RISK REDUCTION INTERVENTIONS TO PREVENT SEXUAL VICTIMIZATION IN COLLEGE WOMEN: UPDATING PROTOCOL AND EVALUATING EFFICACY

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RISK REDUCTION INTERVENTIONS TO PREVENT SEXUAL VICTIMIZATION IN COLLEGE WOMEN: UPDATING PROTOCOL AND EVALUATING EFFICACY

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Through theoretical modifications to program protocol, a more comprehensive array of program evaluation measures, and the adoption of an updated research design, the current study extends the development and evaluation of The Ohio University Sexual Assault Risk Reduction Program, an existing and previously evaluated sexual assault risk reduction program for college women. A series of focus groups was used to evaluate potential revisions to program protocol and pilot program evaluation measures. The modified risk reduction program protocol maintained its focus on the use of the health belief model, the elaboration likelihood model, and social learning theory, and also incorporated theory of planned behavior and the transtheoretical model to address the subtle—but critical—role of cognitive appraisals in participants’ decisions to adopt self-protective strategies. The current study also implemented a theoretically driven health intervention among control group participants, rather than a non-treatment control group.

Participants included 278 undergraduate women from a medium sized Midwestern university. Participants completed a pretest assessment, a 3-hour risk reduction program, a 2-hour self-defense program, and a 1 ½ -hour booster session review of program material. Participants in the treatment control group participated in a pretest assessment, a 3-hour peer education and awareness program on vaccine preventable diseases, and a 1 ½ -hour booster session review of vaccine preventable diseases. Participants in both the risk reduction program and the vaccine preventable disease program returned for a 2-month and 4-month follow-up to report incidence of
sexual victimization over the interim and complete measures of attitude and behavior change.

The risk reduction program was not effective in reducing incidence of sexual victimization among program participants, with or without a history of sexual victimization, over the 2-month or 4-month interim. Participants in the risk reduction program evidenced increases in open sexual communication and self-efficacy in enacting self-protective behaviors compared to participants in the control-group intervention. Program participants also maintained levels of self-protective behaviors over the course of the study, whereas levels of self-protective behaviors evidenced decline among control group participants.

Approved:

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Introduction

Sexual victimization of women is a pervasive form of interpersonal violence, especially on college campuses (Koss, Gidycz, & Wisniewski, 1987). On a time-based clock, the FBI estimates that one forcible rape occurs in the general population every 5.5 minutes (FBI, 2002a). Studies focusing specifically on college populations suggest that the rate of sexual victimization among college women is approximately three times greater than the victimization rate among the general population (Sorenson, Stein, Seigel, Golding, & Burnam, 1987). For example, a recent study of a nationally representative sample revealed that 20% of undergraduate women, at some time during their lives, had sex forced on them against their will (Brener, McMahon, Warren, & Douglas, 1999). Similarly, telephone interviews of a nationally representative sample of 8,000 women and 8,005 men revealed that 14.8% of the women surveyed and 2.1% of the men surveyed experienced a completed rape at some time in their lives (Tjaden & Thoennes, 2000).

Preventing sexual victimization on college campuses is of high concern for psychologists and health officials due to the strong connection between sexual victimization and a wide range of health problems. Such aftereffects include increased physician visits and healthcare costs (Koss, Woodruff, & Koss, 1991), depressive and anxiety disorders (Acierno, Resnick, & Kilpatrick, 1997), post-traumatic stress disorder (Thompson et al., 2003), and alcohol dependency (Ullman & Brecklin, 2003).

Given the pervasiveness of sexual assault and its devastating aftereffects, over the past three decades researchers and social advocates have developed various interventions and awareness campaigns in hopes of combating the high rates of sexual victimization on college campuses and within the greater population. However, the vast majority of these
Interventions have undergone little theoretical development, research and outcome evaluation. Furthermore, sexual assault prevention and risk reduction programs differ in theoretical conceptualization, content as well as target audience.

For example, the elaboration likelihood model (ELM; Petty & Cacioppo, 1981, 1986) is frequently utilized within program development to increase the likelihood of producing long-term attitude and behavior change. According to ELM, attitude change is conceptualized along a continuum. Peripheral route processing, where an individual attends to the superficial cues of a persuasive message, is associated with fleeting and transitory change. Central route processing, where an individual finds a message personally relevant and engages in issue-relevant thinking, is associated with more stable and long-term attitude change. Research suggests that programs that maximize central route processing of program information may be more successful in influencing the behavior of participants (Gilbert, Heesacker & Gannon, 1991; Heppner, Neville, Smith, Kivlighan & Gershuny, 1999; Heppner, Humphrey, Hillenbrand-Gunn & Debord, 1995). While some programs are structured according to various theories in behavior change, not all programs undergo such systematic conceptual development.

