, sample sizes, and other aspects of research design (Kruttschnitt et al., 2014). The National Crime Victimization Survey (NCVS) estimates the number of sexual assaults or rapes against persons aged 12 years or older in 2020 as 319,950 and the number of individuals victimized as 192,820 (Morgan & Thompson, 2020). Though a commonly used source for sexual violence statistics, the NCVS may underestimate incidence and victims (Kruttschnitt et al., 2014). For example, the National Intimate Partner and Sexual Violence Survey (NISVS) estimates the number of individuals aged 18 or older victimized in the past 12 months to be over 14 million, compared to 208,960 in the same period in the NCVS (Basile et al., 2022). Based on NISVS estimates, 54.3% of women in the United States experienced some form of sexual violence in their lifetime, including attempted or completed rape, sexual coercion, or other unwanted sexual contact (Basile et al., 2022). Specifically, 26.8% reported completed or attempted rape, 23.6% reported experiencing sexual coercion (i.e., using pressure to force sexual contact with someone against their consent), and 47.6% reported experiencing other unwanted sexual contact at some point in their lifetime (Basile et al., 2022).

Sexual violence research focusing on men and individuals who identify as lesbian, gay, bisexual, transgender or gender non-conforming, or queer or questioning (LGBTQ) is growing, but these populations are still largely under-researched. The NISVS estimates that 30.7% of men in the U.S. have experienced some form of sexual violence in their lifetime, with 14.5% reporting

experiencing completed or attempted rape or being made to penetrate, 10.9% reporting experiencing sexual coercion, and 23.3% reported other unwanted sexual contact in their lifetime (Basile et al., 2022). LGBTQ individuals, compared to their cisgender and heterosexual counterparts, have a heightened risk for sexual violence across their lifetime (Chen et al., 2020; Flores et al., 2020; Messinger & Koon-Magnin, 2019). Transgender individuals are an especially vulnerable group within the LGBTQ community to violent crimes particularly homicide, much of which is linked to interpersonal violence (i.e., domestic and sexual violence; Jordan et al., 2020). The 2015 United States Trans Survey (USTS), the largest national sample of transgender and gender non-conforming individuals to date, reported that 47% of respondents disclosed experiencing sexual violence in their lifetime (James et al., 2016).

The #MeToo Movement

In recent years, sexual violence received increased attention in the media due in part to the rise of the #MeToo Movement (Acquaviva et al., 2021). The #MeToo Movement encouraged survivors to share personal accounts of their experiences with sexual assault and harassment. In particular, the #MeToo Movement promoted viewing sexual violence within a broader structural context (Jaffe et al., 2021); however, there is limited research on the impact of the #MeToo Movement on the prevalence and perceptions of sexual assault. Research focused on addressing this gap found an association between the #MeToo Movement and a shift in societal scripts for sexual assault allowing for greater recognition of the range of behavioral experiences recognized as sexual assault in a college student sample (Jaffe et al., 2021). Nevertheless, in the face of increased attention and awareness, there is still stigma and shame associated with sexual victimization (Acquaviva et al., 2021).

Moreover, it is integral to recognize and acknowledge the cultural and social limitations of the #MeToo Movement impacting its ability to uphold and support all survivors. Specifically, the movement unintentionally reinforces patriarchal structures by depicting sexual violence as a gender-based issue involving a female victim and a male offender, possibly reinforcing stereotypes about who is a believable victim (Depraetere et al., 2020). Additionally, much like other social movements, the

#MeToo Movement follows historical patterns of highlighting and uplifting the accounts of certain populations, especially affluent, White women (Coykendall, 2021). This narrow focus reinforces the stories already widely shared and publicized in the media and disregards the stories of people of color and individuals of diverse socioeconomic and ability statuses (Johnson & Renderos, 2020).

Victim Race. There are racial disparities in how the criminal justice system responds to cases of sexual victimization. The United States legal system has a long history of failing to extend equal protection to women of color who are sexually assaulted (O'Neal et al., 2019). According to the sexual stratification hypothesis (Collins, 1975; LaFree, 1980), this failure is linked to the historical belief that the "obedience of Blacks [and other people of color] can only be obtained and maintained through uncontrolled authority over the body" (O'Neal et al., 2019, p. 1289). This belief system allows the sexual assault of Black women to function under misogynoir and often leads to Black women being stereotyped as hypersexual beings, providing justification for the sexual exploitation and objectification of the Black female body (Loft, 2020; National Organization for Women [NOW], 2018; Walsh, 1987). Research on racial differences in sexual violence rates and risk show that Black women experience higher rates of rape and sexual assault compared to their White counterparts but are the least likely to disclose unwanted sexual experiences compared to other racial groups (Slatton & Richard, 2020; Ullman & Lopez, 2021).

When combined with issues of mass incarceration, police brutality, and over-policing of minority neighborhoods, Black women are especially vulnerable when reporting crimes of sexual violence as their racial and ethnic background influence case attrition, victim believability, and preparator accountability (O'Neal et al., 2019). Further, Black women with intersecting marginalized identities (e.g., LGBTQ identity, HIV positive, low income, and disability) have an elevated risk of experiencing sexual victimization (Ullman & Lopez, 2021).

Victim Disability. Another vulnerable population often overlooked in sexual violence research is individuals of diverse ability statuses, specifically individuals with mental health conditions. While these individuals are at higher risk of experiencing sexual violence, there are numerous barriers to reporting these crimes (Harrell, 2021; Iudici et al., 2019; Teplin et al., 2005). Some of these barriers are

discrimination, perceived lack of credibility, and accessibility, all of which contribute to these individuals being less likely to report their victimization to the police and more likely to be victimized in the first place when compared to the general population (Harrell, 2021; Teplin et al., 2005).

It is important to note there are differences in how individuals with various mental health conditions are perceived. Individuals with severe mental health conditions such as schizophrenia are often perceived as less credible due to their psychological symptoms (i.e., delusions and hallucinations) and negative mental health stigma (Teplin et al., 2005). As a result, in court proceedings these individuals often are considered impaired in their ability to recall relevant case details (Levi, 2022; Parcesepe & Cabassa, 2013; Teplin et al., 2005). This perception allows violence against individuals with severe mental illness to go unchecked and contributes to the prevalence of rape and sexual assault.

Purpose

As outlined above, research demonstrates sexual violence is prevalent, underreported, and even when it is reported, victims are viewed with skepticism. Moreover, the risk of experiencing sexual violence is higher for people with marginalized identities, such as women, people of color, and individuals with disabilities. Most research on perceptions of victim credibility focuses on women. Much less attention is given to race or disability, and the impact of race when combined with disability, particularly mental health status, has not been explored in sexual assault literature. Due to intersectionality not being a focus in sexual assault literature, there are significant gaps in our understanding of sexual violence and perceptions of victim credibility. Given these gaps within the literature, the purpose of the current study is to identify factors important in understanding perceptions and doubts about sexual assault allegations, specifically in terms of victim race and mental health history. The overarching purpose of this study is to fill gaps within the sexual assault literature.

Significance

There are numerous studies focused on exploring the effect of victim gender in perceptions of sexual assault allegations, so my study will focus primarily on the impact of victim race and mental

health. Previous research on the impact of race on perceptions of victim credibility exists but is limited relative to studies on gender (e.g., Fiebert & Osburn, 2002; Pilling, 2021; Shaw & Lee, 2019; Slatton & Richard, 2020; Ullman & Lopez, 2021), and few studies examine the impact of victim mental health in the context of sexual assault (e.g., Boysen & Isaacs, 2022; Coverdale, 2020; Khalifeh et al., 2016; Stuart, 2003).

My study may help increase representation of these issues in the sexual assault literature. Furthermore, my study will be the first to explore the interaction between victim race and mental health history in perceptions of sexual assault allegations. This type of investigation has the potential to highlight how factors such as rape myth acceptance, racism, misogynoir, and sanism interact to alter the perceived credibility of sexual assault allegations. My findings may alter the future of interpersonal violence research and hopefully encourage researchers and professionals to consider the role of historical and systemic oppression in producing unique and complex outcomes for victims of sexual assault from marginalized identities.

A Note about Terminology

There are varying definitions of sexual assault, rape, and sexual violence used in research versus definitions used in the legal system. The Rape, Abuse, & Incest National Network (RAINN, 2023a) defines sexual violence as an "all-encompassing, non-legal term" describing criminal actions such as sexual assault. Sexual assault is often used as an umbrella term to signify various forms of sexual behaviors occurring without an individual's consent. This can include unwanted sexual touching or acts, completed or attempted forced penetration, and/or aggravated stalking (RAINN, 2023a). For the purposes of the current study, *rape* and *sexual assault*

were both referred to as *sexual assault* or *sexual violence*.

Literature Review

The stigma and shame surrounding sexual assault is upheld by numerous factors. One of those factors is society's tendency to evaluate sexual assault cases through the lens of the traditional archetype of the "ideal" or "real" sexual assault victim (Randall, 2011). This archetype of sexual

violence functions to establish stereotypes of the "authentic" victim and appropriate victim responses (Randall, 2011); however, this stereotype does not encompass the unique and complex nature of sexual assault cases. Instead, these assumptions often reinforce mythologies surrounding sexual assault and contribute to doubting a victim's allegations and shifting the blame for sexual violence to the victim (Coykendall, 2021). As a result, these assumptions impact legal and social outcomes of sexual assault cases. Specifically, these narratives influence law enforcement and justice officials' decision-making and contribute to case attrition.

Case Attrition

Case attrition rates in sexual assault cases are noted to be high, yet there are mixed findings on exactly how high. NCVS data analyzed by RAINN (2023b) suggest that out of every 1,000 sexual assaults, 975 perpetrators will walk free. A comparative analysis of five countries' (United States, Australia, Canada, England and Wales, and Scotland) rape and sexual assault statistics from the 1970s to 2005 estimated the average conviction rate across all countries as 12.5% (Daly & Bouhours, 2010), but this estimate was based on cases that were actually reported and resulted in criminal charges. The Department of Justice (2017) estimates only 0.09% of sexual assault cases in the United States are referred for prosecution. In another study, researchers found that in 999 sexual assault cases of female victims reported to Los Angeles County from 2005 to 2009, 44.6% were rejected before an arrest was made, 19% were declined by prosecution following arrest, and less than 2% went to trial (Spohn & Tellis, 2012). In a study replicating these findings in six jurisdictions in Los Angeles County, the researchers found of 2,887 sexual assault cases of female victims, only 363 cases resulted in charges being filed (Morabito et al., 2019).

Considering many sexual assaults go unreported to the police, the number of cases also falling out of the criminal justice system is staggering. When reviewing factors impacting case attrition, researchers found prosecution often cited legal (e.g., the strength of physical evidence, criminal severity, eye witness, rape kit) and primarily extra-legal factors (e.g., perceived victim character and cooperation, intoxication, race, and age) as reasons for not moving forward (Bryden & Lengnick,

1997; Lovell et al., 2021; Morabito et al., 2019; Murphy-Oikonen et al., 2022; O'Neal et al., 2015; Spohn & Tellis, 2012). Other factors often considered are the location of the assault, victim-offender relationship, gratuitous injuries to the victim, and reporting time (Lovell et al., 2021). Prosecutors clearly have substantial power in determining whether a case moves forward; however, the prosecution is not solely responsible for case attrition because the first point of entry into the legal process begins with filing a report with the police.

Police officers play a pivotal role in the process as their discretionary power determines the resources afforded to an investigation and whether a case proceeds to the prosecution, regardless of the survivor's intentions (Murphy et al., 2014; Murphy-Oikonen et al., 2022). Police officers' decision-making is influenced by departmental policies and culture, particularly cultures with a prevalence of rape myth acceptance and downstream orientation, which is when officers pursue cases based on the prosecutions' likelihood of accepting them (Lovell et al., 2021; Sleath & Bull, 2017). Police officers' attitudes and behaviors can also contribute to a victim withdrawing their police report, or never reporting their victimization at all (Sleath & Bull, 2012).

Survivors cite various reasons for refraining from reporting their assault, such as substance use, fear of exposure to friends and family, lack of evidence, stress of the process, and fear of retaliation (Murphy-Oikonen et al., 2022). One reason survivors emphasize is the fear of being disbelieved by the police, highlighting the importance of positive interactions between victims and the police. Patterson (2011) found individuals with positive interactions with the police had higher rates of engagement and disclosure compared to those with negative interactions. Furthermore, the fear of disbelief from the police contributes to individuals ascribing to the "real rape" narrative in an effort to garner credibility for their case (Murphy-Oikonen et al., 2022).

Although the literature cannot determine what factors weigh more or less, or when they matter in the process, two consistent and strong predictors for the successful prosecution of a sexual assault case are perceived victim cooperation and credibility (Lovell et al., 2021). Navigating the process requires buy-in from the survivor; however, insensitive behaviors and attitudes toward victims reduce

victim cooperation. Evaluating biases and defects in perceptions surrounding sexual assault is integral for appropriately analyzing factors moderating victim cooperation, especially as these perceptions directly impact case outcomes and leave many survivors without justice or access to necessary support resources (e.g., counseling, housing accommodations, and community resources). Therefore, the perceived veracity of sexual assault complainants is a critical factor in criminal cases and is often referred to as victim credibility.

Victim Credibility

Despite victim credibility having a critical role in the judicial process and fact-finding determinations, there is no standard definition for credibility in research (Voogt et al., 2019). Much of this is due to various biases and beliefs impacting our perceptions of credibility; however, according to *Black's Law Dictionary*, credibility is defined as "the quality that makes something (as a witness or some evidence) worthy of belief" (2019). In the context of sexual assault, what makes a victim's allegations worthy of belief?

Alternatively, feminist philosophers view credibility in sexual assault cases as a reflection of a patriarchal legal system's attempt to control and regulate women's bodies and sexuality (Barn & Kumari, 2015; Mack, 1993). Therefore, credibility is defined through a feminist perspective as "narratives attesting to the veracity of the crime of rape in ways that are consistent with the perspectives of the criminal justice system" (Barn & Kumari, 2015, p. 435). In other words, how can a victim's allegations be understood in a way that fits existing assumptions and practices? Credibility in criminal cases becomes a form of economy, where deficits and excesses occur for both the victim and the perpetrator based on their ability to fit the paradigm of a typical victim or perpetrator of sexual assault (Yap, 2017). Consequently, credibility assessments serve to disqualify testimonies that do not fit the archetype of the "ideal" victim and legitimize those that do (Larcombe, 2002).

Researchers studying factors shaping perceived credibility take a multidimensional approach to defining it. Some of the constructs used to measure credibility include believability, honesty, truthfulness, suggestibility, accuracy, and reliability (Alderden & Ullman, 2012; Campbell et al.,

2015; Jordan, 2004; Lievore, 2004; Nason et al., 2019; Voogt et al., 2019; Wilinsky & McCabe, 2021). Believability is the extent to which a claim is viewed as worthy of belief, but it can also represent a "victim's willingness to lie about the events" (Nason et al., 2019; Pozzulo et al., 2010, p. 53; Voogt et al., 2019). As a result, believability taps into how knowledgeable, intelligent, and confident a person appears to be; however, this is influenced by attitudes surrounding sexual violence and victim and perpetrator characteristics (Campbell et al., 2015; Nason et al., 2019; Voogt et al., 2019). For example, negative perceptions about victim culpability, prior sexual relationships, age, and substance use history can all contribute to an individual being portrayed as less believable and more willing to lie.

Related constructs are truthfulness and honesty, both focusing on a complainant "not lying" which makes it hard to separate the two constructs (Voogt et al., 2019). Truthfulness refers to a victim's level of honesty; an honest complainant will not intentionally present false information, so their claim will be convincing and believable (Griffin, 2018; Voogt et al., 2019; Wilinsky & McCabe, 2021). Yet, truthfulness is limited as a construct because there is often no single truth or whole picture in criminal cases. Instead, truth-seeking in criminal cases is based on "culling and arranging of facts" to prompt certain conclusions or decisions (Griffin, 2018, p. 23). Accuracy, on the other hand, is a broader construct focused not on who lied but on the consistency of a statement (Voogt et al., 2019). Consistency is centered on judgments about an individual's memory, ability to recall information, and clarity about the situation or what constitutes the proposed offense (e.g., knowledge about what constitutes a non-consensual sexual act; Lievore, 2004; Nason et al., 2019; Voogt et al., 2019).

Cognitive competence is a significant barrier to perceived accuracy as during sexual cases survivors will have to recount their story numerous times (Deck, 2021). Further, guilt-assuming inquiries and counterarguments seek to diminish or devalue this competence by questioning an individual's intelligence, mental capacity, and/or clarity of the events. These questions can also impact reliability which refers to the "degree to which a juror can depend on the statements made by the victim or defendant" (Pozzulo et al., 2010, p. 53; Voogt et al., 2019). A person's mental capacity

could prompt questions about whether they misunderstood the events of the situation. Another facet is whether a person was coached or fooled into changing their story, referred to as suggestibility (Voogt et al., 2019).

This multidimensional approach highlights credibility is not a directly observable variable, but a perceived or inferred construct (Voogt et al., 2019). These perceptions and inferences do not operate in a vacuum; they are influenced and moderated by numerous factors underlying the intricacy of sexual violence and the systemic biases shaping survivors' experiences. One of the factors often cited in research as important for understanding sexual violence is culture (Burt, 1980; Kalara & Bhurga, 2013; Prime & Priya, 2020). Culture influences our perceptions, beliefs, and attitudes about social roles, appropriate sexual behaviors, and sexual stereotypes. Consequently, in egocentric and patriarchal societies, there is a longstanding history of viewing interpersonal violence through a gendered lens resulting in the propensity to focus on women as victims and men as perpetrators (Hines et al., 2012; Kalara & Bhurga, 2013; Stemple & Meyer, 2014).

Gender Stereotypes. Much of the reason behind this gendered understanding of sexual violence, with women as natural victims and men as natural perpetrators, may be shaped partly by the social meanings attributed to gender, as well as the biological or evolutionary theories used to explain interpersonal violence. From an evolutionary perspective, sexual violence occurs as a result of sexual selection with men having "natural sexual urges" motivating them to engage in reproductive strategies (including sexual violence) to enhance their propensity to reproduce (Kalara & Bhurga, 2013; McKibbin et al., 2008; Thornhill, 1999). Although evolutionary researchers emphasize these theories are not implying genetic determinism, the belief that men cannot control their urges contributes to misconceptions about sexual assault that can negatively affect conviction rates by justifying male sexual violence as something men are incapable of controlling and shifting the responsibility of preventing it to women. Further, it reduces sexual violence to an issue of male sexual gratification which disregards and stigmatizes the experiences of male survivors and minimizes the social and cultural phenomena baked into our perceptions of the gendered differences between men and women.

Much of the driving force behind these perceptions are gender stereotypes. Stangor and Lange (1994) describe "stereotypes as a mental association between certain characteristics and a label of a social category" (as cited by Schwark, 2017, p. 2). Stereotypes are persistent in our society and provide insight into our associations about a social group's status and role (Schwark, 2017). Women, as a social group, are often portrayed as passive and weak social agents incapable of protecting themselves, while masculine identity is associated with perceived or real experiences and feelings of power, dominance, and strength (Kalara & Bhurga, 2013; Schwark, 2017). Therefore, gender inequality is not about individual differences but sociocultural configurations and ideologies about male dominance and toughness compared to weakness and vulnerability in women. Unfortunately, these stereotypes influence both sexual victimization and how the public and criminal justice system responds to it.

Specifically, women who do not align with gender stereotypes or traditional gender roles may be viewed as less credible due to sexist attitudes increasing evaluations of fault and blame (Grubb & Turner, 2012). These attitudes may suggest these women could have stopped the assault or are being punished for not fitting into their social role as innocent or pure beings (Grubb & Turner, 2012). However, women who do fit the stereotype may still be viewed as not credible because of the societal propensity to view sexual assault victims as different from other women and as gullible or suggestible (Grubb & Turner, 2012; Randall, 2011). These viewpoints aid in creating a culture that promotes sexual assault.

Epistemic Injustice. Burt (1980) defines rape as a "logical and psychological extension of a dominant-submissive, competitive, sex role stereotyped culture" (p. 229). Sexual violence involves elements of power, control, dominance, and superiority which are gained through coercion, manipulation, isolation, and sexual abuse; however, power is not obtained solely through the act itself. Power, control, and dominance are also entangled with knowledge by influencing "ways in which people can be wronged in their capacity as knowers," which is referred to as epistemic injustice (Fricker, 2007, p. 44). In the criminal justice system, one's knowledge (typically in the form of testimony) and the reliability of this

knowledge can be diminished by social, cultural, or historical prejudices. This phenomenon is referred to as epistemic injustice as it indicates a "mismatch between rational authority and credibility" so that social identities associated with less power tend to be given deflated levels of credibility (Fricker, 1998, p. 170; Fricker, 2006).

Epistemic injustice comes in two forms: testimonial injustice and hermeneutical injustice (Fricker, 2007). Testimonial injustice refers to those instances where systemic identity prejudices influence how an individual's credibility is perceived. Testimonial injustice in sexual assault cases occurs when women's knowledge, even of their own experiences, is discredited as a result of their status as a woman. Through discrediting these testimonies, individuals in power positions shape and affect how credibility is assessed and who is capable of being seen as truthful or rational.

Hermeneutical injustice on the other hand is when systemic prejudice interferes with an individual's ability to have the conceptual resources to express or understand their experiences (Fricker, 2007; Yap, 2017). In other words, there is no language to describe an experience. An example of this was women being unable to accredit and label non-consensual sexual acts in their marriage as rape prior to marital rape laws. A hermeneutical injustice occurred as the absence of legal precedent and societal understanding impacted these individuals' abilities to communicate and make meaning of their experiences. Further, these structural injustices contribute to an absence of self-recognition and interpretation.