Sexual assault prevention and risk reduction programming exists for male, female as well as mixed-sex audiences. Programs fashioned for a mixed-sex audience often utilize interactive (Frazier, Valtinson, & Candell, 1994), didactic as well as video-based programming (Anderson, Stoelb, Duggan, Hieger, Kling & Payne, 1998) and address a wide variety of topics. Common discussion topics include resistance strategies and safety precautions (Briskin & Gary, 1986), societal attitudes toward rape (Harrison, Downes & Williams, 1991; Nelson & Torgler, 1990), the role of advertising in promoting oppressive
sex role stereotypes (Harrison et al., 1991), myths of sexual assault (Briskin & Gary, 1991; Dallager & Rosen, 1993; Fonow, Richardson & Wemmerus, 1992), gender role socialization and peer pressure (Feltey, Ainslie, & Geib, 1991), description of common characteristics of perpetrators (Borden, Karr & Cadwell-Colbert, 1988; Lenihand, Rawlins, Eberly, Buckley & Masters, 1992), consent (Holcomb, Sarvela, Sondag & Holcomb, 1993; Holcomb, Sondag & Holcomb, 1993), local rape laws (Fischer, 1986) as well as statistics, definitions and local resources (Lenihand et al., 1992). In addition, programs frequently discuss reactions to sexual victimization (Briskin & Gary, 1986), discuss the experiences of survivors of sexual assault (Ellis, O’Sullivan, & Sowards, 1992) or include a discussion of rape trauma syndrome (Borden et al., 1988). Research by Gidycz, Layman et al. (2001) is currently the only study which evaluated a mixed-sex program’s effectiveness in reducing rates of sexual victimization among women and perpetration of sexual aggression in men. According to their report, the program failed to show reductions in rates of victimization or perpetration among women and men, respectively (Gidycz, Layman, et al., 2001).

Increasingly, experts in the field of sexual assault risk reduction programming advocate the need for single-sex programming (Gidycz, Rich & Marioni, 2002). Given that the audience of a mixed-sex sexual assault risk reduction program may contain potential perpetrators, some of the topics of mixed-sex programming—such as resistance strategies, and the common characteristics of perpetrators—may be unethical topics for discussion. According to Gidycz and her colleagues (2002), it is inappropriate to share risk reduction strategies with men, as it could provide potential rapists with information about what factors can make women more vulnerable to sexual assault. Furthermore,
Gidycz and her colleagues (2002) note as many of the program goals for men and women’s programming do not overlap, information in mixed-sex programming may not be personally relevant to all participants and therefore ineffective in producing attitude and behavior change. Not only, then, is single-sex programming the most ethical method of conducting preventative and risk reduction programming, it may also be the most effective method of producing attitude and behavior change among program participants.

Preventative programming for men often appeals to the moral development of group members and addresses the harms of rape and societal attitudes that perpetuate rape-prone environments (Parrot, Cummins, Marchell, & Hofher, 1994; Ring & Kilmartin, 1992). Research suggests that men who are educated on the effects of sexual violence are less likely to hold rape-supportive beliefs (Buckner, 1981; Fischer, 1986; Hamilton & Yee, 1990; Lee, 1987, Schaeffer & Nelson, 1993). Early preventative programming developed by Egidio and Robertson (1981) stressed value clarification and aimed to increase self-awareness among male participants. Other programs have addressed the harms of pornographic materials in fostering a rape-supportive culture (Intons-Peterson, Roskos-Ewoldsen, Thomas, Shirley & Blut, 1989). Commonly, all-male programs aim to increase empathy towards victims of sexual assault (Berg, Lonsway & Fitzgerald, 1999; Gilbert et al., 1991; Schewe & O’Donohue 1993), educate participants with factual knowledge about sexual victimization (Lee, 1987; Schewe & O’Donohue, 1993), provide participants with information on how to help survivors (Foubert & Marriott, 1997), and aim to dispel common myths about sexual assault (Berg et al., 1999; Schewe & O’Donohue, 1996).
Risk-reduction programs for women maintain that the perpetrator is always to blame for sexual victimization. However, researchers assert that it is necessary to provide women with strategies to reduce their own risk of sexual victimization while efficacious programming is being developed for all-male audiences. Generally, sexual assault risk-reduction programming for women aims to reduce incidence of sexual victimization by educating women on self-protective strategies, situational risk factors as well as the typical characteristics of perpetrators. Other topics included in risk reduction programming include a discussion of statistics, the pervasiveness of sexual assault and the societal forces that foster rape-supportive environments, education on practical risk reduction strategies, discussion of rape myths, and education on assertive dating behaviors (Gidycz, Lynn et al., 2001; Gidycz, Rich, Orchowski, King & Miller, in press; Hanson & Gidycz, 1993).

Only a few risk reduction programs tailored specifically to women are documented within program evaluation literature. The Women Against Rape Program (1980) focuses on assertive behaviors, and utilizes confrontation training and self-defense courses as well as a discussion of the politics of rape to stress the overall program goal of self-empowerment. Women-only programming by Gray, Lesser, Quinn and Bounds (1990) focuses on women’s risk taking behaviors, and aims to maximize the integration of program protocol through personalization of the program material.

It is important for researchers of risk reduction and sexual assault prevention programs to be aware that their audience will most likely contain a number of survivors and perpetrators of sexual assault, and standard interventions may be ineffective for these subgroups (Gidycz et al., 2002). For example, research by Hanson and Gidycz (1993)
revealed that while sexual assault risk reduction programming was successful in reducing risk of victimization for women without a history of sexual assault, the program was ineffective in reducing risk of victimization for women with a history of sexual victimization. As a result, several researchers have begun to develop programs specifically tailored to women with histories of sexual assault (e.g., Breitenbecher & Gidycz, 1998; Himelein, 1999; Marx, Calhoun, Wilson & Meyerson, 2001). One such program specifically tailored to reducing risk of revictimization developed by Breitenbecher and Gidycz (1998) includes discussion of the risks of sexual victimization, as well as a specific focus on the psychological effects of victimization including issues of recovery and self-blame.

Although United States Federal Law mandates all colleges and universities that receive federal funding to implement some type of rape prevention program (National Association of Student Personnel Administrators, 1994), prevalence rates of sexual assault remain high (Brener et al., 1999) and apparently unchanged over the past decade (Rozee & Koss, 2001). Moreover, evaluation of sexual assault risk-reduction programs shows little support for their effectiveness in reducing incidence of sexual violence (Breitenbecher & Gidycz, 1998; Breitenbecher & Scarce, 2001; Yeater & O’Donohue, 1999). Whereas some studies have measured the program’s effects on participants’ knowledge of rape (Breitenbecher & Scarce, 1999; Hanson & Gidycz, 1993: Himelein, 1999), and some studies evaluate programs’ effect on incidence of sexual assault (Breitenbecher & Gidycz, 1998; Breitenbecher & Scarce, 1999; Gidycz Layman et al., 2001; Gidycz, Lynn et al., 2001; Hanson & Gidycz, 1993; Marx et al., 2001), program evaluation suggests that these programs frequently have little effect on longstanding
attitude or behavior change (see Breitenbecher, 2000 for a review). Even when improvements in attitudes toward sexual assault are recorded immediately following program participation, they tend to regress to pre-test levels during further follow-up assessments (Breitenbecher, 2000).

However, the apparent failure of sexual assault risk-reduction programs in reducing the incidence of sexual assault must at least partially be considered a result of an absence of effective program evaluation and the infancy of the field rather than an indicator of the overall “failure” of preventative efforts (Breitenbecher, 2000). Of the colleges and universities that implement some form of sexual assault risk reduction programming, few evaluate the effectiveness of the program on altering the attitudes or behaviors of program participants (McCall, 1993). Likewise, given that few studies measure the program’s effectiveness in decreasing incidence of sexual assault (Gidycz et al., 2002; Yeater & O’Donohue, 1999). Measures typically used to evaluate program effectiveness (i.e., rape myth acceptance, sex-role stereotypes, rape empathy) have also been criticized (Breitenbecher, 2000; Gidycz et al., 2002; Yeater & O’Donohue, 1999). It is possible that measures of attitude and behavioral change are too subtle to detect the effects of an intervention, or may not survey relevant constructs of behavior change. It is also possible that the use of some behavioral assessments of sexual victimization (i.e., Sexual Experiences Survey), as well as participation in risk reduction programming, may sensitize participants to the definition of sexual assault and influence subsequent reporting among program participants.

A similarly overlooked area of sexual assault prevention program evaluation is the validity of the research design. Comparison of treatment groups to a non-treatment
control group has been long considered problematic in the field of treatment outcome study. Yet, even studies that utilize a control group comparison to evaluate the efficacy of a sexual assault risk reduction program typically fail to utilize any type of equivalent intervention among control participants. Thus, it is hypothesized that participants in the risk reduction program group maintain a greater investment in study participation than control group participants, who simply complete questionnaires.