In terms of sexual assault, gender has been at the forefront of epistemic injustice research as sexual violence is considered an issue of sex equality (Tilton, 2019; Yap, 2017). Sex inequality arises due to rape culture which is a cultural environment where sexual violence against women is "expected, feared, and used as a mechanism of social control" (Crewe & Ichikawa, 2021; Tilton, 2019, p. 3). Within this culture, women are portrayed as less trustworthy, honest, and accurate about their accounts because of their identity as a woman in addition to prejudicial beliefs about what constitutes "real" rape (Grubb & Turner, 2012; Randall, 2011; Tilton, 2019).

Misogynoir. Although gender plays an integral role in our understanding of epistemic injustice, it is not the sole social identity leading to gaps in power and control. Particularly, much consideration is needed when reflecting on the question, "Are all women the same?" Nash (2008) described the word "woman" as a "contested and fractured terrain" (p. 3), because the individuals encapsulated under this label are shaped by vastly different experiences, interests, and cultural backgrounds. Considering these differences, there are other social identities that increase the likelihood a woman's knowledge is viewed as deficient or inferior. Specifically, there is a history of Black, Indigenous, Women of Color (BIWOC) experiencing violence and law enforcement's response to these events discrediting or ignoring their experiences (Garcia-Hallett et al., 2022; Rushing et al., 2022; Williams, 2021).

Particularly, Black women's experiences with sexual violence may differ from other Women of Color. Black women's experiences with violence, especially sexual assault, has historically been ignored, accepted, and promoted (Collins, 1998; Gaston, 2021; Long & Ullman, 2013; Slatton, 2018). Moya Bailey (Bailey, 2021) originated the portmanteau term "misogynoir" in 2008 to illustrate how anti-Black sexism maintains and perpetuates the invisibility, hatred, and distrust of Black women and girls. This contempt directed toward Black women began during the Transatlantic slave trade, and the deep-rooted impacts of slavery on Black womanhood lays the foundation for understanding Black women's experiences of sexual assault.

During slavery, the Black body was property and viewed and used as a commodity to be bought or sold (Dixon, 2018). Arising out of this dehumanization were stereotypes serving to justify violence, mechanisms of control, and ideologies about Black inferiority. In terms of stereotypes, Black women were depicted as sexually delinquent and "animalistic" with an insatiable lust for sexual acts (Awad et al., 2015; Harris & Kruger, 2020; Loft, 2020; Long & Ullman, 2013; Slatton & Richard, 2020). According to the sexual stratification hypothesis (Collins, 1975; LaFree, 1980), these stereotypes provided justification for sexually exploiting Black women and allowed rape to function as a means of social control.

Moreover, the hyper-sexualization of Black women acted as both a testimonial and hermeneutical injustice. Black women's experiences of sexual violence were dismissed and ignored because they did not fit societal standards of womanhood. Alang et al. (2023) stated "womanhood is typically perceived as White" (p. 31), and since womanhood during this time centered on being seen as "delicate and pure" (p. 4), Black women were not afforded the legal protections White women received (Loft, 2020). These attitudes left Black women unable to obtain legal recourse for sexual victimization, even when the perpetrator was a Black man, and ultimately placed the responsibility and blame on Black women for any sexual assault and abuse they experienced (Bailey, 2019).

Narratives surrounding the sexual promiscuity of Black women did not end with slavery. In today's society, Black women still face these stereotypes and numerous studies (Harris & Kruger, 2020; Perillo et al., 2023; Zounlome et al., 2019) recognize how these stereotypes contribute to the adultification and sexualization of Black girls. Therefore, inequities in protection and justice from sexual victimization for Black women starts at a young age. In a study on childhood sexual abuse, Black women reported a higher prevalence of childhood sexual abuse (34.1%) than their White counterparts (22.8%; Amodeo et al., 2006). NISVS data found 53.6% of non-Hispanic Black women reported experiencing interpersonal violence (e.g., sexual violence, physical violence, and stalking) in their lifetime (Basile et al., 2022).

Through these hardships, Black women have been labeled as "strong" and self-reliant, again placing Black women in a separate category from other women and contributing to misconceptions that Black women are impervious to pain (Slatton & Richard, 2020). Additionally, these misconceptions affect Black women's ability to see themselves and be recognized as "real" sexual assault victims, impacting how they disclose their experiences to family, friends, and law enforcement personnel. Research into racial differences in sexual violence rates and risk show that Black women experience higher rates of sexual assault or rape when compared to their White counterparts but are the least likely to disclose unwanted sexual experiences compared to other racial groups (Slatton & Richard, 2020; Ullman & Lopez, 2021).

Black women's decisions to not disclose their experiences to family and legal entities are often due to the culture of secrecy within the Black community (Jacques-Tiura et al., 2010; Slatton & Richard, 2020). Throughout the years, silence has allowed Black women to cope with racial trauma and violent victimization in ways that are protective of both themselves and others. For example, Black women sexually assaulted by other Black individuals face significant barriers to reporting their assault due to the fear of betraying their community (e.g., collectivist values) and societal pressure to maintain the strong Black woman image (Slatton & Richard, 2020). Black women's decision to choose racial solidarity over reporting may also be influenced by negative relationships between the police and the Black community (Collins, 2000; Gómez & Gobin, 2020); however, negative racial attitudes about Black individuals also impact how police officers handle cases of victims who do come forward.

The perpetuation of negative racial stereotypes toward the Black community fuels implicit bias in policing and gives rise to mass incarceration and negative credibility assessments (Johnson, 1996; Rushing et al., 2022; Thompson, 2018; Young, 2005). Particularly, critical race scholars note that courtrooms were intentionally created to be White spaces with legal narratives and behavior codes centered around White individuals, explicitly White men (Carlin, 2016; Muñiz, 2023). Black individuals and People of Color were excluded from the courtroom because of their legal and social status (e.g., slavery) and inability to sit on juries or testify against White individuals (Carlin, 2016; Young, 2005). As a result, Carlin (2016) asserts legal truths "developed as distinctly White" (p. 453), and White actors set the standard for what is deemed as reliable and trustworthy. Consequently, Whiteness becomes an epistemic advantage (Muñiz, 2023). When individuals do not conform to these White codes of conduct, they are viewed as inappropriate and, by extension, non-credible. Black women, when placed in this environment, face extensive barriers to overcoming potential racial prejudice and exclusion in addition to conflicts arising from their gender identity (Brown, 2012; Duhaney 2022; Williams, 1986).

Therefore, race and gender may be factors contributing to epistemic injustice for these individuals which, when evaluating sexual violence through a gender-focused lens, poses a substantial conflict. Crenshaw (1989) articulates that this dilemma arises from race and gender being treated as "mutually exclusive categories" (p. 139), which erases the experiences of individuals living in the intersection of these identities. Further, this single-axis framework limits inquiries and experiences to those from privileged members of the group (Crenshaw, 1989).

A pointed illustration of this is the #MeToo Movement. Although the #MeToo Movement is considered a "significant mobilization in the women's movement," it did not capture all women (Williams, 2021, p. 1798). The movement itself was built off the experience of Tarana Burke, a Black woman who originated the phrase and concept of "#MeToo" in 2006 by sharing her story of sexual violence on social media to allow other people to connect and share their stories using the MeToo hashtag (Mosely, 2021). Much of the movement's notoriety, however, is due to White celebrity women using the hashtag 11 years later. Although these women increased the movement's visibility and garnered media attention through the Harvey Weinstein allegations and trial, the defining stories of the movement became focused primarily on these famous White women (Leung & Williams, 2019). The Robert Kelley (R. Kelly) scandal and its non-famous Black women victims did not garner the same media attention, despite the story coming out three months earlier than the Weinstein case and representing a new insurgence of allegations against the singer who had faced similar allegations two decades earlier (Leung & Williams, 2019). The Bill Cosby case followed a similar trajectory with the media portraying and curating the image that Cosby's victims were solely White women although nearly a quarter were Black, Indigenous, Women of Color (BIWOC; Leung & Williams, 2019).

Intersectionality

Society's failure to address the grievances of Black women and other women of color in the #MeToo Movement is in part due to the stories the media chose to highlight, but that is not the underlying issue. The underlying problem is the movement's singular focus on gender and its perennial inattention to how gender interconnects with other social identities, such as race, class, and

romantic and sexual orientation. This singular focus is especially detrimental to Black women as their identities are "shaped by how these categories interact in particular historical, social, and cultural contexts" (Leung & Williams, 2019, p. 1; Nash, 2009). The term used in research to capture the multidimensional nature of an individual's social and political identity is intersectionality (Crenshaw, 1989). Kimberle´ Crenshaw coined the term in the late 1980s to provide a conceptual framework for understanding racial variations within gender, particularly for Black women, and critique feminists' claims of advocating for *all* women and the legal system's notion of being a color-blind and neutral entity (Crenshaw, 1989; Nash, 2008).

Intersectionality is now a scholarly buzzword centered around social identity (Nash, 2008); however, feminist, critical race and intersectional theorists advocate for a more rich and complex understanding of intersectionality as it is not simply depicting personal identity, but also accounting for power (Cooper, 2015). Identity is both self and societally determined, so there is no unilateral and absolute process for depicting marginalization (Phoenix & Pattynama, 2016). Social identities exist within social-structural contexts where social positions, environment (e.g., group, neighborhood, nation, state), and history give rise to discrimination and inequality (Bowleg & Bauer, 2016). Therefore, power and privilege are the essence of intersectionality as systems of oppression influence and shape people's lived experiences, especially those with multiple marginalized identities (Bowleg & Bauer, 2016; Wyatt et al., 2022).

Disability. To study this exchange, intersectional research has historically used Black women as quintessential research subjects and has centered on exploring the gender/race binary (Nash, 2008). Yet, this focus ultimately reinforces the notion that *all* Black women are the same and does not allow for analysis of how other social categories (e.g., class, age, skin color, sexuality) shape and mediate Black women's experiences of violence and oppression. A multi-layered approach is especially integral for research into Black women's experiences with sexual assault as sexual violence at its core is about domination across all social categories (Armstrong et al., 2018). One social category often overlooked in the matrix is disability. Disability, as a term, has had various definitions across history with its meaning

and criteria shifting over time and changing based on social and cultural contexts (Francis & Silvers, 2016). Historically, disability has been viewed as a deformity or deficit, with some cultures and religions signifying it as a personal tragedy or punishment from God (Brinkman et al., 2023; Marini, 2017).

As a result, throughout history, the overall attitude and treatment of individuals with disabilities have been marked by fear, prejudice, and discrimination and these individuals have been subjected to isolation, abuse, experimentation, sterilization, imprisonment, and death (Marini, 2017; Pons et al., 2022). Inherently, these experiences contributed to marginalization and stigma toward people with disabilities—referred to as ableism—and promoted viewing individuals with disabilities as having less worth and humanity than individuals without disabilities (Brinkman et al., 2023). The notion that a disability reduces a person's humanity has been maintained and promoted by how disability is modeled and conceptualized. At one point, disability described legislative mandates preventing individuals from engaging in social, political, or economic activities (Francis & Silvers, 2016). For instance, in the past, married women were barred from owning property as they were considered explicitly disabled by law (Francis & Silvers, 2016).

Through the development of the medical model, disability shifted from a legal mandate to an "individual-level deficit in need of correction" (Brinkman et al., 2023, p. 3). While this model allowed for the development of medical treatments and increased accessibility to insurance and healthcare benefits, it also placed individuals with disabilities in passive sick roles (Brinkman et al., 2023; Francis & Silvers, 2016). Power became vested in medical professionals, again leading to individuals with disabilities being considered inept. Further, the medical model does not consider how systemic and interpersonal factors (e.g., income, social class), especially when combined with marginalized identities, present social, economic, and political barriers (Brinkman et al., 2023; Clare, 2019). Over time there was a push to shift from the medical model to other approaches, such as the social, affirmative/positive identity, human rights, and cultural models. These new models helped launch the disability movement by promoting disability empowerment and shifting the focus of disability from a deficit to a culture (Brinkman et al., 2023).

One of the ways this culture has shifted the conversation on disability is through its definition. According to the Centers of Disease Control and Prevention (CDC, 2020), a disability is an umbrella term used to describe both apparent (e.g., a disability requiring a supportive tool) and non-apparent (e.g., chronic illness, learning disorder), mental and physical conditions which act as an impairment, activity limitation (e.g., difficulty seeing, hearing, or problem-solving), or participation restriction (e.g., engaging in social activities and obtaining healthcare). Therefore, disability signifies both bodily differences and social marginalization and individuals with disabilities compromise the largest marginalized group in the United States (Brinkman et al., 2023; Grue, 2016).

Disability stigma presents a significant barrier for this community in that individuals with disabilities, compared to those without disabilities, have a heightened risk of experiencing negative behaviors from others (e.g., microaggressions, insults), discrimination, and violent victimization (Basile et al., 2016; Hughes et al., 2012; WHO, 2011). These individuals are particularly vulnerable to sexual violence for numerous reasons, such as myths surrounding autonomy and sexuality for people with disabilities (e.g., right to consent, being viewed as eternally a child, asexual, or hypersexual), reliance on others for daily living tasks, and their disability serving as a perceived weakness or vulnerability for perpetrators of interpersonal violence (Basile et al., 2016; Ledingham et al., 2022; Thompson et al., 2021). Ledingham's (2022) study of women aged 18 to 44 from 2011 to 2017 found that women with disabilities experienced sexual violence in their lifetime at a rate double (30%) that of individuals without disabilities (16.9%), with women with multiple disabilities experiencing the greatest prevalence. Other studies replicate these findings, demonstrating that violence against women with disabilities occurs with increased severity and duration when compared to women without disabilities (Basile et al., 2016; Breiding & Armour, 2015; Child et al., 2011; Nannini, 2006; Thompson et al., 2021).

When reporting these experiences, individuals with disabilities may face obstacles like communication/language barriers, societal and internalized stigma about disability and sex, and lack of service accessibility (e.g., architectural barriers, lack of interpreters, inability to write a report)

(Iudici et al., 2019). Women with disabilities may also experience difficulties recognizing and identifying signs of abuse and what constitutes an appropriate sexual encounter due to having less knowledge and sex education about sexuality and consent (Iudici et al., 2019; McGilloway et al., 2018; Thompson et al., 2021). These limitations, when combined with living in isolation and segregation, being taught to be compliant, or experiencing repeated exposure to abuse, can leave women with disabilities without the conceptual resources to describe their experiences (Smith et al., 2017; Thompson et al., 2021). As a consequence, healthcare professionals and law enforcement officers may buy into negative stereotypes and perceptions about disabilities contributing to perceptions that these individuals are less credible and competent than those without disabilities (Child et al., 2011; Iudici et al., 2019; Thompson et al., 2021).

Sanism. In the past, mental health was left out of the discourse about disability due to it often being a non-apparent impairment and to misconceptions that psychological disorders are either not real (simply excuses for unacceptable behaviors) or untreatable (real but hopeless; Brinkman et al., 2023; Kattari et al., 2018; Ringland et al., 2019, Subedi & Shyangwa, 2018). Societal views and beliefs around mental illness have shifted allowing for increased awareness and acknowledgment of mental health as an impairment (Kattari et al., 2018; Subedi & Shyangwa, 2018). However, much like disability as a whole, internalized and public stigma still exists for people living with mental illnesses (PLWMI). While discrimination against mental illnesses is often encapsulated under ableism, a term used in research to describe the unique oppression faced by PLWMI is sanism.

Perlin (2003, p. 684) describes sanism as an "irrational prejudice against people with mental illness which permeates all aspects of mental disability law and affects all participants in the mental disability law system." Sanism largely goes unnoticed because it is societally acceptable (Perlin, 2003; Poole et al., 2012) and maintained by stereotypes and myths deeply ingrained into perceptions about mental health. These myths separate people who experience mental health concerns from people who do not by associating mental distress with labels such as, "mad," "crazy," "erratic," or "lunatic" (LeBlanc & Kinsella, 2016). In criminal cases, sanist views take the form of self-referential or

heuristic reasoning about mental illnesses (e.g., “I think people with depression are unkempt, therefore this person has to be unkempt”), and they influence assessments about an individual’s intellectual capacity or ability to engage in socially acceptable behavior (Perlin, 2003).

For instance, an individual’s mental health history can be used to question their testimony in criminal trials and raise skepticism about believability and reliability (Benedet & Grant, 2012; Iudici et al., 2019; McGilloway et al., 2018; Smith et al., 2017). As a result, mental illness is an identity-based prejudice impacting perceptions about an individual’s capacity as a knower. Yet not all mental health conditions are treated the same.

Public perceptions about mental health vary based on assumptions about course, severity, and ability to recover; but, stigmatizing beliefs about dangerousness and incompetency in people with mental illnesses is widespread and these beliefs commonly affect perceptions about individuals with serious mental illnesses, such as schizophrenia (Gearing et al., 2023; Martin et al., 2000; Parcesepe & Cabassa, 2013). Articles (Angermeyer & Matschinger, 2003; Gearing et al., 2023; Wood et al., 2014) exploring public attitudes about depression, anxiety, and schizophrenia found that overall stigma surrounding mental health diagnoses has decreased since the 80s; however, schizophrenia was still associated with negative stereotypes about the ability to recover, dangerousness, and unpredictability.

The psychological symptoms underlying schizophrenia (e.g., delusions and hallucinations), when combined with these negative stereotypes, can greatly impact perceptions about victim credibility (Gous et al., 2022; Teplin et al., 2005). Levi’s (2022) study examining how victim mental health impacts juror-decision making for a rape case showed participants rendered more guilty verdicts, had more anger toward the defendant, and viewed the victim as more credible in the non-mental health (i.e., allergy) and depression condition than in the schizophrenia condition. Therefore, the type of mental health diagnosis can greatly impact pro-victim attitudes (credibility) and level of mental health stigma.

The Intersection of Ability, Race, and Gender

Women living with mental illnesses may be subjected to disability bias as well as sexism but, for women of color, race can present as a third layer of bias; throughout history, both identities (womanhood and BIPOC identity) have been associated with perceptions of defective citizenship (Froschl et al., 1999; Parker, 2015). The intersection of these identities is critical for Black women with disabilities because their ability status, race, and gender can all present greater risks of biases and inequalities (Correa-de-Araujo, 2016).

According to the Center for Disease Control, 14.8% of non-Hispanic Black adults aged 18 to 44 received mental health treatment in 2021 (Terlizzi & Schiller, 2022). The Substance Abuse and Mental Health Services Administration's (SAMHSA; 2022) 2020 national survey of drug use and health found that 5.3 million African American adults aged 18 and older endorsed having a mental illness, and 1.4 million disclosed having a serious mental illness. Despite these numbers, Black women have notably reduced formal help-seeking compared to their White counterparts even after sexual assault, as finances, religion, culture, fear, shame, and guilt pose significant barriers (Ullman & Lorenz, 2021).

Moreover, racial and ethnic minorities are more likely to become disabled than White individuals and the impact of ability status on employment and educational opportunities for African American individuals is greater than their white counterparts (Erkulwater, 2018; Goodman et al., 2017; Kail et al., 2018; Mitra et al., 2022). Although research has explored the role of racism and disability discrimination, little is known about how race, gender, and mental health history impact credibility perceptions for Black women with mental health conditions. Evaluating the factors impacting credibility perceptions for these individuals are intermingled into the framework of epistemic injustice as they are baked into the myths people have about sexual assault cases and can prejudice the listener's view of the survivors' trustworthiness.

Rape Myth Acceptance

These mythologies are referred to as rape myths. Lonsway and Fitzgerald (1994) define rape myths as "attitudes and beliefs that are generally false but are widely and persistently held, and that serve to deny and justify male sexual aggression against women" (p. 134). By providing justification or denial of sexual violence, rape myths promote blaming victims for their victimization and limit actions considered to be sexual assault (Burt, 1980; Hayes et al., 2013; Iconis, 2008). Examples of rape myths include, "only women who are asking for it are raped" or "a lot of times, girls who claim they were raped have emotional problems" (Bowie, 2018; Burt, 1980; Lonsway & Fitzgerald, 1994). These false beliefs about sexual assault can fall within three main types: dishonesty, consent, and/or blame myths, according to Jenkins (2021). Dishonesty myths suggest women frequently lie about rape, erroneously inflating the prevalence of false rape allegations (Jenkins, 2021). Dishonesty myths imply women regularly lie about consensual sex to get revenge or to avoid being cast in a negative light. Consent myths go hand in hand with dishonesty myths as they also obscure what constitutes a non-consensual sexual encounter. Consent refers to an individual using their choice, freedom, and capacity of mind to agree to sexual behavior which can be given or removed at any time (Edwards et al., 2022; RAINN, 2023c).

Common consent myths include the beliefs that "consent, once given, cannot be withdrawn and that non-consensual sex always involves overwhelming physical force" (Jenkins, 2021). Both consent and dishonesty myths may be followed by myths surrounding victim blame, such as beliefs that women who drink alcohol or take drugs are to blame if they are raped (Bowie, 2018; Jenkins, 2021). Numerous studies show a positive relationship between rape myth acceptance (RMA) and victim blaming, such that as RMA increases so does victim blaming. Victim blaming is often fueled by contextual factors, including the relationship between the victim and the perpetrator, the victim's clothing, religion, and individual beliefs (e.g., Just World Belief; Hammond et al., 2011; Hayes et al., 2013; Hine & Murphy, 2019; Nason et al., 2019; Russell & Hand, 2017; Stack & Kanavy, 1983; Suarez & Gadalla, 2010). Particularly, one study evaluating the impact of rape myths on memory

construction found that participants who scored higher in rape myth acceptance blamed the victim more and their memory was more attuned to information in the vignette scenario congruent with rape myths (Dawtry et al., 2019).

Although not all rape myths will fit into these three categories and there is overlap between them, they highlight how rape myths undermine the credibility of individuals who deviate from society's beliefs about what constitutes a "real" sexual assault victim (Randall, 2011). Moreover, these myths impact criminal cases and police officers' decision-making by influencing case attrition and minimizing perpetrator accountability (Ayala et al., 2018; Grubb & Turner, 2012). Since rape myths are framed around women being the victim and men being the perpetrator, these myths are often discussed in the context of gender and sexist ideologies. Specifically, rape myths are maintained and upheld by traditional gender roles and ambivalent sexism which perpetuate and reward male domination, violence against women, and the idea that women's desirability and trustworthiness are based on their sexual history and behaviors (Prina & Schatz-Stevens, 2020). Women who do not conform to these roles are judged as responsible for their fate.

Because of the prevalence of rape myths and their influence on evaluations of victim blame, rape myths are an epistemic injustice (Jenkins, 2017). For instance, dishonesty myths present women as a group as suspicious and untrustworthy characters lacking credibility when disclosing experiences of sexual violence (Jenkins, 2021). Rape myths can also permeate into how sexual violence is defined and understood in criminal cases by providing incorrect and inappropriate criteria for establishing whether a crime was committed for jurors and judges influenced by these myths (Jenkins, 2021; MacKenzie, 2022). Those seeking to testify and share their experiences are faced with these explicit barriers leading to gaps in self-recognition of what constitutes an unwanted sexual encounter.

As a result, these individuals may experience fear about being believed, silenced, or ridiculed, ultimately impacting their ability to articulate their experiences and compromising their view of themselves and knowledge of resources to navigate their circumstances. Hänel (2020) articulates that individuals from marginalized identities are especially at risk for the hermeneutical injustices formed

from rape myths as "misrecognition targets primarily subjects who are already victims of oppression due to their social group membership" (p. 344). Marginalized groups' self-identity and history are shaped by past, current, and future misrecognition and suppression which is exacerbated by systemic oppression, patriarchy, misogyny, and racism (Hänel, 2020; Jenkins, 2017; MacKenzie, 2022).

Rurality

Whether and to what degree factors like rape myth acceptance, anti-Black racism, sexism, misogynoir, and sanism vary by community type (rural vs. non-rural) is not always clear. Rape myth acceptance may be similar in rural and non-rural areas (Kennon, 2023; King & Roberts, 2011; Lizarraga & Terry, 2021; Logan et al., 2005), but there are other factors that may interfere with believing victims, such as greater likelihood of knowing the accused (Annan, 2006; Averill et al., 2007; Lewis, 2003; Lizarraga & Terry, 2021). In addition, there may be higher degrees of racism (Cook et al., 2018; Gonzales et al., 2022; Harris & Worthen, 2003; Haynes et al., 2017) and sexism (DeKeseredy et al., 2006; Miller et al., 2007; Rennison et al., 2013) in rural areas, as well as more stigma around mental illness (Komiti et al., 2006; Schroeder et al., 2021; Stewart et al., 2015), but how these factors may or may not be related to perceptions of victim credibility is not known.

Current Study

Aims

The aim of the current study was to address gaps in the literature by identifying factors important in understanding perceptions and doubts about sexual assault allegations, specifically in terms of victim race and mental health history, by examining the impact of victim race and victim mental health history. This study also explored the interaction of both factors on perceived credibility of sexual assault allegations.

Hypotheses

<u>Primary study hypotheses</u>:

1. Based on previous research (Brown, 2012; Carlin, 2016; Crenshaw, 1989; Crenshaw, 1991; Duhaney, 2022; Johnson, 1996; Slatton & Richard, 2020), I hypothesized that

participants would report lower levels of perceived credibility for the Black victim than the White victim.

2. Based on previous research (Angermeyer & Matschinger, 2003; Campbell, 2015; Gous et al., 2022; Jordan, 2004; Levi, 2022; Pescosolido, 2013; Wilkinson-Ryan, 2005), I hypothesized that participants would report lower levels of perceived credibility when the victim had a mental health condition (i.e., depression or schizophrenia) versus the control (i.e., asthma/no mental health diagnosis diagnosis). Further, I hypothesized that participants would report levels of perceived credibility for the victim with schizophrenia as the lowest, followed by depression, and no diagnosis.
3. Based on the limited body of research available (Armstrong et al., 2018; Bailey, 2019; Basile, 2016; Campbell, 2015; Carlin, 2016; Clare, 2019; Levi, 2022; Slatton & Richard, 2020), I hypothesized there would be an interaction between race and mental illness status, such that, within the mental illness condition, the White woman would have a steadier decline in perceived credibility from no diagnosis to depression to schizophrenia versus a Black woman. A Black woman would have a steep drop off from depression to schizophrenia such that a Black woman with schizophrenia would be seen as the least credible.
4. Based on previous findings (e.g., Hammond et al., 2011; Hayes et al., 2013; Hine & Murphy, 2019; Russell & Hand, 2017; Sleath & Bull, 2012; Suarez & Gadalla, 2010), I hypothesized that participants who report higher levels of rape myth acceptance (RMA) would perceive the victim as less credible across all conditions.
    - Based on findings by Ayala et al. (2018), I hypothesized lower levels of RMA would be associated with higher levels of perceived credibility for both Black and White victims, but as RMA increased, credibility ratings would decrease, especially for Black women.

Exploratory study questions:

1. I explored whether RMA differed by rural status. Because the research is limited in this area, no directional hypothesis was made.
2. I explored whether religiousness is associated with RMA. Prior research (Barnett et al., 2018; Heath & Sperry, 2021) has established a positive association between religiousness and RMA.
3. I explored an interaction between participant race (Black or White) and victim race (Black or White) on participant ratings of victim credibility.
4. Finally, I explored whether RMA and credibility assessments differed based on participant gender. Prior research (Angelone et al., 2021; Barnett et al., 2018; Walfield, 2021) established a connection between higher RMA and individuals who identify as men.

CHAPTER 2

METHOD

Participants

An initial pool of 689 participants was recruited from a college student population using two recruiting strategies. Participants were either recruited through a departmental SONA Systems account, an online participant pool management system allowing participants to sign up for departmental research studies, or through a flyer distributed to students in psychology classes, criminal justice classes, and through the university pre-law advising office and a pre-law society. Inclusion criteria for the study required all individuals enrolled in the study to be at least 18 years of age, be currently enrolled as an undergraduate student, and provide consent to participate.

To protect the integrity of the data, data from 139 participants were removed from all analyses due to insufficient effort across both sections of the study (the vignette section and the questionnaires section). An additional 490 participants were removed from vignette analyses due to insufficient effort in that section, and 144 participants were removed from questionnaire analyses due to insufficient effort in that section. Participants whose data were removed from the vignette analyses were retained for questionnaire analyses if they demonstrated sufficient effort in that section. Splitting the sample allowed for exploration of both the subsample who passed the vignette section and the subsample who passed the questionnaires section. Exploring the responses of participants who may have not passed the vignette was important because the vignette section may have had unique characteristics that limited participants' engagement, so participants who failed the effort checks there could have still paid attention and given sufficient effort later when completing the questionnaires. Consequently, separate study demographics are provided for the vignette and questionnaire analyses.

Participant Demographics

Vignette Subsample. The final sample used for the vignette analyses consisted of 199 participants. Most (119; 59.8%) found the study through SONA; 60 participants (30.2%) learned about the study in a psychology class, 17 (8.5%) in a criminal justice class, and 3 (1.5%) reported they

learned about the study through another source. The other sources listed were either a criminal justice professor or a psychology class. Participants had a mean age of 21.42 (*SD* = 4.80, Range: 18-54).

Most participants identified as cisgender women. For the purposes of data analysis, the category of transgender woman (*n* = 1) was combined with the cisgender women category to create an overall category for people identifying as women, regardless of their sex assigned at birth. Additionally, there was an overall category for people identifying as men, regardless of their sex assigned at birth, but there were no study participants who explicitly identified as transgender men. A few individuals identified as nonbinary (*n* = 3) and gender queer (*n* = 2). The category of gender queer was combined with the nonbinary category to create an overall gender queer or nonbinary persons category. Some (*n* = 13) participants opted to self-describe their gender; however, they provided descriptions (e.g., "biological woman!!") consistent with the other available gender categories. Thus, those 13 responses were recoded as either men, women, or missing based on their descriptions. See **Error! Reference source not found.** for participant gender. See Appendix A for a complete list of open-ended text responses and recoding decisions.

Participants selected one or more race or ethnicity categories. The final vignette sample consisted of 123 participants (61.8%) who identified as White; 39 (19.6%) as African, Afro-Caribbean, Black, or African American; five (2.5%) as Hispanic, Latin, or Latinx; two (1%) as Asian; and two (1%) as biracial or multiracial. A total of 20 participants (10.1%) selected multiple options, one chose to self-describe, and six preferred not to answer. One participant's information was missing. All participants also described their race or ethnicity in their own words. Participants' descriptions were combined with their selected race or ethnicity responses and recategorized. Following recoding, five new categories were created: Black, Non-Hispanic; Black, Hispanic; White, Hispanic, White, Non-Hispanic; and White, Native American.

For the purposes of data analysis, a binary race variable for Black (*n* = 53) and White (*n* = 127) participants was utilized. The category of Black, Hispanic (*n* = 5) was combined with the Black, Non-Hispanic (*n* = 48) category to create an overall category for participants identifying as Black,

regardless of their ethnicity. Further, the categories of White, Hispanic (*n* = 4) and White, Native American (*n* = 2) were combined with the White, Non-Hispanic (*n* = 121) category to create an overall category for participants identifying as White, regardless of their ethnicity. See **Error! Reference source not found. Error! Reference source not found.**for vignette participants' race and ethnicity. Open-ended text responses are not reported here due to some of them being highly specific and potentially identifying.

The vignette subsample consisted of 65 participants (32.7%) who grew up in rural areas, 96 (48.2%) who grew up in suburban areas, and 37 (18.6%) who grew up in urban areas. The current living area was rural for 44 participants (22.1%), suburban for 115 (57.8%), and urban for 38 (19.1%). See **Error! Reference source not found.**.

Finally, most participants (94, 47.2%) reported never experiencing sexual assault. Forty-four (22.1%) participants disclosed experiencing sexual assault at least once, 41 (20.6%) disclosed experiencing sexual assault more than once, and 19 (9.5%) preferred not to respond. One participant's information was missing for experiences with sexual violence. Most participants (103, 51.8%) reported receiving a mental health diagnosis or experienced symptoms of a mental health condition. Eight participants (4%) preferred not to respond, and one participant's information was missing. See **Error! Reference source not found.**.

Table 1
Participant Demographics

	Vignette Subsample (*N* = 199)		Questionnaire Subsample (*N* = 545)	
Gender, all categories selected	*n*	%	*n*	%
Cisgender Men	27	13.6	74	13.6
Cisgender Women	145	72.9	389	71.4
Transgender Women	1	0.5	1	0.2
Gender Queer Persons	2	1.0	4	0.7
Nonbinary Persons	3	1.5	8	1.5
A Better Description Not Listed	13	6.5	44	8.1
Prefer Not to Answer	6	3.0	19	3.5
Missing Data	2	1.0	6	1.1

Gender, recoded	*n*	%	*n*	%
Men	32	16.1	88	16.1
Women (includes cisgender and transgender women)	154	77.4	416	76.3
Gender Queer or Nonbinary Persons	5	2.5	13	2.4
Unclear	0	0	3	0.6
Race/Ethnicity, all categories selected	*n*	%	*n*	%
African, Afro-Caribbean, Black, or African American	39	19.6	118	21.7
Asian	2	1.0	5	0.9
Biracial or Multiracial	2	1.0	7	1.3
Hispanic, Latin, or Latinx	5	2.5	17	3.1
White	123	61.8	322	59.1
A Better Description Not Listed	1	0.5	3	0.6
Prefer Not to Answer	6	3.0	14	2.6
Multiple Options Selected	20	10.1	56	10.3
Missing Data	1	0.5	3	0.6
Race/Ethnicity, recoded	*n*	%	*n*	%
Black, Non-Hispanic	48	24.1	139	25.5
White, Non-Hispanic	121	60.8	318	58.3
Black, Hispanic	5	2.5	9	1.7
White, Hispanic	4	2.0	17	3.1
Hispanic, Latin, or Latinx[1]	4	2.0	13	2.4
Asian, Native Hawaiian, or Pacific Islander	2	1.0	7	1.3
Biracial or multiracial	11	5.5	27	5.0
Black and American Indian or Alaska Native	0	0	2	0.4
White and American Indian or Alaska Native	2	1.0	8	1.5
Unclear	1	0.5	2	0.4
Race/Ethnicity, recoded, binary	*n*	%	*n*	%
Black (all ethnicities)	53	26.6	150	27.5
White (all ethnicities)	127	63.8	343	62.9
Childhood Location	*n*	%	*n*	%
Rural	65	32.7	178	32.7
Suburban	96	48.2	241	44.2
Urban	37	18.6	123	22.6
Missing Data	1	0.5	3	0.6
Current Location	*n*	%	*n*	%
Rural	44	22.1	104	19.1
Suburban	115	57.8	330	60.6
Urban	38	19.1	107	19.6
Missing Data	2	1.0	4	0.7
Sexual Assault Experiences	*n*	%	*n*	%
Yes, once	44	22.1	121	22.2
Yes, more than once	41	20.6	108	19.8

No, never	94	47.2	267	49.0
Prefer Not to Respond	19	9.5	46	8.4
Missing Data	1	0.5	3	0.6
Mental Health Experiences	*n*	%	*n*	%
Yes	103	51.8	288	52.8
No	87	43.7	230	42.2
Prefer Not to Respond	8	4.0	23	4.2
Missing Data	1	0.5	4	0.7

Note. [1] Participants in this group identified only as Hispanic, Latin, or Latinx.

Questionnaires Subsample. For the questionnaire analyses, the final sample consisted of 545 participants. Many (351; 64.4%) of these participants were excluded from vignette analyses but appeared to give good effort during the questionnaires portion of the study so were retained for questionnaire-specific (non-vignette-related) analyses.

Most (279; 51.2%) participants heard about the study through SONA, with 185 (33.9%) learning of the study in a psychology class, 68 (12.5%) in a criminal justice class, 1 (0.2%) through a pre-law advising office or pre-law society, and 12 (2.2%) through another source. Participants who indicated they learned about it through another source nevertheless described their source as a professor, a criminal justice professor, or a psychology class. Participants had a mean age of 21.22 (*SD* = 4.809, Range: 18-64).

A majority of the participants identified as a cisgender woman (389; 71.4%). Like with the vignette subsample, the category of transgender woman (*n* = 1) was combined with the cisgender women category to create an overall category for people identifying as women, regardless of their sex assigned at birth. Additionally, there was an overall category for people identifying as men, regardless of their sex assigned at birth, but no study participants identified transgender men. A few individuals identified as nonbinary (*n* = 8) and gender queer (*n* = 4). The categories were combined to create an overall nonbinary and gender queer category. Some (*n* = 44) individuals opted to self-describe their gender; however, just like with the vignette subsample, 41 of the descriptions were consistent with the other available gender categories and were recoded either men, women, or gender queer or nonbinary

persons. See **Error! Reference source not found.** for participant gender data. See Appendix A for a complete list of open-ended text responses and recoding decisions.

Participants selected one or more race or ethnicity categories. Most (322; 59.1%) of the final questionnaire sample consisted of participants who identified as White; 118 (21.7%) as African, Afro-Caribbean, Black, or African American; 17(3.1%) as Hispanic, Latin, or Latinx; 5 (0.9%) as Asian; and 7 (1.3%) as biracial or multiracial. There were 56 participants (10.3%) who selected multiple options, and 3 (0.6%) elected to self-describe. Fourteen participants (2.6%) preferred not to answer and 3 (0.6%) participants' information was missing. All participants also described their race or ethnicity in their own words, and just like with the vignette subsample, their descriptions were combined with their selected race or ethnicity responses and recategorized. See **Error! Reference source not found.** for questionnaires participants' race and ethnicity data, along with recoded categories. Once again, open-ended text responses are not reported here due to some of them being highly specific and potentially identifying.

For the questionnaire sample, 178 participants (32.7%) reported growing up in rural areas, 241 (44.2%) in suburban areas, and 123 (22.6%) in urban areas. Three (0.6%) participants' information was missing for childhood rurality. For current rurality, 104 participants (19.1%) endorsed currently living in a rural area, 330 (60.6%) in a suburban area, and 107 (19.6%) in an urban area. Four individuals' information was missing for current geographic location. See **Error! Reference source not found.**.

In terms of experiences with sexual assault, most participants (267, 49.0%) reported they never experienced sexual assault, with 121 (22.2%) participants experiencing sexual assault at least once, 108 (19.8%) experiencing sexual assault more than once, and 46 (8.4%) preferred not to respond. Three (0.6%) participants' information was missing for experiences of sexual assault. Most participants (288, 52.8%) reported receiving a mental health diagnosis or experiencing symptoms of a mental health condition at some point in the past, with 23 participants (4.2%) preferring not to respond, and four participants' (0.7%) information missing. See **Error! Reference source not found.**.

Materials

Participants completed the study on Qualtrics, an online data collection platform. Materials included a vignette, questions about the vignette, and questionnaires about rape myth acceptance, color blind racial attitudes, mental illness stigma, religiousness, and demographics.

Stimuli

Vignette. Case vignettes are the most common approach used in research investigating perceptions surrounding sexual assault because they allow researchers to ethically reproduce sexual assault situations and manipulate contextual variables (Anderson & Beattie, 2001; Sleed et al., 2002). Prior research has upheld that case vignettes have high face validity; however, the methodological rigor of these findings is mixed, and there are no standardized rape or sexual assault vignettes in the literature (Anderson & Beattie, 2001; Persson & Dhingra, 2021; Sleed et al., 2002). Therefore, six versions of a case vignette were created specifically for this study. Immediately upon consenting to participate, participants were randomly assigned to read one of six versions of a vignette that varied in terms of victim race (Black vs. White) and victim mental health history [Asthma (no diagnosis/control condition) vs. Depression, vs. Schizophrenia].

The vignette depicted a fictional online newspaper article detailing a sexual assault court case. Anderson and Beattie's (2001) research on vignettes used in sexual violence studies found that newspaper accounts of sexual violence provide information about "how people would react to, say, newspaper accounts of rape" (p. 17), enhancing the ability to capture general attitudes about sexual assault. In the vignette for the current study, a woman was described testifying about being sexually assaulted by a man she met at a party. The vignette was accompanied by a picture of the victim testifying in court. In keeping with journalistic standards not to identify victims, the victim's name was not used, and her face was blurred. Her body (e.g., hands, neck) was visible so that participants could infer the race of the victim. The victim's mental health history was highlighted by the defense's questioning of her state of mind (i.e., reliability of the victim's account of the events) due to being hospitalized for either asthma (control condition), depression, or schizophrenia a week prior to the sexual assault. In accordance with journalistic

standards, the defendant's name was formatted to appear as if it has been included in the original news story but redacted for use in the study. The vignette as a whole was written and formatted to appear like a screenshot of a real news article. See Appendix B for all six versions of the vignette.

Measures

Post-Vignette Evaluation Questions. After reading the vignette, participants answered 14 questions about their perceptions about victim credibility, victim blame, and overall certainty of the event. One attention check was also embedded in the questionnaire. The 14 questions were scored on an eight-point (0 to 7) response scale and were a mixture of new items and items adapted from Voogt et al. (2019) and Kennon (2023). For the current study, the primary variable of interest was victim credibility, which was based on a single item, which was also the first question presented to participants after reading the vignette ("Based on the article, how would you rate the credibility of the woman's testimony?"). Other items about accuracy, responsibility, and overall certainty that a sexual assault occurred were included to allow for exploratory or follow-up analyses for future studies. Data from those items were not analyzed for the current study. The full version of the post-vignette evaluation is in Appendix B.

Post-Vignette Manipulation and Reading Checks. After completing the post-vignette evaluation questions, participants answered five questions about the vignette. Two questions served as manipulation checks. Only participants who passed both of the manipulation check items were included in vignette analyses. Another three questions served as general reading checks to see how closely participants read the article. Only one of these reading checks ("True or False? The alleged victim was a woman.") was mandatory for participants to pass in order to be included in data analysis, but everyone who passed the manipulation checks also passed the question about the victim's gender. See Appendix B.

Color Blind Racial Attitude Scale (CoBRAS; Neville et al., 2000). The CoBRAS is a 20-item measure of racial attitudes indicating denial or unawareness about structural inequalities and racial discrimination faced by racial and ethnic minorities. The CoBRAS has three subscales reflecting dimensions of color-blind racial attitudes: *Racial Privilege*, *Institutional Discrimination,* and *Blatant Racial Issues*. The first subscale, *Racial Privilege*, consists of seven items designed to target assumptions

about the existence of White privilege (e.g., “White people in the U.S. have certain advantages because of the color of their skin”). The *Institutional Discrimination* subscale, has seven items questioning the necessity of social policies and the effects of institutional racism (e.g., “Due to racial discrimination, programs such as affirmative action are necessary to help create equality”). The *Blatant Racial Issues* subscale, contains six items reflecting higher awareness about the pervasive nature of racial issues and discrimination (e.g., “Racial problems in the U.S. are rare, isolated situations”).

The CoBRAS uses a 6-point Likert Scale, where 1 = *strongly disagree* and 6 = *strongly agree*. Scores were totaled for a total CoBRAS score. However, items two, four, five, six, eight, eleven, twelve, fifteen, seventeen, and twenty were reverse scored so higher scores indicate greater endorsement of color-blind racial beliefs. Neville et al. (2000) found good internal consistency with subscale α = .83, .81, .76, respectively and the total scale alpha was .91. Moreover, Neville et al. (2000) reported good concurrent validity with higher CoBRAS scores associated with greater levels of racial intolerance and prejudice (e.g., modern racism). The CoBRAS has been used in a wide range of populations, and studies using the measure reported good internal consistency, with α ranging from .81 to .88 (Awad et al., 2005; Burkard & Knox, 2004; Gushue, 2004; Neville et al., 2006). Neville et al. (2000) also found correlations between the CoBRAS and global belief in a just world (e.g., the world is fair, and people get what they deserve). In the current study, primary study analyses relied on the total score of the CoBRAS, which showed excellent internal consistency (α = .91). Though not included in current analyses, the *Racial Privilege* (α = .86), *Institutional Discrimination* (α = .81), and *Blatant Racial Issues* (α = .77) subscales showed good to excellent internal consistency in this study.