Rather, it is necessary for the field of sexual assault intervention research to improve upon the validity of the standard treatment versus non-treatment research design, and look toward evaluating program efficacy using summative evaluation (i.e., comparison to another theoretically driven health intervention). Such a comparison between two treatment groups allows for equivalent investment in study participation, and increases the validity of between-group comparisons.

Overall, sexual assault risk reduction programming must be evaluated through prospective, longitudinal designs using control group comparisons, measure incidence of sexual victimization across an adequate interim, and utilize a comprehensive array of measures of attitudinal and behavioral change. Program development is further improved when program modification and evaluation is an ongoing process, involving continued revision and evaluation of program protocol according to feedback from program participants and various theoretical models, and data from previous evaluation.

The current research addresses each of these three aforementioned concerns in the field of sexual assault risk reduction program evaluation. The current study utilizes a prospective longitudinal design to evaluate modifications to an existing and previously evaluated sexual assault risk reduction program by using a wide array of measures
corresponding to the program’s theoretical models of attitude and behavior change. This study also addresses issues of validity in the research design by utilizing a summative evaluation design to compare the efficacy of the sexual assault risk reduction program to another theoretically driven health intervention for college women. A survey manipulation was also implemented in order to explore the role of increased knowledge of the definition of sexual assault on reports on the Sexual Experiences Survey. Through these updates to program evaluation, design and protocol, the current study will add to the research of sexual assault risk reduction programming by providing a better understanding of the essential components of risk reduction programs for college women.

Assessment of Sexual Victimization

Definitions of Rape and Sexual Assault

The Uniform Crime Report, issued by the Federal Bureau of Investigation (FBI), defines forcible rape simply as “the carnal knowledge of a female forcibly and against her will” (FBI, 2000), in which “carnal knowledge” is interpreted as penile-vaginal penetration (Koss, 1993). Local definitions of rape are more precise. According to Ohio State Law (1961), rape is defined as an act of sexual conduct committed by force against a woman without her consent (Ohio Revised Code §5924.120, 1961). In this definition, sexual conduct (i.e., rape) is defined by law as the penetration, however slight, of the vagina, mouth or anus by the penis, hand, finger or other object (Ohio Revised Code §§28907.01-2907.02, 1998). This definition of rape was expanded in 1998 to include the administration of a drug, intoxicant or controlled substance (either secretly or by the use of force) in order to lower the victim’s resistance, regardless of the sex of those involved (Ohio Revised Code §§28907.01-2907.02). Some research studies have expanded these
legal definitions of rape to include reports of both attempted and completed rape. For example, the definition of rape used by the National Violence Against Women Survey (NVAWS) includes both completed and attempted acts of penetration using a penis, object or fingers (Brecklin & Ullman, 2002, emphasis added). In this expanded definition, women were considered victims of rape if they “had ever in their lifetime been forced or threatened by a man or woman to have anal, oral or vaginal intercourse” (Brecklin & Ullman, 2002 p. 58).

Whereas these legal definitions of rape are quite explicit, the legal definition of rape does not always correspond to the spectrum of experiences that may be encompassed in sexual victimization (Muehlenhard, Powch, Phelps, Giusti, 1992). For example, Koss and Oros (1982) identified five levels of sexual victimization, with rape representing one extreme behavior along a continuum of sexual activity. In order from least to most severe, this continuum includes: (a) no sexually aggressive contact: no history of sexually aggressive behavior; (b) sexually aggressive contact: the use of continual arguments, one’s authority, or physical force to coerce a woman into sex play, including fondling, kissing or petting, but not sexual intercourse, (c) attempted rape: the use of physical force, alcohol, or drugs to attempt sexual intercourse with a woman, but intercourse did not occur, (d) sexual coercion: the use of authority, continual arguments and pressure to compel a woman into sexual intercourse, and (e) rape: the use of alcohol, drugs, or physical force to coerce a woman into sexual intercourse, including anal and oral sex.

Similar to previous research in The Laboratory for the Study and Prevention of Sexual Assault at Ohio University, the current study plans to assess a broad spectrum of
experiences of sexual victimization, according to the definition of Koss and Oros (1982). Sexual victimization before age 14 will be considered to be experiences of childhood sexual victimization, and sexual victimization from the age of 14 on will be considered to be experiences of adolescent victimization. Similar to previous evaluation of the Ohio Sexual Assault Risk Reduction Program (e.g., Gidycz et al., in press; Gidycz, Lynn et al., 2001), the five levels of sexual victimization as identified by Koss and Oros (1982) will be classified into three levels in order to allow for more statistical power. These levels include none, moderate (i.e., sexually aggressive contact, attempted rape or coercion), or severe (i.e., a rape experience). Experience of victimization will be classified according to the most severe victimization experience identified. Incidence of revictimization will also be assessed.