Adapted Day’s Mental Illness Stigma Scale. The Adapted Day’s Mental Illness Stigma Scale (DMISS; Day et al., 2007) measures stigmatizing attitudes toward individuals with mental health conditions. The current study adapted the scale to focus solely on mental illness as a whole by removing the questionnaire instructions before the scale and not varying the mental health condition names in the scale. Instead of varying the name of the mental health conditions, the current study used “mental illness” in all items. The DMISS has 28 items and seven subscales: *Interpersonal Anxiety*, *Relationship*

Disruption, *Hygiene*, *Visibility*, *Treatability*, *Professional Efficacy*, and *Recovery*. These subscales are dimensions capturing how public attitudes about mental health influence perceptions of interpersonal, daily living, and behavioral (e.g., trust, risk of physical harm) functioning.

The *Interpersonal Anxiety* subscale has seven items assessing feelings of fear, discomfort, or nervousness about people with mental illnesses (e.g., "I feel anxious and uncomfortable when I'm around someone with a mental illness"). *Relationship Disruption* subscale constitutes six items where higher endorsement indicates difficulties trusting or establishing relationships with people with mental illnesses (e.g., "I would find it difficult to trust someone with a mental illness"). Subsequently, the *Hygiene* subscale is composed of four items focused on beliefs that mental illnesses negatively impact personal grooming (e.g., "People with mental illnesses ignore their hygiene, such as bathing and using deodorant"). The *Visibility* subscale has four items reflecting participants' perceptions of their ability to recognize the symptoms of mental illnesses in others (e.g., "I can tell that someone has a mental illness by the way he or she acts"). Similarly, *Treatability* comprises three items gauging participants' attitudes about mental illnesses responsiveness to treatment (e.g., "There is little that can be done to control the symptoms of mental illness"). Moreover, the *Professional Efficacy* subscale has two items targeting perceptions about healthcare professionals' abilities to provide effective treatments (e.g., "Psychiatrists and psychologists have the knowledge and skills needed to effectively treat mental illnesses"). Finally, the *Recovery* subscale contains two items doubting the potential of recovery for people living with mental illnesses (e.g., "People with mental illnesses will remain ill for the rest of their lives").

The DMISS uses a 7-point Likert scale, where 1 = *completely disagree* and 7 = *completely agree*; scores vary in strength based on dimension and degree of stigmatizing attitudes. In the current study, the scale was summed for a total Adapted DMISS score and Michalak et al.'s (2014) scoring procedures were followed, by reverse-coding some items (1, 9, 23, and 28) so higher scores across all items and subscales indicate greater levels of stigma toward individuals with mental health conditions. Day et al. (2007) found good internal consistency across the subscales with subscale alphas ranging

from .71 to .90. Varaich's (2019) study on addressing mental health stigma in nursing education found good internal consistency for the DMISS with initial and follow-up test alphas being $\alpha = .84$ and $\alpha = .87$, respectively. DeFreitas et al.'s (2018) research on mental health stigma in Latinx and African American college students found adequate reliability across the subscales (.66 to .94; reliability scores for the treatability subscale were lower in African American participants (.66) versus Latinx participants (.73). In the current study, internal consistency for the DMISS total score was very good ($\alpha = .89$). See Appendix D for the internal consistency scores for the DMISS total score and other questionnaire total scores across race and ethnicity.

Modified Illinois Rape Myth Acceptance Scale. The Modified Illinois Rape Myth Acceptance Scale (Modified IRMA; McMahon & Farmer, 2011) is a revision of Payne et al.'s (1999) scale and includes updated language to be relevant to high school and college students and to capture more covert rape myths, given that some more overt rape myths have become less socially acceptable (McMahon & Farmer, 2011). The Modified IRMA contains 22 items and four subscales: *She Asked for It, He Didn't Mean To, It Wasn't Really Rape,* and *She Lied*. These subscales measure how modern sexism and victim blaming influence attitudes and beliefs on sexual assault with item content focusing on women victims.

The *She Asked for It* subscale, consists of six items focused on attitudes blaming the victim's behavior for the sexual assault (e.g., "If a girl goes to a room alone with a guy at a party, it is her own fault if she is raped"). The second subscale, *He Didn't Mean To*, comprises six items reflecting beliefs that lower perpetrator accountability by implying the perpetrator did not intend to sexually assault the victim (e.g., "Guys don't usually intend to force sex on a girl, but sometimes they get too sexually carried away"). The *It Wasn't Really Rape* subscale has five items identifying attitudes denying the assault occurred and reflecting stereotypes surrounding sexual assault (e.g., "If a girl doesn't physically resist sex—even if protesting verbally—it can't be considered rape"). Lastly, the *She Lied* subscale consists of five items questioning the believability and credibility of the victim (e.g., "A lot of times, girls who claim they were raped just have emotional problems"). The Modified IRMA uses a 5-point Likert scale, where 1 = *strongly agree* and 5 = *strongly disagree*; scores were totaled for a

total Modified IRMA score. With standard scoring, higher scores indicate greater rejection of rape myths; however, scoring was reversed for the current study (with higher scores indicating greater acceptance of rape myths) to make results more interpretable.

McMahon and Farmer (2011) reported good internal consistency (α = .87) for the Modified IRMA, though subscale alphas ranged from .64 to .80. Huck and James (2022) also found excellent internal consistency (α = .92) for the total score and more variable alphas across the subscales. The Modified IRMA total score displayed excellent internal consistency (α = .93) in the current sample, and like in other studies, the subscale internal consistencies were somewhat more variable: *She Asked for It* (α = .86), *He Didn't Mean To* (α = .74), *It Wasn't Really Rape* (α = .83), and *She Lied* (α = .91). For the current study, only the total score was used. In addition, a dichotomous score was created by splitting the total score at the 50th percentile for the current sample. IRMA total scores below 36 were classified as low, and scores at or above 36 were classified as high.

Duke Religion Index. The Duke Religion Index (DUREL; Koenig & Büssing, 2010) is a five-item questionnaire measuring religious involvement by assessing three dimensions of religiosity: *Organizational Religious Activity*, *Non-organizational Religious Activity*, and *Intrinsic Religiosity (or subjective religiosity)*. These dimensions help distinguish between formal versus private religious involvement and religious sentiments and activity (Toscanelli et al., 2022). The *Organizational Religious Activity (ORA)* dimension consists of one item assessing attendance for church or other religious meetings and the *Non-organizational Religious Activity (NORA)* dimension consists of one item measuring time spent engaging in private religious activities (e.g., prayer, meditation). The *ORA* dimension uses a 6-point Likert scale (1 *Never*; 2 *Once a year or less*; 3 *A few times a year*; 4 *A few times a month*; 5 *Once a week*; 6 *More than once/week*). The *NORA* dimension uses a 6-point Likert scale (1 *Rarely or never*; 2 *A few times a month*; 3 *Once a week*; 4 *Two or more times/week*; 5 *Daily*; 6 *More than once a day*). The *Intrinsic Religiosity (IR)* dimension consists of three statements focused on religious beliefs and experiences. Participants rate the extent to which each statement is true or not true using a 5-point Likert Scale (1 *Definitely not true*; 2 *Tends not to be true*; 3 *Unsure*; 4 *Tends to be true*; 5 *Definitely true of me*).

The overall score range for the DUREL is five to 27 and for this study the scale was summed for a total DUREL score. Higher scores indicated greater religious involvement.

Koenig and Büssing (2010) reported high test-retest reliability (intra-class correlation = 0.91), internal consistency (Cronbach's alphas = 0.78-0.91), and convergent validity with other measures of religiosity (r = 0.71-0.86), for the DUREL. Moreover, other studies using this measure reported good internal consistency, with α ranging from.78 to .91, and the DUREL has been translated into different languages and validated in numerous studies (Plante et al, 2002; Storch et al., 2004; Thomas et al., 2018; Toscanelli et al., 2022). In the current sample, internal consistency for the DUREL total score was very good (α = .89).

Demographics Form. Participants provided basic demographic information such as age, gender, race and ethnicity, religious affiliation, major, sexual assault history, mental health history, and rurality (see Appendix C). The current study only examined gender, race and ethnicity, sexual assault history, mental health history, and childhood rurality. Rurality was measured in terms of both current area of residence (current rurality) and the area in which they were raised (childhood rurality). Participants were asked to classify both current and childhood as rural (less than 10,000 people), suburban (greater than 10,000 people but less than 50,000 people), or urban (greater than 50,000 people); however, it was unclear whether they based their responses about their current residence on their permanent residence or local housing on or near the university's rural or urban campuses. Thus, study analyses focused on childhood rurality. In addition, suburban and urban participants were collapsed into one group (non-rural), yielding a binary childhood rurality variable (rural vs. non-rural).

Data Quality Checks. To ensure high-quality data, data quality checks were included in the study. Insufficient effort was assessed using three strategies: manipulation checks, attention checks, and self-reported seriousness during the study. After reading the vignette and completing the vignette evaluation questions, participants answered five questions about what they recalled from the vignette. There were two manipulation checks and three reading checks. These five items were specific to the vignette and intended to identify participants who did not read the vignette closely. Participants

completed two attention check items (e.g., “It is important you pay attention to this study. Please leave this item blank”) embedded within the post-vignette evaluation questions and the Modified IRMA. Lastly, participants were asked if they took the study seriously or just clicked through (see Appendices B and C).

Procedures

Following recruitment, participants used the study link provided on SONA or on the flyer to take them to Qualtrics. They then read the informed consent (see Appendix E) and selected if they would like to consent to this study (options included: “Yes, I read the terms above and consent to participate in this research” or “No, I do not consent to participate in this research”). Participants who declined to participate were directed away from the study and not allowed to continue. If they consented, participants were randomly assigned to read one of the six versions of the vignette. The initial enrolled sample was 689 participants. After low quality data were excluded, 199 participants were retained for analyses of the vignette. See Table 2 for the numbers of retained participants assigned to each study condition.

Table 2
Number of Retained Participants Randomly Assigned to Each Condition

Victim Race	Victim Diagnosis	N
Black	Asthma	33
	Depression	34
	Schizophrenia	46
	Total	113
White	Asthma	23
	Depression	24
	Schizophrenia	39
	Total	86

Note. This table includes only cases retained for vignette analyses (n = 199).

Next, participants completed the CoBRAS, DMISS, Modified IRMA, and DUREL, in random order. Lastly, participants completed the Demographics Form and answered a seriousness check. Following completion of all study measures, participants were debriefed and provided a list of resources (see Appendix E). At that point, participants were also given instructions for how to claim their compensation for completion of the study. Participants recruited through SONA were

compensated with one unit of research credit, and those recruited in class were compensated with extra credit. Individuals recruited through the pre-law advising office or pre-law society did not receive compensation.

The duration estimate provided by Qualtrics was skewed by participants reaching the end of the survey but not clicking 'submit' for several minutes or hours, causing the mean duration to be 3,608.01 seconds (*SD* = 16,133.23; Range: 271.00-184,660.00), or a mean of 60.13 minutes and *SD* of 4.48 hours. To eliminate this skew on the mean study duration, a separate study duration variable was created by summing the time participants spent on each page, except for the final debriefing page. This new duration variable resulted in a mean time spent on the whole study of 1,310.83 seconds (*SD* = 744.65; Range: 251.39-6,910.92), or a mean of 21.84 minutes and a *SD* of 1.92 hours.

Data Integrity

To be included in vignette analyses, participants had to pass the attention check item embedded within the vignette evaluation questions and both manipulation checks. They also had to pass one of the reading check items about the victim's gender, but everyone who passed the manipulation checks also passed that reading check. Participants also had to pass the seriousness item at the end of the study. The data from participants who failed one or more of these criteria were excluded from vignette analyses. These criteria led to the removal of 490 of the original sample of 689 participants.

Because the vignette was a static image, participants who may have completed the study on a small screen (e.g., smart phone) might have had to rotate their device or manually zoom in to read it. This might have contributed to low engagement with the vignette. In addition, the image of the victim (race manipulation) was at the top of the article, and the text describing the victim's recent hospitalization (diagnosis manipulation) was at the bottom of the page, which could have led to more participants missing the diagnosis manipulation check (n = 274) than the race manipulation check (n = 239).

There was a significant difference in time spent on the vignette between participants who were included in vignette analyses and those who were excluded (see Table 3). Participants who were included in the vignette analyses spent significantly more time reading the vignette than those who

were excluded, but there was not a significant difference in the time they spent on the post-vignette evaluation questions or manipulation and reading check questions. There was also a significant difference in total duration in that participants included in the vignette analyses spent significantly more time on the study overall.

Table 3
Time Spent on Vignette by Participants Included and Excluded in Vignette Analyses

	Included		Excluded				
Source	M	*SD*	M	*SD*	*df*	*t*	*p*
Vignette Page Duration	169.77	224.41	113.67	166.57	650	3.54	<.001
Vignette Section Duration	363.23	255.67	325.36	344.37	617	1.53	.17
Total Study Duration	1310.83	744.65	1024.12	1027.45	687	3.57	<.001

Note. Duration measured in seconds

Because the vignette might have been a unique obstacle to participant attention and motivation, I decided that participants who otherwise demonstrated reasonable effort on the questionnaire portion of the study could still be included in analyses of questionnaire data. To be included in the questionnaire analyses, participants had to pass the attention check item embedded within the Modified IRMA and the seriousness item at the end of the study.

For the questionnaire analysis, I again compared time duration differences between participants who were included and excluded. There were significant differences in duration for participants who were included and excluded, with participants who were included spending more time on the questionnaires and the study overall compared to participants who were excluded. See Table 4 for results of the questionnaire time analysis.

Table 4
Time Spent on Questionnaires by Participants Included and Excluded in Questionnaire Analyses

	Included		Excluded				
Source	*M*	*SD*	*M*	*SD*	*df*	*t*	*p*
Questionnaire Section Duration	784.88	797.97	345.87	304.73	601	3.35	<.001
Total Study Duration	1,272.82	931.25	479.09	811.27	687	9.33	<.001

Note. Duration measured in seconds

CHAPTER 3

RESULTS

Primary Analyses

Hypotheses 1-3

To test the first three study hypotheses, I conducted a 2 (Race: Black and White) x 3 (Mental Health History: No Diagnosis, Depression, and Schizophrenia) between-subjects analysis of variance (ANOVA). The dependent variable was participant ratings of victim credibility (i.e., "Based on the article, how would you rate the credibility of the woman's testimony"). It was expected that participants would report lower perceptions of credibility for the Black woman compared to White woman and lower perceptions of credibility for the woman with a mental health diagnosis (especially schizophrenia) compared to the woman with asthma (no diagnosis/control). Further, an interaction between victim race and diagnosis was expected, such that perceptions of the White victim's credibility would have a steadier decline from no diagnosis to depression to schizophrenia compared to perceptions of the Black victim's credibility, which would have a steeper decline across mental health diagnoses. See Table 5 for the results of the ANOVA. (See Appendix F for supplemental figures of nonsignificant findings.)

Table 5
Results of Between-Subjects ANOVA of Victim Credibility Based on Two Vignette Conditions

Source	*df*	Mean Square	*F*	*p*	Partial η^2	Observed Power
Intercept	1	5008.22	3119.15	<.001	.94	1.00
Victim Race	1	.86	.53	.46	.003	.11
Victim Diagnosis	2	1.45	.90	.40	.01	.21
Victim Race x Victim Diagnosis	2	.48	.29	.74	.003	.10
Error	193	1.61				

Note. Table includes only cases retained for vignette analyses (n = 199).

Based on an a priori power analysis conducted in G*Power (Faul et al., 2007), a minimum of 251 participants were needed for power (95%) to find a medium effect size (a *partial* η^2 of about .06); however, despite recruiting 689 participants, only 199 could be retained for this analysis. Effects sizes

were very small and might not have been meaningful, but observed power suggests that this analysis is not appropriately powered to make strong conclusions.

There was not a significant main effect for victim race; ratings of victim credibility did not differ significantly by victim race in the vignette. There was not a significant main effect of victim diagnosis. There was also not a significant interaction between victim race and diagnosis. The first three hypotheses were not supported but, as noted, could not be adequately tested with the current sample.

Hypothesis 4

A 2 (Race: Black and White) x 3 (Mental Health History: No Diagnosis, Depression, and Schizophrenia) x 2 (Modified IRMA: Low, High) ANOVA was used for hypothesis 4 (expecting that participants who report high RMA would perceive the victim as less credible across all conditions but would rate victim credibility especially low for the Black woman). Participants were grouped based on IRMA score, with 96 participants in the low IRMA group and 99 in the high IRMA group. The dependent variable was participant ratings of victim credibility. The results showed no significant main effects of victim race or diagnosis and no significant interaction between the two; however, consistent with the fourth hypothesis, participants with high IRMA scores rated the victim as less credible than participants with low IRMA scores. No other variables were significant. See Table 6 and Figure 1. (See Appendix F for supplemental figures of nonsignificant findings.)

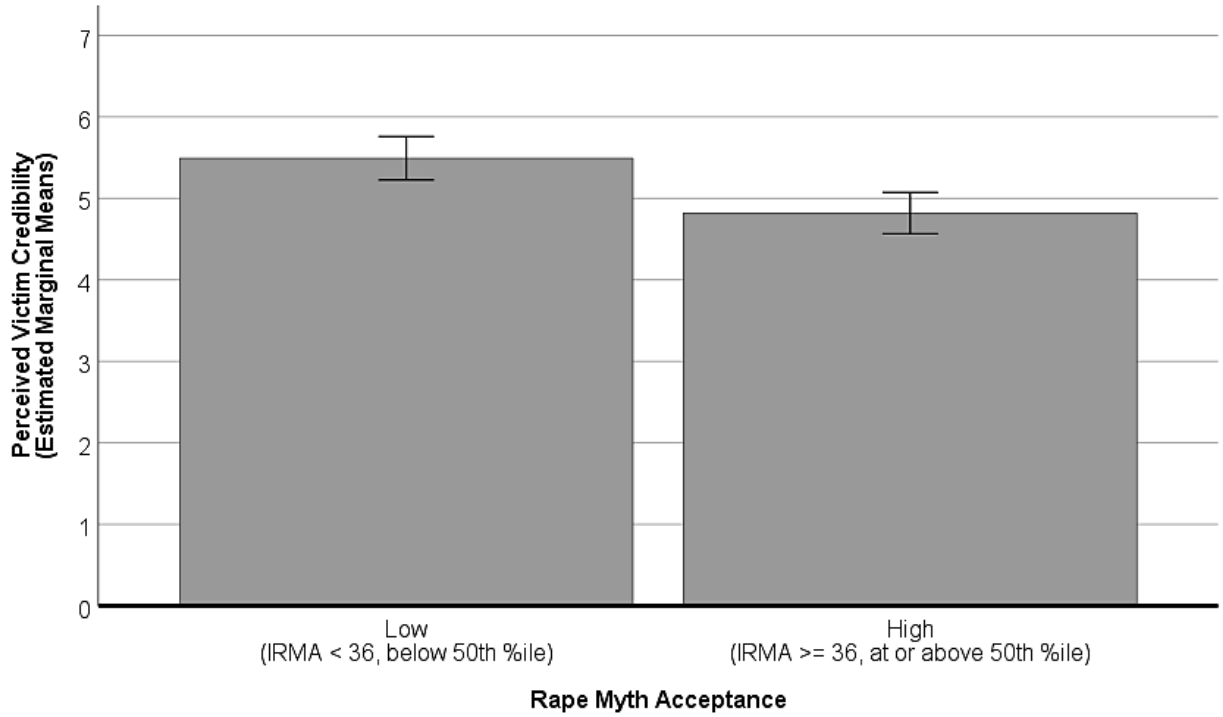
Table 6
Main Effect of High IRMA Scores on Perceived Victim Credibility

Source	*df*	Mean Square	*F*	*p*	*Partial* η^2	Observed Power
Intercept	1	4784.46	3153.66	<.001	.95	1.00
Victim Race	1	.82	.54	.46	.003	.11
Victim Diagnosis	2	1.91	1.26	.29	.01	.27
IRMA Low-High	**1**	**20.38**	**13.43**	**<.001**	.07	**.95**
Victim Race x Victim Diagnosis	2	.39	.26	.77	.003	.09
Victim Race x IRMA Low-High	1	.05	.03	.86	<.001	.05
Victim Diagnosis x IRMA Low-High	2	.59	.39	.68	.004	.11
Victim Race x Victim Diagnosis x IRMA Low-High	2	2.74	1.80	.17	.02	.37

Error	183	152	

Note. Table includes only cases retained for both the vignette and questionnaire analyses (n = 195).

Figure 1
Main Effect of Rape Myth Acceptance on Perceived Victim Credibility



Note. Errors bars reflect standard errors of the means. Figure includes only cases retained for both the vignette and questionnaire analyses (n = 195).

Based on an a priori power analysis, a minimum of 251 participants were needed to have enough power (95%) to find a medium effect size. I was able to find a significant medium-sized effect of IRMA scores with 95% observed power. Nevertheless, other small effects may have been underpowered, and those null results should be interpreted with caution.

Exploratory Questions

Rurality

To explore potential differences between rural and non-rural participants on rape myth acceptance, racist attitudes, ableist attitudes, and religiousness, I conducted independent *t* tests comparing groups on these scores. See Table 7 and Figure 2 for the results of the analyses. There was a no significant difference in racist attitude scores for rural and non-rural participants. Similarly, rural and non-rural

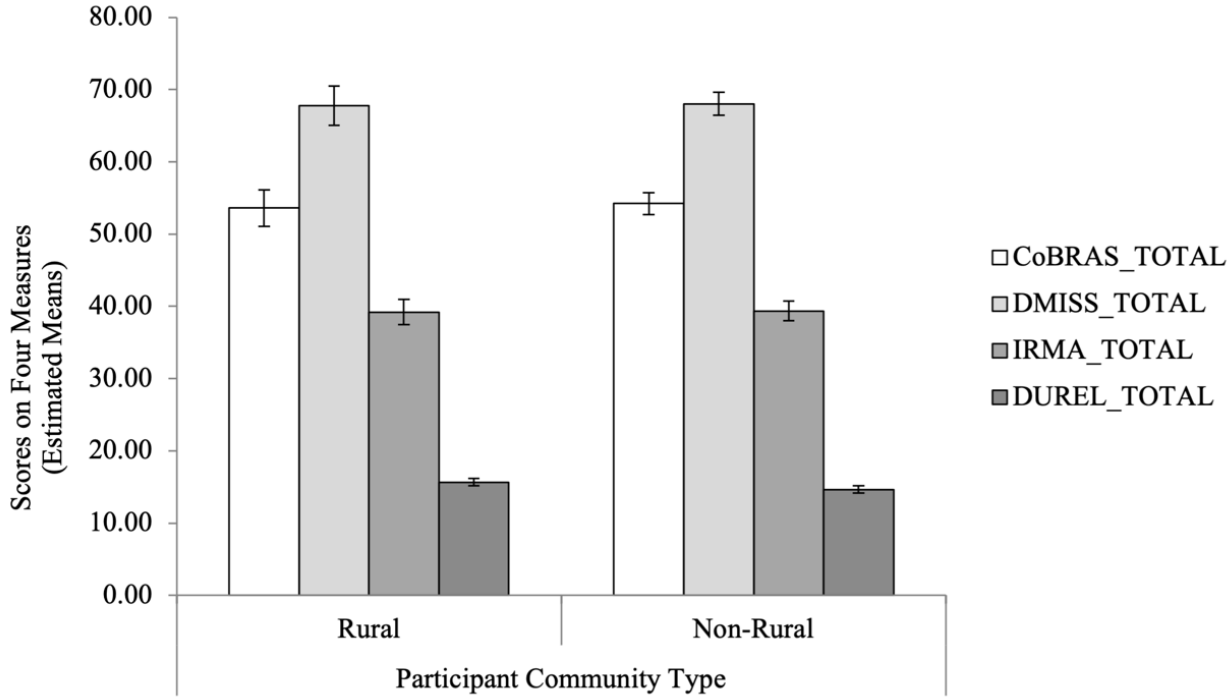
participants reported indistinguishable ableist attitudes. Further, there was a not a significant difference in rape myth acceptance scores for rural and non-rural participants. These results suggest that participants' level of color-blind racial attitudes, rape myth acceptance, ableist attitudes, and religiousness did not vary by the community type (rural vs. non-rural) they grew up in.

Table 7
Differences between Rural and Non-Rural Participants on Questionnaire Scores

	Rural		Non-Rural				
Source	*M*	*SD*	*M*	*SD*	*df*	*t*	*p*
CoBRAS Total Score	54.23	19.67	53.36	17.64	522	.51	.61
DMISS Total Score	69.02	22.15	68.77	20.31	512	.13	.90
IRMA Total Score	37.85	12.83	38.38	13.53	528	.43	.67
DUREL Total Score	15.81	6.22	14.94	6.50	535	1.47	.14

Note. Table includes only cases retained for questionnaire analyses ($N = 545$).

Figure 2
Differences between Rural and Non-Rural Participants on Questionnaire Scores



Note. Errors bars reflect standard errors of the means. Figure includes only cases retained for questionnaire analyses ($N = 545$).

Religiousness

To explore potential relationships among participant religiousness and rape myth acceptance, racist attitudes, and ableist attitudes, I conducted Pearson correlations among these study variables. Table 8 highlights the inter-relationships. Rape myth acceptance and religiousness were positively correlated. Racist attitudes and religiousness were also positively correlated, but ableist attitudes were not correlated with religiousness. Though not the focus of this analysis, it is also important to note that racist attitudes and ableist attitudes, racist attitudes and rape myth acceptance, and ableist attitudes and rape myth acceptance were also all significantly correlated in the positive direction.

Table 8
Pearson Correlations among Questionnaire Scores

Variables	1	2	3	4
1. CoBRAS Total Score	-	.27**	.46**	.16*
2. DMISS Total Score	.27**	-	.32**	.001
3. IRMA Total Score	.46**	.32**	-	.17*
4. DUREL Total Score	.16*	.001	.17*	-

Note. Table includes only cases retained for questionnaire analyses (n = 545).
* Correlation is significant at the 0.05 level (2-tailed)
**correlation is significant at the 0.1 level (2-tailed)

Race

To explore whether participant race may be related to differences in their ratings of the victim's perceived credibility, I re-ran the original 2 (Race: Black and White) x 3 (Mental Health History: Asthma/Control, Depression, and Schizophrenia) between-subjects ANOVA but added the binary participant race variable (Black, ethnicities and White, all ethnicities) as an additional independent variable. See Table 9 for the results of the ANOVA.

Table 9
Results of Between-Subjects ANOVA of Victim Credibility Adding Participant Race

Source	*df*	Mean Square	*F*	*p*	*Partial* η^2	Observed Power
Intercept	1	3044.86	1990.47	<.001	.92	1.00
Victim Race	1	.50	.32	.56	.002	.09
Victim Diagnosis	2	1.59	1.04	.35	.01	.23
Participant Race	1	2.09	1.36	.24	.01	.21
Victim Race x Victim Diagnosis	2	1.10	.71	.48	.01	.17
Victim Race x Participant Race	1	1.14	.75	.38	.004	.14
Victim Diagnosis x Participant Race	2	1.93	1.26	.28	.02	.27
Victim Race x Victim Diagnosis x Participant Race	2	2.68	1.75	.17	.02	.36
Error	168	1.53				

Note. Table includes only cases retained for both the vignette and questionnaire analyses and for whom binary race data were available (n = 180).

There was no significant main effect of victim race; ratings of victim credibility did not differ significantly based upon victim race within the vignette. There was also no significant main effect of victim diagnosis, indicating ratings of victim credibility did not differ by victim diagnosis. Additionally, there was no significant main effect of participant race. There were no significant interactions with participant race. There was no significant interaction between victim diagnosis and participant race. Lastly, the three-way interaction of victim race, victim diagnosis, and participant race was tested. There were no significant effects. See Appendix F for supplemental figures for nonsignificant findings.

I also compared Black and White participants on IRMA scores. Black (n = 145, M = 36.50, SD = 11.74) and White (n = 336, M = 38.54, SD = 13.39) participants did not significantly differ on their level of rape myth acceptance, $t(308.98) = 1.68$, $p = .10$, $d = .16$.

Gender

To explore whether participant gender is related to differences in perceived credibility across study conditions, I re-ran the original 2 (Race: Black and White) x 3 (Mental Health History: No Diagnosis, Depression, and Schizophrenia) between-subjects ANOVA but added participant gender (Men, Women, and Gender Queer or Nonbinary Persons) as an additional variable. See Table 10.

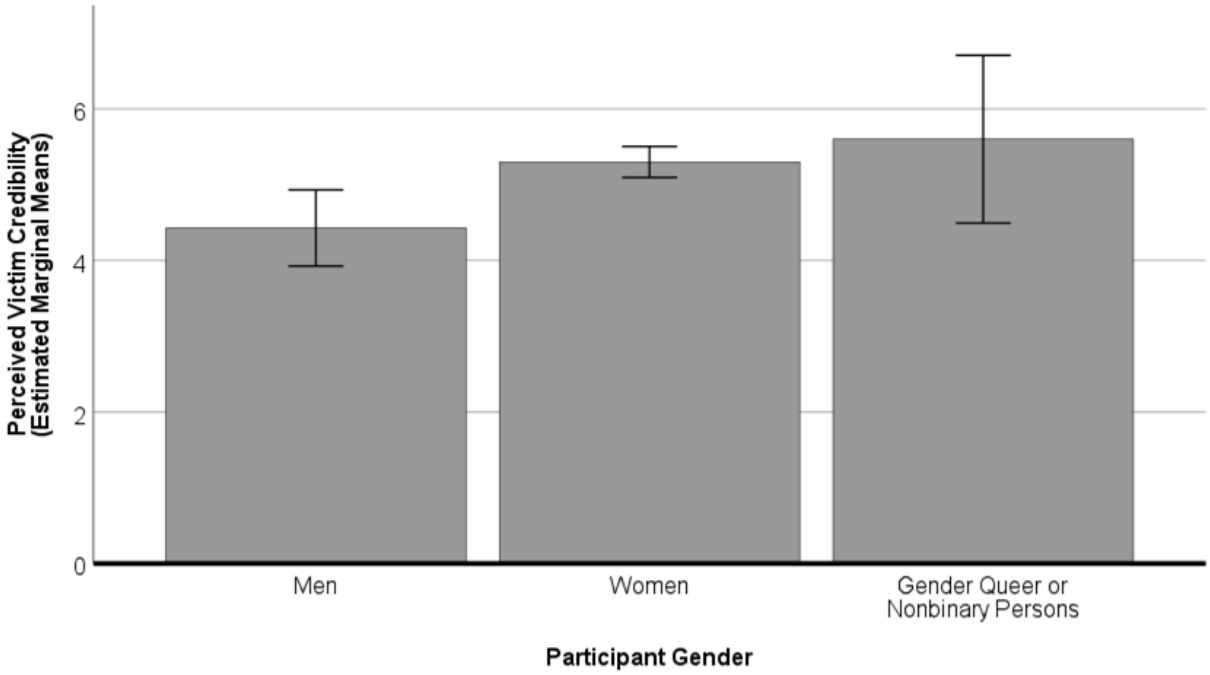
Table 10
Results of Between-Subjects ANOVA of Victim Credibility Adding Participant Gender

Source	*df*	Mean Square	*F*	*p*	*Partial* η^2	Observed Power
Intercept	1	932.42	608.98	<.001	.77	1.00
Victim Race	1	1.01	.66	.41	.004	.13
Victim Diagnosis	2	2.17	1.41	.24	.01	.30
Participant Gender	**2**	**8.84**	**5.77**	**.00**	**.06**	**.86**
Victim Race x Victim Diagnosis	2	.48	.31	.72	.004	.10
Victim Race x Participant Gender	2	1.56	1.02	.36	.01	.23
Victim Diagnosis x Participant Gender	4	1.36	.89	.047	.02	.28
Victim Race x Victim Diagnosis x Participant Gender	3	2.13	1.39	.24	.02	.37
Error	174	1.53				

Note. Table includes only cases retained for both the vignette and questionnaire analyses and for whom gender data were available (n = 180).

There was no significant main effect of victim race; ratings of victim credibility did not differ based upon victim race within the vignette. There was also no significant main effect of victim diagnosis, indicating ratings of victim credibility did not differ by victim diagnosis. However, there was a significant main effect of participant gender. Participants who identified as men rated the victim significantly lower in terms of credibility compared to participants who identified as women. See Figure 3. Gender queer and nonbinary participants' ratings showed more variability (wider error bars) than the others possible due partly to smaller sample size.

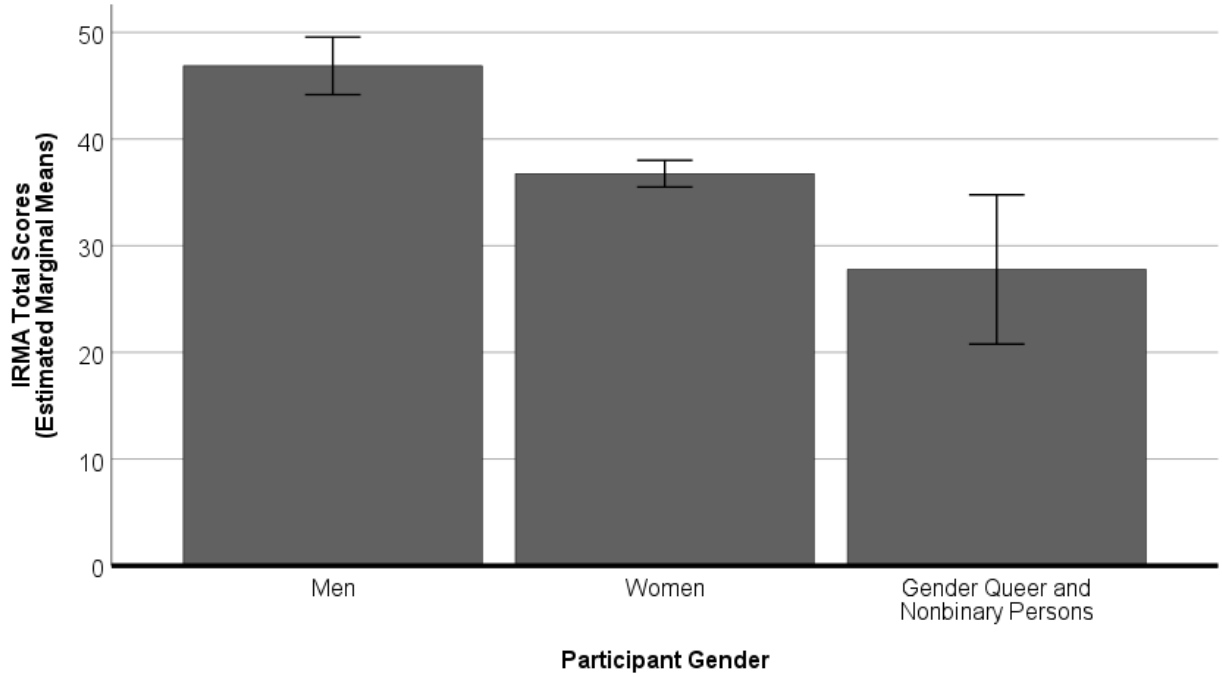
Figure 3
Main Effect of Participant Gender on Perceived Victim Credibility



Note. Errors bars reflect standard errors of the means. Figure includes only cases retained for both the vignette and questionnaire analyses and for whom gender data were available (n = 180).

I also compared IRMA total scores across participant gender and found significant differences, $F(2, 502)$, = 27.63, $p < .001$, *partial* $\eta^2 = .10$. Specifically, men reported the highest level of rape myth acceptance and were significantly higher than women who were significantly higher than gender queer/nonbinary participants (see Figure 4).

Figure 4
IRMA Total Scores across Participant Gender



Note. Errors bars reflect standard errors of the means. Figure includes only cases retained for the questionnaire analyses and for whom gender data were available (n = 505).

CHAPTER 4

DISCUSSION

While the #MeToo Movement has shifted societal understanding and awareness of sexual violence (Acquaviva et al., 2021; Jaffe et al., 2021), sexual assault is still prevalent and barriers to receiving legal and social support remain (Miller, 2017; Russell & Bolen, 2000; Sigurdsson, 2018; Stipek, 2021). For individuals from marginalized and underserved communities, these barriers can be amplified by differences in the stories widely shared and publicized in the media, cultural expectations (e.g., stigma surrounding disclosing victimization, cultural standard of being strong and self-reliant) and systemic disparities, such as societal and internalized stigma about disability and sex and the epistemic advantage of Whiteness (Iudici et al., 2019; Long & Ullman, 2013; Muñiz, 2023; Slatton, 2018).

Considering the psychological and physical impacts of sexual violence and that many sexual assaults go unreported to the police, it is important to explore factors influencing perceptions of victim credibility, especially for survivors with intersecting identities. The current study sought to examine the impact of victim race and mental health history on college students' ratings of victim credibility. Further, the study aimed to investigate the roles of participant rape myth acceptance (RMA), race, and gender in perceptions of victims; rural-non-rural differences in RMA, color-blind racial attitudes, mental illness stigma, and religiousness; and relationships among RMA, color-blind racial attitudes, mental illness stigma, and religiousness.

Summary of Findings

Victim Race

I hypothesized that participants would report lower levels of perceived credibility for the Black victim than the White victim. Analyses examining the main effect of victim race status found no significant effect. Although the findings in the current study were not significant, previous research demonstrated racial disparities in reporting and perceptions of credibility for Black woman (Brown, 2012; Carlin, 2016; Duhaney, 2022; Johnson, 1996; Slatton & Richard, 2020). In Shaw and Lee's (2019) systemic review on how race influences the criminal justice systems response to sexual assault, they

found that Black women were more likely to be deemed as uncooperative by police and less likely to have their case referred to prosecution or have charges filed by the prosecution. Further, economic disparities, neighborhood context (e.g., "street codes," high rates of crime, social and protective mechanisms among community members), and negative relationships with the police are all significant barriers to reporting and disclosing sexual assault for Black women (Bucerius, & Tonry, 2014; Collins, 2000; Gómez & Gobin, 2020; Jacques-Tiura et al., 2010; Ullman & Lopez, 2021).

Despite the current study's findings being inconsistent with past research, there are various influencing variables. First, a priori power analyses suggested 251 participants were needed to obtain statistical power; this sample size was not met due to having to remove 490 (71.1%) respondents who failed to demonstrate sufficient effort during the vignette portion of the study. Inadequate participant sample sizes in the vignette conditions may have impacted the findings due to underpowered analyses. Secondly, past research largely focused on racial dyads based on victim and offender race (i.e., White vs. White, White vs. Black, Black vs. Black, Black vs. White; Shaw & Lee, 2019; Stacy et al., 2017). Therefore, providing the race of the perpetrator may have changed the study's results. However, the perpetrator's race may have also detracted from the focus on how race influences perceptions between victims because suspect race may influence results more than victim race (Shaw & Lee, 2019; Stacy et al., 2017).

Victim Mental Health

The hypothesis that victims with a mental health condition (i.e., depression or schizophrenia) versus the control would receive lower ratings of perceived credibility was not supported by study analyses. Again, large numbers of excluded cases due to insufficient effort may have contributed to a broadly underpowered analysis.

I also hypothesized that there would be an interaction between race and mental illness status; within the mental illness condition, perceptions of the White victim's credibility would show a steadier decline from asthma (no diagnosis/control) to depression to schizophrenia versus the Black victim who

would show a steeper drop off from depression to schizophrenia such that a Black woman with schizophrenia would be seen as the least credible. I did not find support for the interaction.

Because the impact of race when combined with disability, particularly mental health status, has not been explored in sexual assault literature, the investigation of the interaction is new. Past research on the influence of victim mental health history on law enforcement, legal officials, and jurors' decision making is very limited due to mental health literature largely focusing on issues of stigma and negative public perceptions about mental health diagnoses (Jordan, 2004; Kelley et al., 2019; Levi, 2022; Maras et al., 2019). In spite of these limitations, a few studies found that courtroom perceptions about mental health conditions depend on type of diagnosis with mental illnesses deemed more severe (e.g., schizophrenia, antisocial personality disorder) contributing to more negative perceptions about credibility, reliability, and/or guilt compared to other mental health diagnoses (e.g., depression, anxiety) or no diagnosis (Angermeyer & Matschinger, 2003; Levi, 2022; Pescosolido, 2013). These past studies and the current study's findings point to the idea that intersecting identities should be considered when developing studies of or treatment interventions for survivors of sexual assault.

Although the current study could not answer some of the questions called for by the literature, the study itself is among the first to attempt to directly study the intersection of racism and mental illness stigma in a sexual assault victim credibility context. Moreover, study methods may be instructive for other researchers designing similar studies (e.g., barriers to participant engagement).

Rape Myth Acceptance

I hypothesized that participants reporting higher levels of RMA would perceive the victim as less credible across all conditions. This hypothesis was supported. Participants with higher RMA rated the victim as less credible than participants with lower RMA did. This finding aligns with previous research demonstrating the influence of RMA in shaping attitudes and beliefs about sexual violence (Hammond et al., 2011; Hayes et al., 2013; Hine & Murphy, 2019; Russell & Hand, 2017). Particularly, numerous studies show that high RMA contributes to higher victim blaming and decreased ratings of perpetrator responsibility (Hayes et al., 2013; Hine & Murphy, 2019; Russell & Hand, 2017; Sleath & Bull, 2012;

Suarez & Gadalla, 2010). In Hine and Murphy's (2019) study evaluating the influence of RMA on police officers' perceptions of sexual assault victims, officers with higher RMA rated victims as more responsible for their victimization and viewed their case as less authentic than officers with lower RMA. Considering the limitations of this study, future research should continue to explore the hermeneutical injustices formed from rape myths for individuals from marginalized and underserved communities. Utilizing an intersectional lens when investigating the impact of RMA can enhance researchers' ability to understand how high RMA can shift case outcomes for individuals with intersecting identities.

Rurality

To test for possible RMA differences by participant rurality, RMA scores were compared between participants raised in rural areas and those who grew up in suburban or urban areas. There were no statistical differences between rural and non-rural participants on RMA. The study also explored differences in racist attitudes, and ableist attitudes between rural and non-rural participants. There were no statistical differences. Research on the lived experiences of individuals in rural communities is limited; however, the finding that RMA is similar in rural and non-rural areas aligns with previous studies (Kennon, 2023; King & Roberts, 2011). This finding emphasizes the need for researchers to recognize that rape myths transcend community type as they are based on a societal tendency to deny and justify sexual aggression.

Rural and non-rural individuals also reported similar levels of religiousness. This finding may be shaped by the demographics of the sample because the participants were all college students attending a university in southeast Georgia. Religion in the southern United States (both Southeast and Southwest states) is influential in shaping culture and organizational involvement (Furman et al., 2004; Harvey, 2015; Vincent et al., 2006). In a survey distributed by a Gallup Poll in 2017, 43% of individuals living in the Southeast and 43% of Georgians indicated that religion was very important to them and that they attend organized religious services either weekly or almost weekly (Norman, 2018). Grammich's (2023) examination of United States religion census data found that Georgia was in the top ten highest states

with the most religious adherents from 2010 to 2020. Living in the South may be more important for predicting religiousness than rurality.

In terms of differences in racist and ableist attitudes, rural and non-rural college students had similar rates. Because these topic areas are notably understudied within rurality, current results add valuable benefit to the topic of differences in social attitudes in rural versus non-rural areas. Previous literature has pushed back against the stereotype that rural areas are non-diverse communities as it dismisses the experiences of rural residents from marginalized identities and does not recognize the historical contexts of racism and lack of disability support in rural communities (Blankley & Votruba, 2023; Grundy & Prusaczyk, 2022; Iezzoni et al., 2006; Kozhimannil & Henning-Smith, 2018). These contexts are also present in non-rural areas but have specifically been showed to contribute to health and social inequities in rural communities (Grundy & Prusaczyk, 2022; Iezzoni et al., 2006; Kozhimannil & Henning-Smith, 2018). Since the study's participants were college students whose residence was based on childhood community type, researchers should consider using a sample where rurality is based on current residence to demonstrate if differences exist between rural and non-rural residents.

Religiousness

Exploratory Pearson correlations were conducted to examine potential relationships among religiousness and RMA, racist attitudes, and ableist attitudes. There was a positive association between RMA and religiousness. The association between religiousness and RMA is not surprising as previous research noted that religion is connected to rape myths by reinforcing unhelpful systems of thought (e.g., Just World Belief, traditional gender roles) contributing to victim blaming (Barnett et al., 2018; Bryant, 2006; Heath & Sperry, 2021). Additionally, there was a positive relationship between religiousness and racist attitudes. This finding is consistent with previous research findings that higher levels of religiousness are associated with more prejudice toward immigrants and refugees and less opposition to racial segregation (Brown, 2011; Deslandes et al., 2019). There was not an association between ableist attitudes and religiousness.

The association between RMA and racist and ableist attitudes was not surprising. In Suarez and Gadalla's (2010) metanalysis of 37 studies on RMA, they demonstrate a robust connection between RMA and prejudicial and discriminatory ideologies, such as racism.

Participant Race

To explore possible differences in victim credibility based on participant race, victim credibility scores between Black and White participants were compared. Black participants reported slightly higher levels of credibility for the Black victim than White participants, but ratings were not significantly different. The generally comparable ratings across victim race and participant race are potentially heartening and highlight the importance of considering the effect of victim race and participant race on case outcomes. Studies have demonstrated negative case outcomes (i.e., increased ratings of guilt, higher sentencing) when victim race differed from juror race due to victim-based racial biases (Bottoms et al., 2004; Deming et al., 2013; Hymes et al., 1993; Sommers, 2007). But, the overall research on racial bias is mixed as it is based on analyses of the interplay of defendant, plaintiff, and/or juror characteristics, primarily gender (Maeder & Yamamo, 2019; Shaw & Lee, 2019; Spohn & Spears, 1996; Wuensch et al., 2002).

Participant Gender

Based on previous studies, I compared whether RMA and victim credibility assessments differ by participant gender. Past research shows men are more accepting of rape myths than women (Buddie & Miller, 2001; Russell & Hand, 2017), and the results of the current study were consistent with these findings. There was a gendered difference for RMA as participants who identified as men were more likely than women and non-binary and gender queer individuals to endorse rape myths. Furthermore, participants who identified as men rated the victim's credibility significantly lower than participants who identified as women and non-binary and gender queer people.

Clinical Implications

From a clinical perspective, this study provides important insights which can help guide treatment interventions and outreach initiatives. Given the pervasive nature of sexual violence, especially on college

campuses, behavioral health providers may benefit from further exploring trauma-informed and strength-based practices for addressing sexual violence from an individual and community perspective. It is important for providers to recognize and challenge assumptions and stereotypes they may have about "ideal" victims, "real" rape, and identity-based rape myths (e.g., Black women are hypersexual, individuals with disabilities are eternally children). Challenging these assumptions may enhance providers' ability to provide victim-centered care and awareness of the factors influencing negative stigma and blame surrounding sexual assault.

Moreover, the study found a relationship between rape myth acceptance, denial of racial privilege and discrimination, and mental illness stigma. These factors were all positively correlated, despite there being limited findings with the vignette, which suggest that understanding perceptions and doubts about sexual assault may require consideration of other kinds of biases. Negative stereotypes and cultural attitudes (e.g., sexism, homophobia, racism, ageism) can be interrelated as the fit into larger cognitive styles which emphasize intolerance towards non-group members, social dominance theory, and just world beliefs (Aosved & Long, 2006). Therefore, for survivors with diverse identities, this study suggests a need for education on an individual and public level that sexual violence is not a women's issue but a public health concern affecting people of *all* genders, racial and ethnic backgrounds, religions, and community types.

In addition, this education should focus on discussing the impact of neighborhood and cultural context on limiting survivors' ability to recognize behaviors that fall under the umbrella of sexual assault and disclose these experiences to both formal (e.g., legal, mental health provider) and informal (e.g., friends, family members, educators) systems. When considering individuals within the Black community, providing validation and resources for coping with police brutality and negative relationships with the police can increase victim's comfort with sharing their experiences and reduce barriers to cooperating in a legal investigation (Long & Ullman, 2013). Moreover, Black girls and individuals with disabilities may especially benefit from educational programs and outreach initiatives focused on raising awareness about consent, body autonomy, emotional difficulties following assault, and support resources due to the

increased vulnerability of these populations. Some of the support resources providers should consider are referrals to a rape crisis or child advocacy center, culturally affirming victim advocates, group therapy, and/or community healing circles. Self-compassion, emotion regulation, and resource allocation (e.g., Victim Inventory of Goals, Options, and Risks) centered psychoeducation and interventions can hopefully translate to minimizing self-blame, emotional deficits, and barriers to healing for survivors from all backgrounds (Frazier et al., 2005; Starzynski et al., 2017).

Police officers and lawyers should focus on creating an environment where survivors are able to report their victimization. For example, legal professionals may benefit from organizational policies emphasizing the use of interviewing strategies that do not judge or blame the victim for the assault or subtly or blatantly reinforce negative stereotypes or assumptions (Department of Justice, 2022). Further, these individuals may benefit from enhancing victim support resources throughout the process by including victim advocates during questioning, ensuring there are transportation and disability support services (e.g., using diagrams, visual aids, gestures, qualified oral or sign language interpreters, assistive listening systems or devices, mental health professionals; Vera Institute of Justice, 2020; Department of Justice, 2022). Mental health providers can help increase legal professionals' ability to provide effective investigations and court proceedings through offering trainings on the impact of trauma on psychological functioning, trauma-informed investigation strategies, and interventions for navigating criminal proceedings with individuals experiencing severe mental health symptoms (e.g., psychosis, mania).

Limitations

There were several limitations in the present study worth noting. The first limitation centers on the creation of the vignettes. The vignettes used a static image requiring participants to drag the image to appropriately read the vignette. Thus, it may have limited participants' engagement with the primary stimuli (victim's race and diagnosis). Future research should consider utilizing a dynamic webpage design to enhance accessibility and participant engagement. Additionally, considerations should be made about the image used for the Black women conditions. In the current study, the image used was of a fairer skin Black woman. As a result, the image may not have made race sufficiently identifiable to some

participants. Further, previous research (Dixon & Telles, 2017; Hunter, 2007; Jablonski, 2021) demonstrated differences in perceptions between darker skinned Black women versus fairer skinned Black women because of colorism. Therefore, replications of this study should consider using an image of a darker skinned Black woman to explore the impact of skin tone on participants' ratings of victim credibility.

Another potential limitation is using data exclusively from a college sample. The current sample was not relatively diverse in terms of gender and race since the sample consisted primarily of White cis-gender women. Thus, the study's sample may not be representative of the general population and results may not generalize to a more representative sample. Moreover, since law enforcement and legal professionals play a crucial role in assessments of victim credibility in sexual assault cases utilizing a sample of individuals from these backgrounds may enhance the study's findings. Taking this into account, researchers should consider replicating this study with law enforcement and legal professionals.

Thirdly, the self-report measures used throughout the study pose a risk for socially desirable responding. It is impossible to determine what, if any, role social desirability played in participants' responses but with the media highlighting instances of sexual assault injustice, it is possible individuals answered in a way reflective of socially acceptable responses. Consequently, follow-up studies should consider including measures of socially desirable response bias (Tan et al., 2021). Additionally, the self-report post-vignette questionnaire was created for the purpose of this study and no pilot study examining its effectiveness prior to the study was completed. In the future, a pilot study should be used to determine effectiveness and validity of the post-vignette questionnaire. Lastly, a potential limitation was the use of a dichotomous IRMA score (high/low). Splitting the sample at the 50^{th} percentile created a difference between participants whose score was 35 versus participants whose score was 36 when there may not be any meaningful differences. To address this limitation, researchers should consider analyzing the IRMA as a continuous score or using alternative cutoffs (e.g., lowest quartile vs. highest quartile).

Future Directions

Future research should consider repeating this study with a dynamic vignette image to gain a better understanding of how victim race and mental health history influence assessments of credibility. Given the lack of diversity in vignette conditions, researchers should also consider changing the variables used in this study by diversifying victim gender (e.g., transgender, non-binary, gender queer, men) and using non-Black racial/ethnicity groups (e.g., American Indian/Alaskan Native, Southeast Asian, Latinx). Recent media and research are recognizing disproportionate rates of violence for Black trans women. This subset of the population experiences sexual victimization with little or no visibility on their experiences and may face decreased victim credibility if sexual assault is reported. For example, prejudicial attitudes toward transgender individuals were found in this study. A small portion of participants who completed the demographic form responded in ways demonstrating misunderstanding, contention, or dismissal toward gender inclusive language and transgender individuals (e.g., "BIOLOGICAL WOMAN!" and "A man, a male. Not a 'cis.' A man with XY chromosomes"). When reflecting on current political tensions and increasing anti-LGBTQIA+ legislation, these participant behaviors warrant further exploration and consideration regarding designing studies that push pass the gender binary.

In terms of RMA, the current study highlighted a need for research focused on addressing RMA on a broader level, especially for individuals who identify as men. Educational programs have been created to discuss consent and healthy relationships, so evaluating the effectiveness of these programs on reducing belief of rape myths can help guide current understandings on RMA and shape interventions for educators, law enforcement personnel, and mental and medical providers.

While this study did not find differences in RMA, racist attitudes, ableist attitudes, or religiosity for rural versus non-rural participants, more research on the saliency of these beliefs in rural communities could help mitigate health inequities faced by rural citizens. Exploring regional variations between rural communities may also shed light on important factors influencing participants' perceptions of sexual assault cases.

General Conclusions

The purpose of this study was to identify factors important in understanding perceptions and doubts about sexual assault allegations, specifically in terms of victim race and mental health history. The overarching purpose of this study was to fill gaps within the sexual assault literature. Although, the study's hypotheses were not fully supported, the findings advance the current body of literature in some notable ways. First, the study found important considerations which should be made when using a vignette image. Second, the study found that religiosity correlated positively with RMA and racist attitudes, emphasizing the need for more effective psychoeducation and educational programs to the public regarding sexual assault and beliefs which bolster victim blaming. Next, the study found men endorsed rape myths more than women and that gender queer and nonbinary participants reported the lowest RMA of the three gender groups. These findings suggest tailoring education on rape myths and sexual assault to address issues of patriarchy, traditional gender roles, and disregard of male victims of sexual assault may be beneficial.

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APPENDIX A

Participant Gender Self-Descriptions

Table A1

Participant Gender Self-Descriptions and Recoding, Vignette Subsample

Verbatim Text Description	Frequency (*N*)	Recoded As:
A WOMAN	1	Woman
BIOLOGICAL WOMAN!!	1	Woman
female	1	Woman
Female	1	Woman
him	1	Man
Man	1	Man
man but not cisgender	1	Man
Straight Man	1	Man
Traditional heterosexual male	1	Man
woman	3	Woman
Woman	1	Woman

Table A2

Participant Gender Self-Descriptions and Recoding, Questionnaires Subsample

Verbatim Text Description	Frequency (*N*)	Recoded As:
A man, a male. Not a “cis”. A man with XY chromosomes	1	Man
A WOMAN	1	Woman
An American	1	*Missing*
BIOLOGICAL WOMAN!!	1	Woman
female	2	Woman
Female	5	Woman
FEMALE	1	Woman
Gender Fluid	1	Non-Binary
him	1	Man
I was born a girl and I know I’m a girl	1	Woman
idk what those mean	1	*Missing*
male	2	Man
Male	2	Man
man	3	Man
Man	2	Man
man but not cisgender	1	Man
natural born woman	1	Woman
straight	1	*Missing*
Straight Man	1	Man
Straight Women	2	Woman
Traditional heterosexual male	1	Man
White male	1	Man
woman	6	Woman
Woman	3	Woman
WOMAN	2	Woman

APPENDIX B

Vignette and Post-Vignette Items

Vignette

The Springdale Sentinel

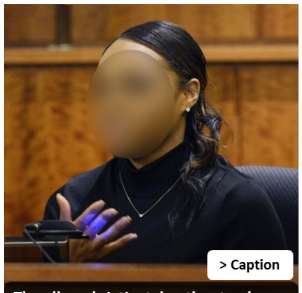
BREAKING NEWS | Weather | Sports | Traffic | Opinion | Classifieds

LATEST

Sexual Assault Trial Enters 3rd Day, Alleged Victim Takes Stand

By Riley Johnson, The Springdale Sentinel | *Updated 4 hours ago*

SPRINGDALE – On Wednesday, as the trial entered its third day, members of the community and press filled Washington County Courthouse to hear from the prosecutions' much-anticipated final witness: the alleged victim.



The alleged victim takes the stand on Wednesday. (Credit: B. Williams, *The Springdale Sentinel*; image modified to protect identify of alleged victim)

The alleged victim, 23, testified that she attended an off-campus New Year's Eve party in 2021, where a mutual friend introduced her to defendant, [redacted], 24. She stated that she spent two hours at the party, drank two beers, and chatted with [redacted] about their shared interest in film.

According to her testimony, she and [redacted] left the party together, [redacted] offered to walk her home, and she invited him into her apartment to watch a movie. She testified that within five minutes of entering her apartment, [redacted] began to touch her thigh and waist, and she initially responded by moving his hand and trying to redirect his attention to the movie. She stated that he continued to touch and push toward her, and she told him she was uncomfortable and told him to stop. She became tearful on the stand as she described [redacted] ignoring her verbal and physical attempts to stop and sexually assaulting her. She also testified to the events after the alleged assault, stating that a few hours later, she called a friend who immediately drove her to the emergency room where nurses conducted a forensic examination and Springdale Police Department officers took her report.

The defense chose not to cross examine, and the prosecution rested. Lead defense attorney, Nancy Miller, spoke with members of the press at the conclusion of today's proceedings and stated that although the alleged victim's testimony was moving, questions remain about her state of mind at the time. She added that the defense intends to call Dr. Robert Davis, a licensed physician and professor of psychiatry, as their first witness tomorrow. Miller stated that Dr. Davis would provide expert opinion on the impact of the alleged victim's hospitalization for [asthma, depression, schizophrenia] the week prior to the alleged assault on their state of mind that night and recollection of events.

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BREAKING NEWS | Weather | Sports | Traffic | Opinion | Classifieds

LATEST

Sexual Assault Trial Enters 3rd Day, Alleged Victim Takes Stand

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SPRINGDALE – On Wednesday, as the trial entered its third day, members of the community and press filled Washington County Courthouse to hear from the prosecutions' much-anticipated final witness: the alleged victim.

The alleged victim takes the stand on Wednesday. (Credit: B. Williams, *The Springdale Sentinel*; image modified to protect identify of alleged victim)

The alleged victim, 23, testified that she attended an off-campus New Year's Eve party in 2021, where a mutual friend introduced her to defendant, [redacted], 24. She stated that she spent two hours at the party, drank two beers, and chatted with [redacted] about their shared interest in film.

According to her testimony, she and [redacted] left the party together, [redacted] offered to walk her home, and she invited him into her apartment to watch a movie. She testified that within five minutes of entering her apartment, [redacted] began to touch her thigh and waist, and she initially responded by moving his hand and trying to redirect his attention to the movie. She stated that he continued to touch and push toward her, and she told him she was uncomfortable and told him to stop. She became tearful on the stand as she described [redacted] ignoring her verbal and physical attempts to stop and sexually assaulting her. She also testified to the events after the alleged assault, stating that a few hours later, she called a friend who immediately drove her to the emergency room where nurses conducted a forensic examination and Springdale Police Department officers took her report.

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Subscribe to The Springdale Sentinel

Six versions of a news article manipulated by alleged victim's race (image of Black woman vs. White woman) and mental health history [statement about hospitalization for asthma (no mental illness) vs. depression vs. schizophrenia]

Text of article:

The Springdale Sentinel

Sexual Assault Trial Enters 3rd Day, Alleged Victim Takes Stand

By Riley Johnson, The Springdale Sentinel | *Updated 4 hours ago*

SPRINGDALE – On Wednesday, as the trial entered its third day, members of the community and press filled Washington County Courthouse to hear from the prosecutions' much-anticipated final witness: the alleged victim.

The alleged victim, 23, testified that she attended an off-campus New Year's Eve party in 2021, where a mutual friend introduced her to defendant, Jonathan Doe, 24. She stated that she spent two hours at the party, drank two beers, and chatted with Doe about their shared interest in film.

[Image caption: **The alleged victim takes the stand on Wednesday.** (Credit: B. Williams, The Springdale Sentinel; image modified to protect identify of alleged victim)]

According to her testimony, she and Doe left the party together, Doe offered to walk her home, and she invited him into her apartment to watch a movie. She testified that within five minutes of entering her apartment, Doe began to touch her thigh and waist, and she initially responded by moving his hand and trying to redirect his attention to the movie. She stated that he continued to touch and push toward her, and she told him she was uncomfortable and told him to stop. She became tearful on the stand as she described Doe ignoring her verbal and physical attempts to stop and sexually assaulting her. She also testified to the events after the alleged assault, stating that a few hours later, she called a friend who immediately drove her to the emergency room where nurses conducted a forensic examination and Springdale Police Department officers took her report.

The defense chose not to cross examine, and the prosecution rested. Lead defense attorney, Nancy Miller, spoke with members of the press at the conclusion of today's proceedings and stated that although the alleged victim's testimony was moving, questions remain about her state of mind at the time. She added that the defense intends to call Dr. Robert Davis, a licensed physician and professor of psychiatry, as their first witness tomorrow. Miller stated that Dr. Davis would provide expert opinion on the impact of the alleged victim's hospitalization for [asthma, depression, schizophrenia] the week prior to the alleged assault on their state of mind that night and recollection of events.

Note about images:

The images were taken from public websites [https://www.wbur.org/news/2015/03/27/shayanna-jenkins-testifies-aaron-hernandez (left), https://www.nytimes.com/video/us/politics/100000008449674/parkland-gunman-trial-recording.html (right)] and were modified for the current study [cropped (both), face blurred (both), and flipped horizontally (right only)] to increase overall similarity in the pictures and to reduce the chance of participants recognizing the persons pictured.

Post-Vignette Items

Part 1: Perceptions of the Individual Described in the Vignette

INSTRUCTIONS: The following questions ask you to make a series of judgments about the scenario you just read. Read each question carefully.

1. Based on the article, how would you rate the credibility of the woman's testimony?

0	1	2	3	4	5	6	7
Not at all credible							Very credible

2. Based on the article, how responsible or culpable would you say the woman was for the events that occurred?

0	1	2	3	4	5	6	7
Not at all responsible							Completely responsible

3. Based on the article, how likely would you say it is that the woman could have avoided or prevented the events?

0	1	2	3	4	5	6	7
Not at all likely							Completely likely

4. Based on the article, how likely would you say the woman misinterpreted the scenario?

0	1	2	3	4	5	6	7
Not at all likely							Very likely

5. Based on the article, how accurately do you think the woman recalled the details of the event?

0	1	2	3	4	5	6	7
Not at all accurate							Very accurate

6. Based on the article, how reliable do you think the woman's memory of the event is?

0	1	2	3	4	5	6	7
Not at all reliable							Very reliable

7. Based on the article, how much do you believe that the woman was able to give an accurate description of what happened?

0	1	2	3	4	5	6	7
Not at all believable							Very believable

8. Based on the article, how much do you believe the woman in the trial was telling the truth?

0	1	2	3	4	5	6	7
Not at all truthful							Very truthful

9. Based on the article, how likely would you say it is that the woman wanted to gain sympathy or attention from the events?

0	1	2	3	4	5	6	7
Not at all likely							Very likely

X. It is important that you pay attention to this study. Please leave this item blank.

0	1	2	3	4	5	6	7
Not at all likely							Very likely

10. Based on the article, how likely would you say it is that the woman intentionally misrepresented the events?

0	1	2	3	4	5	6	7
Not at all likely							Very likely

11. Based on the article, would you say the woman was sexually assaulted?

0	1	2	3	4	5	6	7
Does not at all describe an incident of sexual assault							Completely describes an incident of sexual assault

12. Based on the article, do you think the woman's rights were violated?

0	1	2	3	4	5	6	7
Does not at all describe violation of rights							Completely describes violation of rights

13. Based on the article, how certain are you this incident is considered sexual assault?

0	1	2	3	4	5	6	7
Not at all certain							Very uncertain

14. Based on the article, to what extent did the woman's health history use influence your decision about what happened?

0	1	2	3	4	5	6	7
Not at all							Very much

Part 2: Manipulation and Reading Checks Specific to the Vignette

INSTRUCTIONS: The following questions ask you to recall details about the article you just read. Read each question carefully.

1. True or false? The alleged victim was a woman. **[READING CHECK—REQUIRED TO PASS]**
   - ☐ True **[*correct answer*]**
   - ☐ False
   - ☐ I don't recall

2. True or false? The alleged victim was White. **[MANIPULATION CHECK—REQUIRED TO PASS; *correct answer depends on condition*]**
   - ☐ True
   - ☐ False
   - ☐ I don't recall

3. Based on the article, where did the incident occur? **[READING CHECK—NOT REQUIRED TO PASS]**
   - ☐ At a bar near campus
   - ☐ At a sporting event
   - ☐ At the alleged victim's home **[*correct answer*]**
   - ☐ At a music festival
   - ☐ At the alleged victim's workplace
   - ☐ None of the above
   - ☐ I don't recall

4. Based on the article, which of the following health conditions did the alleged victim have **[MANIPULATION CHECK—REQUIRED TO PASS; *correct answer depends on condition*]**
   - ☐ Social anxiety
   - ☐ Depression
   - ☐ Schizophrenia
   - ☐ Asthma
   - ☐ Diabetes
   - ☐ None of the above
   - ☐ I don't recall

5. True or false? The alleged victim consumed alcohol prior to the incident. **[READING CHECK—NOT REQUIRED TO PASS]**
   - ☐ True **[*correct answer*]**
   - ☐ False
   - ☐ I don't recall

APPENDIX C

Other Study Materials

Demographics Form

1. Your age (in years): _____

2. What is your gender?
   - ○ Cisgender Man
   - ○ Cisgender Woman
   - ○ Transgender Man
   - ○ Transgender Woman
   - ○ Gender queer
   - ○ Nonbinary
   - ○ A better description not listed: ____
   - ○ Prefer not to answer

   [*If any option is selected, other than 'A better description not listed' or 'Prefer not to answer,' this question appears on the same page*] In your own words, how do you typically describe your gender? (Your own words can match what you selected above or can be a little or a lot different. We just want to understand how checkbox options match up to everyday language about gender identity.) _____

3. How would you describe your ethnic and racial background? Check all that apply.
   - ☐ African, Afro-Caribbean, Black, or African American
   - ☐ American Indian or Alaska Native
   - ☐ Asian
   - ☐ Bi-racial or Multi-racial
   - ☐ White
   - ☐ Hawaiian or Pacific Islander
   - ☐ Hispanic, Latin, or Latinx
   - ☐ Middle Eastern or North African
   - ☐ White
   - ☐ A better description not listed: ____
   - ☐ Prefer not to answer

   [*If any option is selected, other than 'A better description not listed' or 'Prefer not to answer,' this question appears on the same page*] In your own words, how do you typically describe your race or ethnicity? (Your own words can match what you selected above or can be a little or a lot different. We just want to understand how checkbox options match up to everyday language about racial or ethnic identity.) _____

4. How would you describe the community in which you grew up?
   - ○ Rural (less than 10,000 people)
   - ○ Suburban (greater than 10,000 people but less than 50,000 people)
   - ○ Urban (greater than 50,000 people)

5. How would you describe the community where you live now?
   - ○ Rural (less than 10,000 people)

- ○ Suburban (greater than 10,000 people but less than 50,000 people)
- ○ Urban (greater than 50,000 people)

6. Would you consider spiritual or religious?
   - ○ Spiritual only
   - ○ Religious only
   - ○ Both spiritual and religious
   - ○ Neither spiritual nor religious

7. How would you describe your current religion or faith, if any?
   - ○ Agnostic
   - ○ Atheist
   - ○ Asian Folk Religion
   - ○ Baha'i
   - ○ Buddhist
   - ○ Christian

     [*If 'Christian' selected, this question appears*] Which denomination, sect, or tradition? (If you're not sure, think about the name of the church or churches you've attended the most or feel most connected to.)
     - ○ African Methodist Episcopal
     - ○ Baptist
     - ○ Catholic
     - ○ Episcopalian/Anglican
     - ○ Historically Black Protestant
     - ○ Holiness
     - ○ Jehovah's Witness
     - ○ Latter Day Saint/Mormon
     - ○ Lutheran
     - ○ Methodist
     - ○ Orthodox
     - ○ Pentecostal
     - ○ Presbyterian
     - ○ Seventh Day Adventists
     - ○ Something else not listed: ____

     [*If 'Christian' selected, this question appears*] Do you consider yourself evangelical?
     - ○ No
     - ○ Yes
   - ○ Druid
   - ○ Hindu
   - ○ Jewish
   - ○ Muslim
   - ○ Native American Folk Religion
   - ○ Pagan
   - ○ Unitarian-Universalism
   - ○ Wiccan
   - ○ A better description not listed: ____
   - ○ Nothing in particular

8. Have you ever experienced a sexual assault?
    - ○ Yes, once
    - ○ Yes, more than once
    - ○ No, never
    - ○ Prefer not to respond

9. Have you ever received a mental health diagnosis or experienced symptoms of a mental health condition?
    - ○ Yes
    - ○ No
    - ○ Prefer not to respond

10. What is your major?
    - ○ Psychology
    - ○ Criminal Justice
    - ○ Something else: ____

11. How did you find out about this study?
    - ○ I found it on SONA.
    - ○ I learned about it from a flyer distributed in a psychology class.
    - ○ I learned about it from a flyer for criminal justice students.

Seriousness Question

You are almost finished! Thank you for participating in this study. We have one more question. We want to know whether participants paid attention during the survey so that we know whether we should include their data in our analyses. No matter your answer, we appreciate you taking the time to be involved in our study, and you will still receive full SONA credit.

Did you pay close attention throughout the survey, or did you mostly click through the survey without paying attention?

- ○ I paid close attention throughout the survey. Keep my data.
- ○ I did not pay close attention and mostly clicked through the survey. Throw out my data.

APPENDIX D

Supplemental Internal Consistency Data

Table D1

Internal Consistencies of Study Questionnaires across Race and Ethnicity

Race/Ethnicity, recoded	CoBRAS Total	DMISS Total	IRMA Total	DUREL Total
Black, Non-Hispanic	.87	.87	.84	.86
White, Non-Hispanic	.91	.91	.91	.92
Black, Hispanic	.61	.61	.98	.80
White, Hispanic	.86	.86	.95	.93
Biracial or multiracial	.93	.93	.97	.89
Hispanic, Latin, or Latinx[1]	.76	.76	.80	.72

Note. Other race and ethnicity groups were not included due to small group sizes.

[1] Participants in this group identified only as Hispanic, Latin, or Latinx.

APPENDIX E

Informed Consent and Debrief

Informed Consent

You are invited to participate in a study conducted by Liyah Morgan, a doctoral student in the Department of Psychology at Georgia Southern University, and Dr. Dorthie Cross, a faculty member student in the Department of Psychology at Georgia Southern University.

You are being asked to participate in this study because you are currently enrolled in at least one course at Georgia Southern University. The purpose of the study is to examine how people make sense of sexual assault allegations. You will be asked to read and evaluate a newspaper account of a sexual encounter between two individuals. You will also be asked questions about your personal opinions and personal experiences related to sexual assault and mental health.

The study should take 20 to 45 minutes to complete and is worth ONE research credit on Sona or extra credit to be determined by your instructor. Any Georgia Southern student can participate in this study, but not all instructors will offer extra credit. You can still participate, but you will not receive compensation for your participation. Instructions for obtaining credit are included at the end of the survey.

Questions about sexual assault may be upsetting for some people. If you wish to seek mental health assistance related to your participation in this study, you may contact the Georgia Southern University Counseling Center:

Statesboro Campus: 912-478-5541
Armstrong Campus: 912-344-2529

Additional resources will be provided at the end of the study.

The information you provide may not benefit you directly but will help researchers and mental health professionals better understand how people make sense of sexual assault allegations. There are no costs to you for participating in the study.

Participation in this study is completely voluntary. Even if you choose to participate, you are free to discontinue the survey at any time. You are also free not to answer any particular question within the survey. Participating in this study is not the only option you have to earn course research credits, bonus points, or participate in research studies. You may choose to participate in other studies instead, or you may choose to complete equivalent alternative assignments as laid out by your instructor.

There is no penalty for choosing not to participate or for discontinuing participation. If you choose not to participate or decide to discontinue, you will not lose research credit, but to earn research credit for this study, you must participate in this study and must navigate to the end of the survey to either be credited by Sona or to retrieve a confirmation code for class bonus. If you are not receiving extra credit or research credit for this study, you will not receive compensation.

No personally identified information will be collected for this study; however, absolute anonymity can never be guaranteed over the Internet. Data from this study will be maintained indefinitely by Dr. Cross. Study data may be used in research publications or presentations. Data from this study may be placed in a publicly available repository for study validation and further research. You will not be identified in any publication, presentation, or public dataset using information obtained from this study. Subsequent uses

of records and data will be subject to standard data use policies which protect the anonymity of individuals and institutions. Individuals from the Georgia Southern University Institutional Review Board may inspect all study records to ensure research procedures are properly followed.

This study has been reviewed and approved by the Georgia Southern University Institutional Review Board under tracking number H23336. For questions concerning your rights as a research participant in this or other studies, contact Georgia Southern University Institutional Review Board at 912-478-5465. For questions about this study, contact Liyah Morgan.

Study Title:
Perceived Credibility of Allegations of Sexual Assault

Principal Investigator:
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Research Advisor:
Dr. Dorthie Cross
1010 Brannen Hall
Department of Psychology
Georgia Southern University
Statesboro, Georgia 30460-8041
dcrossmokdad@georgiasouthern.edu

You must be at least 18 years old to consent to participate in this study.

Please select an option below to indicate whether you agree to participate in this research:

- o Yes, I read the terms above and consent to participate in this research.
- o No, I do not consent to participate in this research.

Debrief

We appreciate your participation, and we recognize that thinking about and answering questions about sexual assault can be upsetting. If these questions made you think about areas of your life that you would like to talk more about, we encourage you to call or visit the Georgia Southern University Counseling Center (912-478-5541) during normal business hours (M-F 8am to 5pm) to find out about resources available to you.

Counseling Center:

Statesboro Campus: 912-478-5541
Armstrong Campus: 912-344-2529
More information: https://students.georgiasouthern.edu/counseling/crisis/

For immediate help after hours or if you are unable to get to the Counseling Center, call the Georgia Southern University Campus Police. They can connect you with an on-call counselor. You may also call the local police department at 911 at any time if you believe you or someone else is at risk.
Emergencies and After Hour Care:

Statesboro Campus Police: 912-478-5234
Armstrong Campus Police: 912-344-3333

Other Resources:

National Suicide Prevention Lifeline
24/7 Crisis Line: 988, press 1
https://988lifeline.org/

The Teal House - Statesboro Regional Sexual Assault & Child Advocacy Center
24/7 Crisis Line: 1-866-489-2225
https://www.srsac.org/

Rape Crisis Center of the Coastal Empire
24/7 Crisis Line: 912-233-7273
https://www.rccsav.org/

Military Crisis Line
24/7 Crisis Line: 988, press 1
24/7 Text Line: 838255
https://www.veteranscrisisline.net/get-help/military-crisis-line

If you would like to learn more about trauma, post-traumatic stress disorder, and other common mental health problems, check out the National Center for PTSD where you can find valuable information relevant to veterans and civilians alike. National Center for PTSD:
https://www.ptsd.va.gov/

APPENDIX F

Supplemental Figures

Figure F1

Nonsignificant Main Effect of Victim Race on Perceived Victim Credibility (Hypothesis 1)

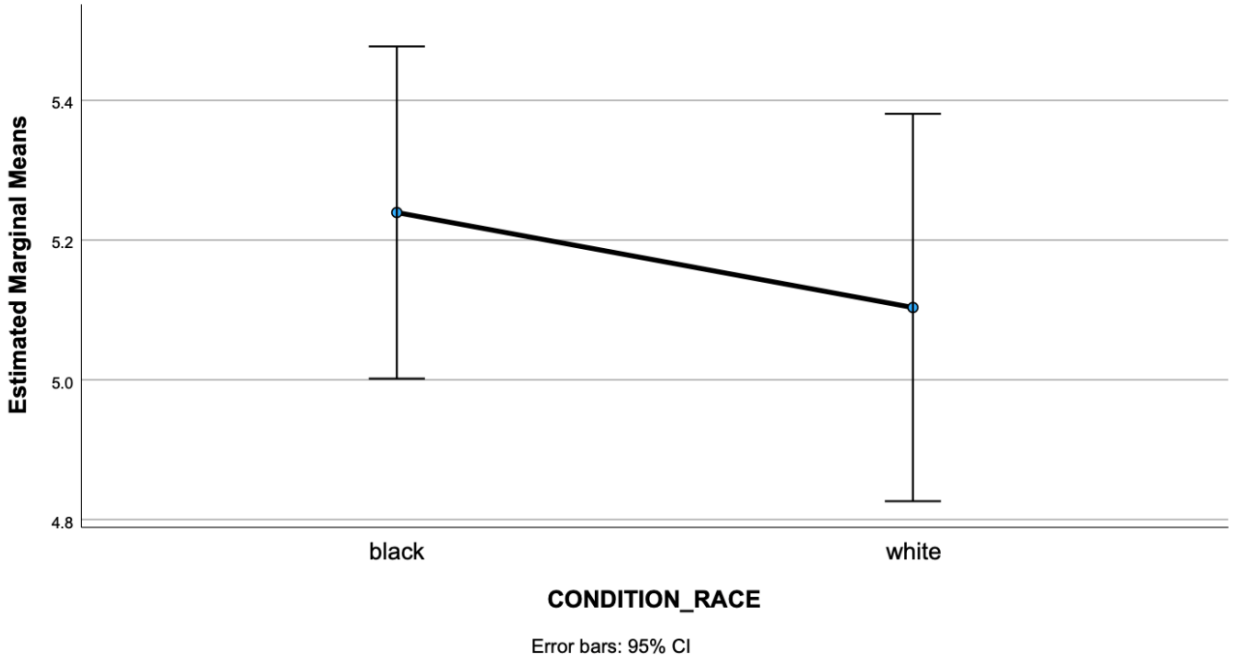

Figure F2

Nonsignificant Main Effect of Victim Diagnosis on Perceived Victim Credibility (Hypothesis 2)

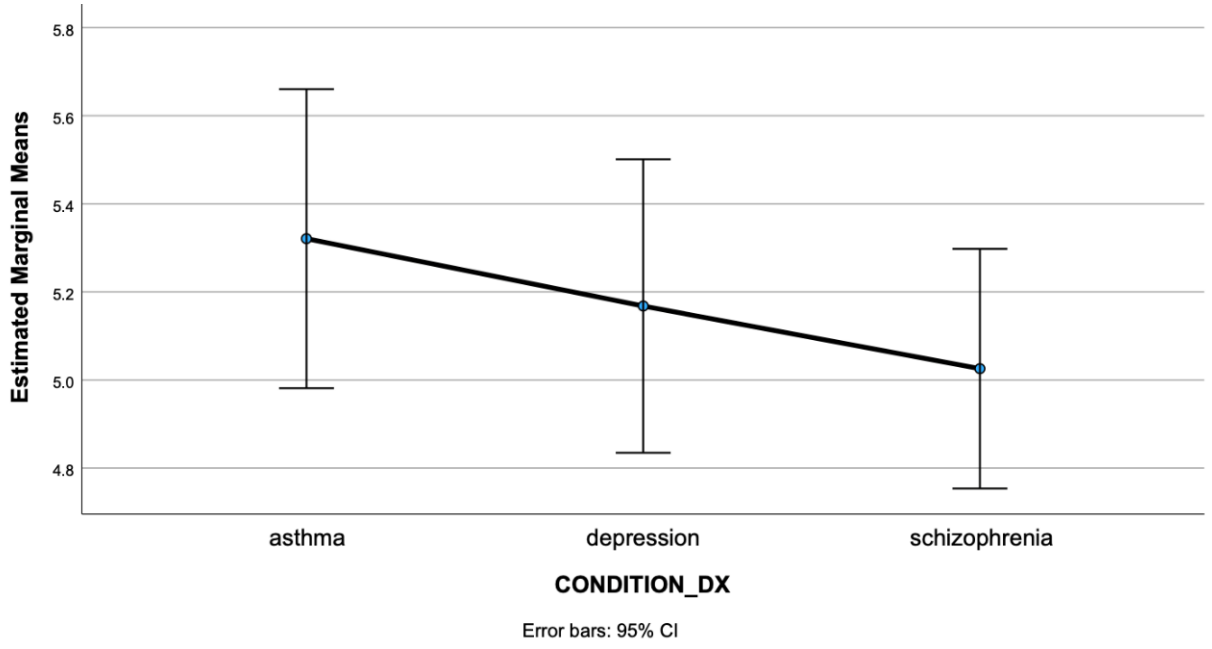

Figure F3

Nonsignificant Interaction of Victim Race and Diagnosis on Perceived Victim Credibility (Hypothesis 3)

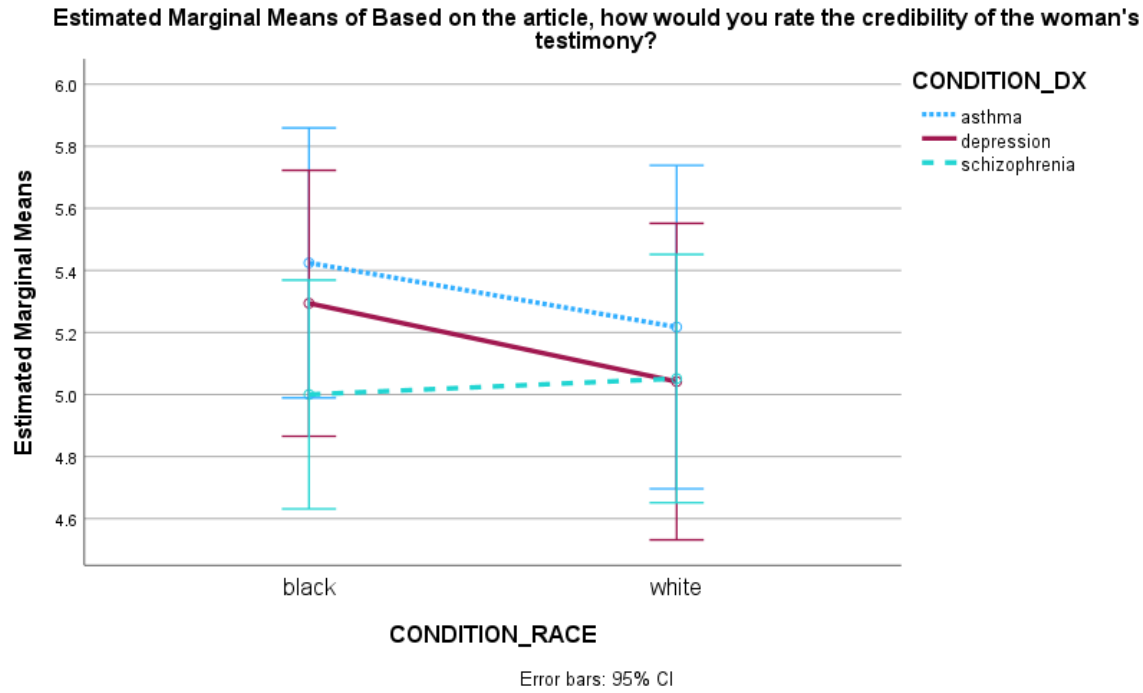

Figure F4

Nonsignificant Effect of Participant Race on Perceived Victim Credibility (Part of Hypothesis 4 Analysis)

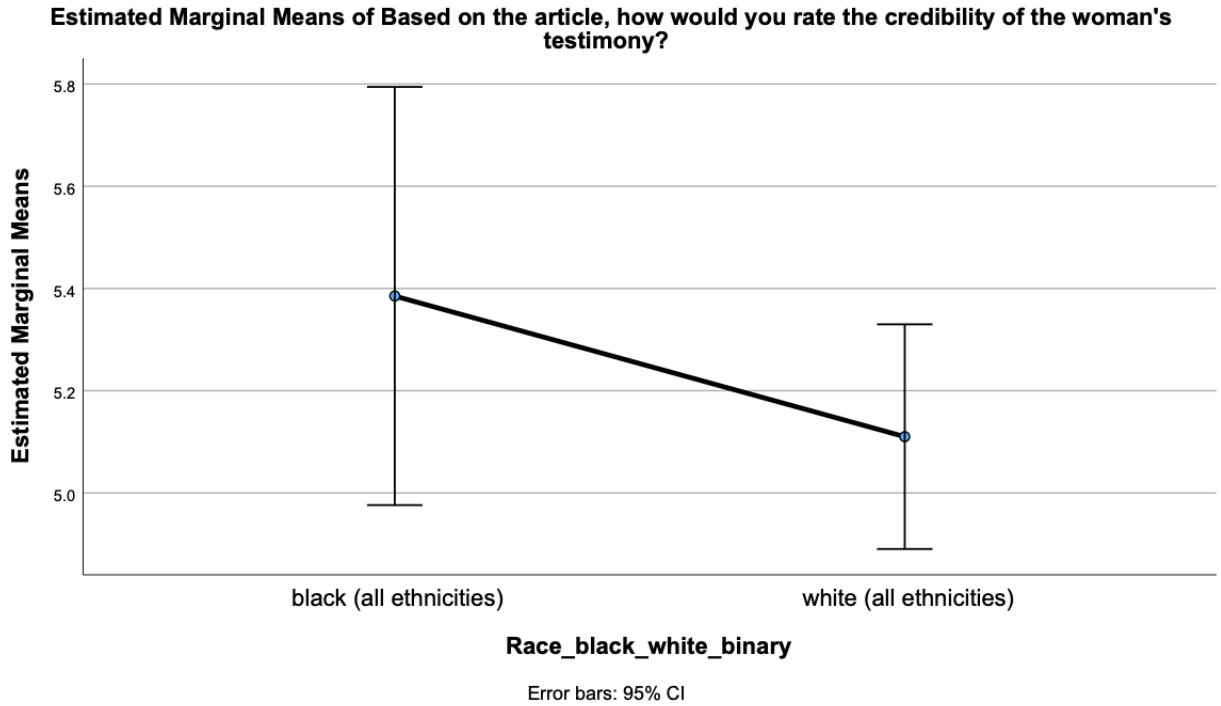

Figure F5

Nonsignificant Interaction of Participant Race and Victim Race on Perceived Victim Credibility (Part of Hypothesis 4 Analysis)

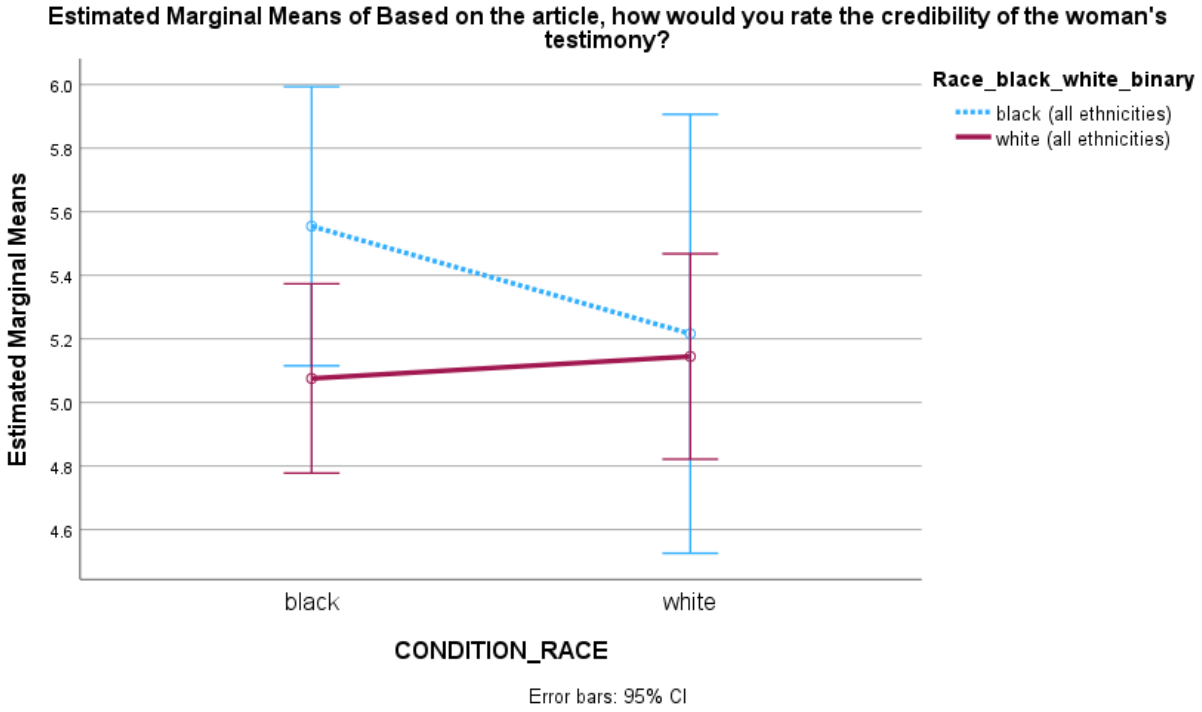

Figure F6

Nonsignificant Interaction of Participant Race and Victim Diagnosis on Perceived Victim Credibility (Hypothesis 4)

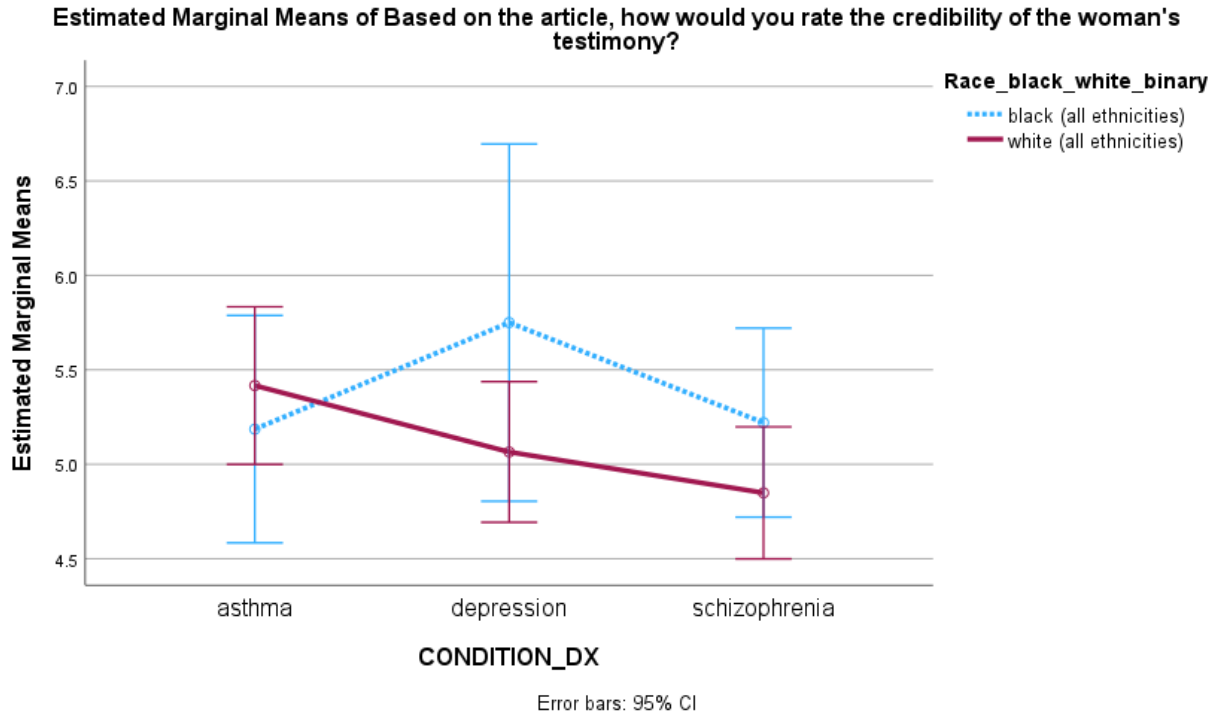

Figure F7a

Nonsignificant Interaction of Victim Races and Victim Diagnosis on Perceived Victim Credibility Among Black Participants (Part of Exploratory Analysis 3)

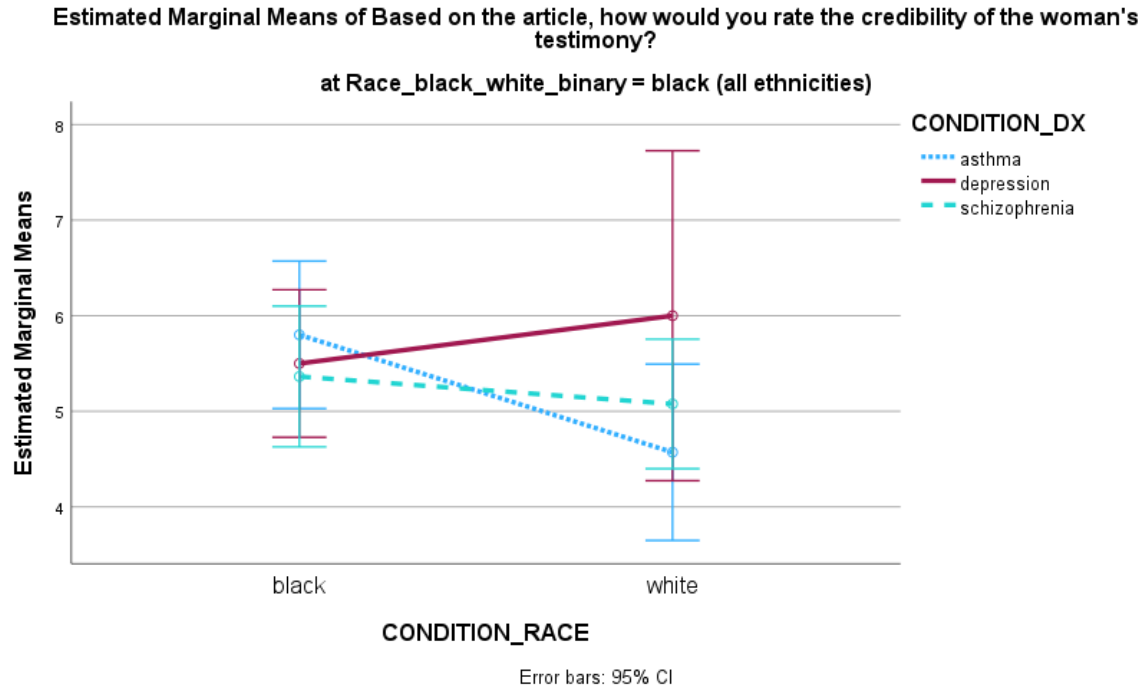

Figure F7b

Nonsignificant Interaction of Victim Races and Victim Diagnosis on Perceived Victim Credibility Among White Participants (Part of Exploratory Analysis 3)

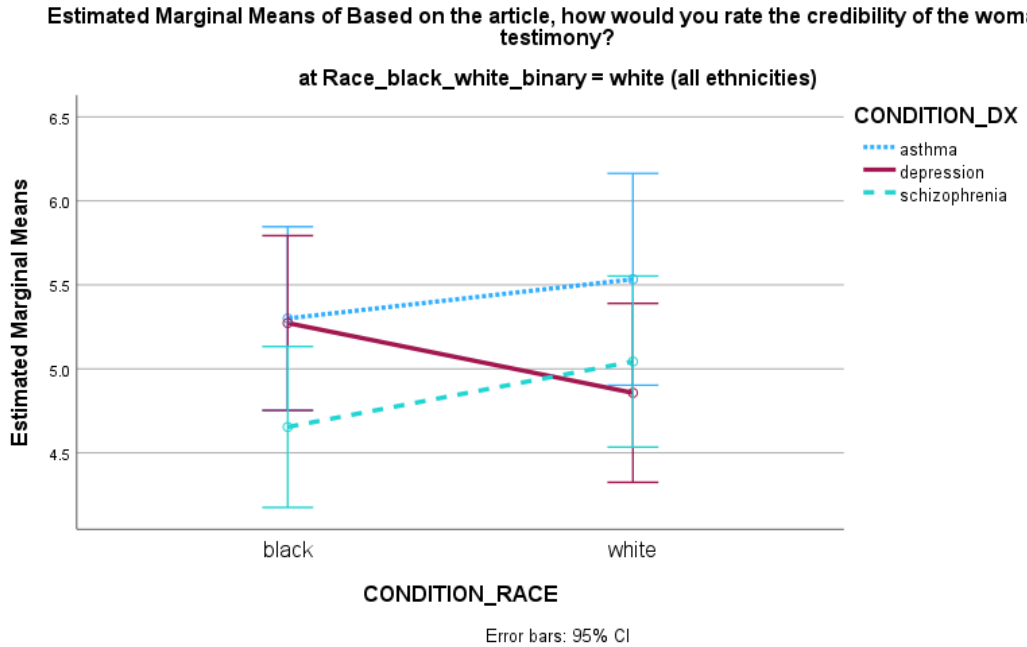

Figure F8

Nonsignificant Interaction of Victim Race and Participant Gender on Perceived Victim Credibility (Part of Exploratory Analysis 4)

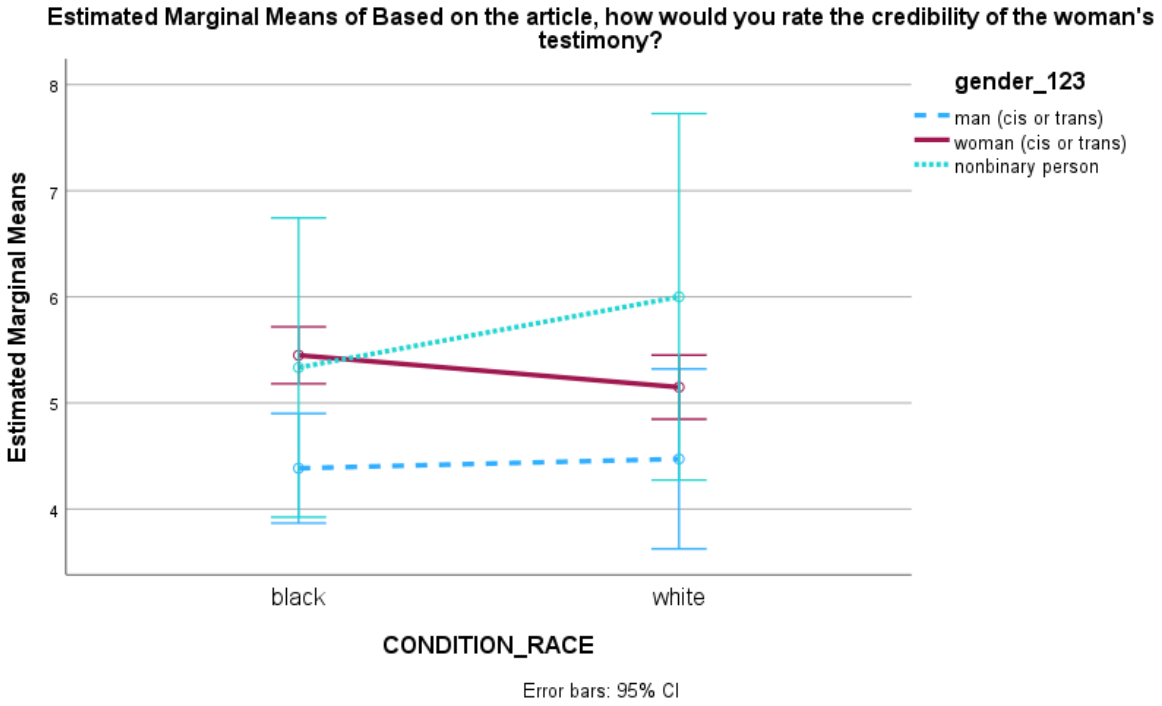

Figure F9

Nonsignificant Interaction of Victim Diagnosis and Participant Gender on Perceived Victim Credibility (Part of Exploratory Analysis 4)

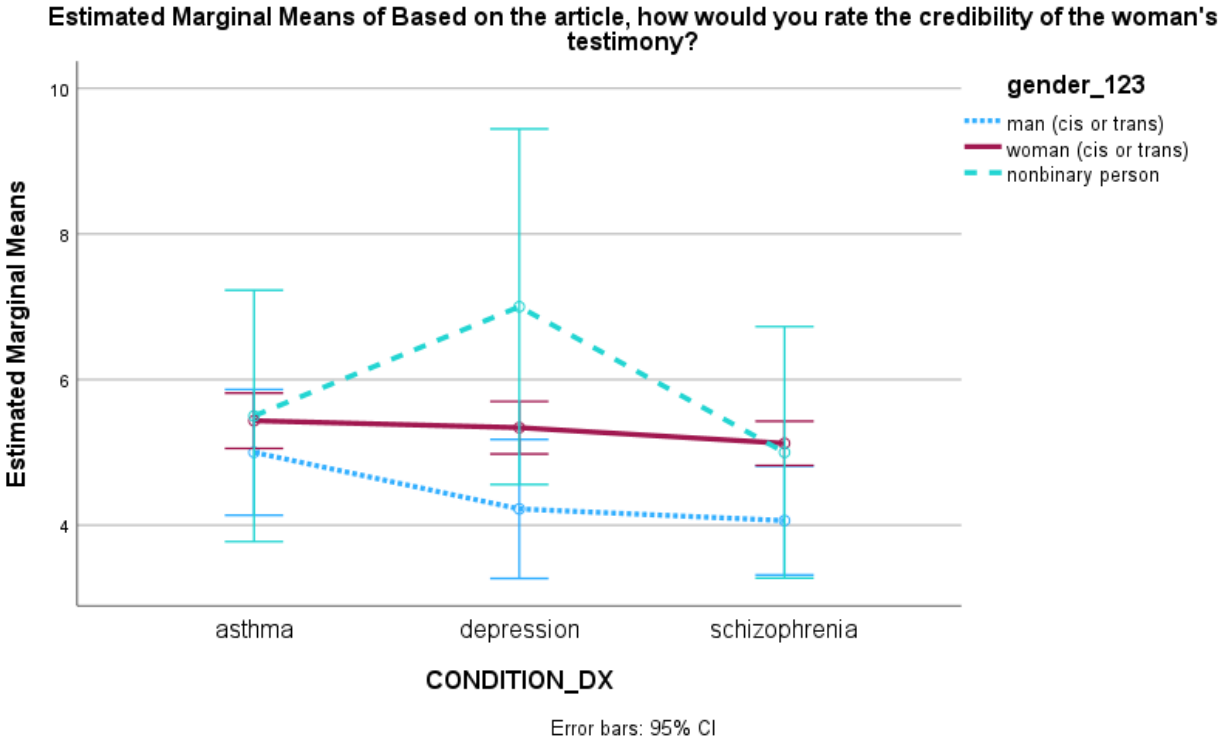

Figure F10a

Nonsignificant Interaction of Victim Race and Victim Diagnosis on Perceived Victim Credibility Among Men (Part of Exploratory Analysis 4)

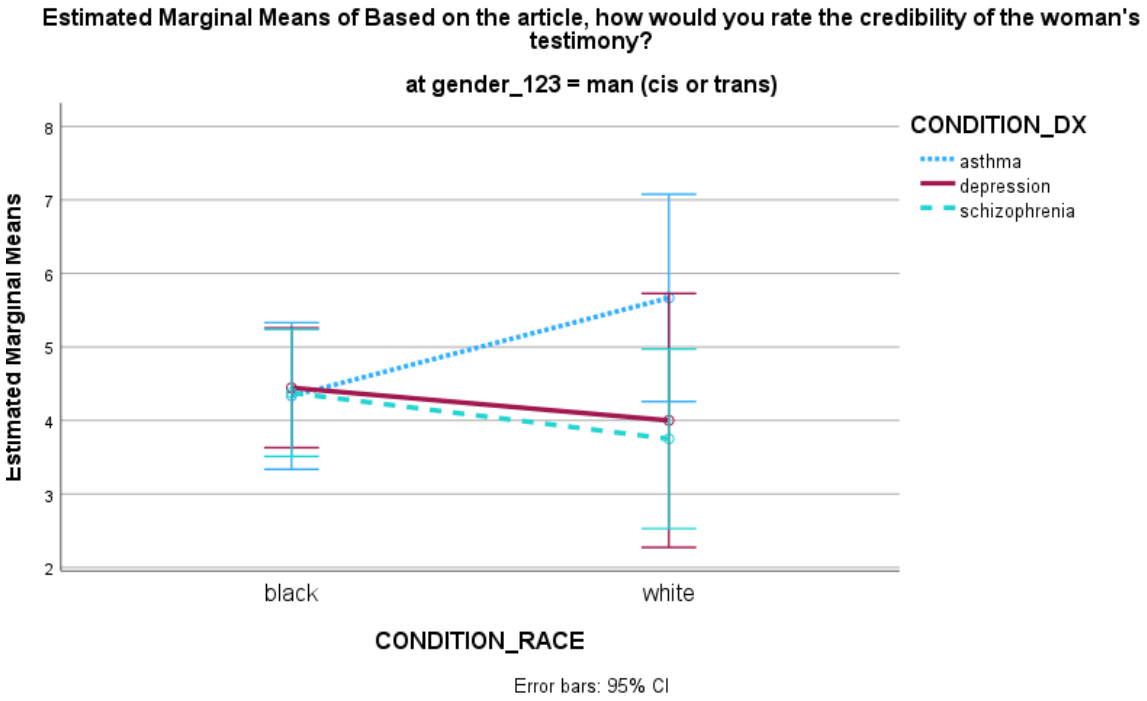

Figure F10b

Nonsignificant Interaction of Victim Race and Victim Diagnosis on Perceived Victim Credibility Among Women (Part of Exploratory Analysis 4)

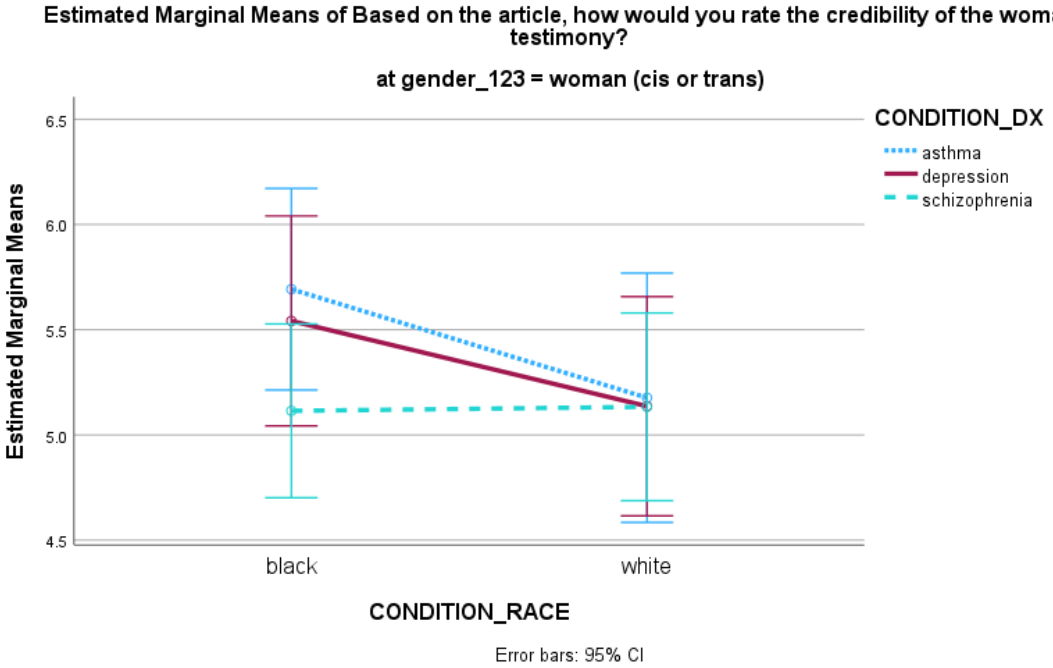

Figure F10c

Nonsignificant Interaction of Victim Race and Victim Diagnosis on Perceived Victim Credibility Among Genderqueer or Nonbinary Person (Part of Exploratory Analysis 4)