Methods of Estimating Prevalence

The diverse classifications of what constitutes sexual victimization have resulted in an array of incidence and prevalence rates, making it difficult to determine the precise extent of sexual violence against women. Moreover, both intentional and unintentional non-reporting of sexual violence poses a serious threat to the estimation of incidence and prevalence rates of sexual victimization (Koss, 1993). In fact, 42% of college women in a nationally representative sample indicated on a survey that they had never disclosed an incidence of sexual victimization (Koss et al., 1987). Therefore, as researchers, it is vital to utilize specific and sensitive, yet subtle measures of screening for victimization experiences.

general United States population that met the legal definition of rape (FBI, 2002b). However, this national estimate includes only those cases reported to the police or other authorities, and may therefore severely underestimate the nationwide incidence of sexual victimization (Koss, 1993). Many victims of unwanted sexual experiences do not identify the experience as sexual victimization, and even if the act is perceived as such, the victim may not report the crime to the police (Kilpatrick, Edmonds & Seymour, 1992).

Because estimates of sexual victimization from studies of undergraduate women do not rely solely on criminal and police records, the estimates of incidence rates of sexual victimization of college women may be more accurate than those provided by the FBI. A prospective study of a national sample of 3,187 college women reported an incidence rate of 353 rapes during a 12-month period (Koss et al., 1987). Similarly, in a recent study of undergraduate women at Ohio University, 16% of participants (n=65) reported moderate to severe cases of sexual victimization over a 3-month interim (Gidycz et al., in press).

Prevalence of sexual victimization. Efforts to establish the prevalence of sexual assault—the measure of overall occurrence throughout the lifespan—are similarly plagued by low reporting rates and the differing definitions of what constitutes sexual victimization. Thus, some researchers have conducted prevalence studies at the national and local levels in order to develop more accurate prevalence rates that include women who do not report an experience of sexual assault to the police. For example, from 1995 to 1996, a random national sample of 8,000 women, age 18-and older, participated in the National Violence Against Women Survey, which was conducted via phone interviews
According to this survey, 18.1% of the respondents reported an attempted or completed rape at some point in their lives (Brecklin & Ullman, 2002).

In a survey of 2,016 undergraduate women, 13% of participants reported an experience that met the legal definition of rape (Koss & Oros, 1982). Moreover, in a national study of university students, Koss and colleagues (1987) found that 53.8% of women reported some form of sexual victimization after the age of 15, including sexual contact (14.4%), sexual coercion (11.9%), attempted rape (12.1%), and rape (15.4%). Overall, 27.5% of college women in this study reported experiencing an act that was legally defined as rape or attempted rape at some point during their lives.

Given that experiences of sexual victimization tend to be reported more frequently when surveyed than reported directly to the police, the current study will examine the incidence and prevalence rates of sexual victimization through survey. Incidence of sexual victimization will be measured over a 2-month and 4-month interim, and prevalence rates of experiences of adolescent sexual victimization will be assessed from the age of 14.

**Risk Factors for Sexual Assault**

Perhaps the most vital aspect in the development of sexual assault risk reduction programs is the understanding of the specific factors that may put a woman at risk for sexual victimization. Five areas have been explored as specific risk factors for future victimization and each has important implications for the development of risk reduction programs.
Past History of Victimization

In both retrospective and prospective analyses, past history of victimization is consistently established as the strongest predictor of future victimization within college populations (Gidycz, Coble, Latham, & Layman, 1993; Gidycz, Lynn et al., 2001; Koss & Dinero, 1989), community samples (Wyatt, Guthrie, & Notgrass, 1992) and clinical populations (Stermac, Addison, & Millar, 2002). Gidycz and her colleagues (1993) suggested that women with victimization histories are between 2 to 3 times more likely to experience victimization than women without a history of sexual victimization. Similarly, telephone interviews with 3006 adult women in a nationally representative sample revealed that women with past victimization experiences were more than 7 times more likely to experience rape than women without past victimization experiences (Acierno, Resnick, Kilpatrick, Saunders, & Best, 1999).

Although researchers are currently working to more effectively understand the cognitive, emotional and behavioral processes that put victims of assault at greater risk for revictimization, the precise mechanisms that increase risk are unclear (see Gidycz, Loh & Lobo, in press). Some studies suggested that poor psychological adjustment following victimization—such as increased anxiety and depression may contribute to increased risk for revictimization (Gidycz et al., 1993). Other studies however, fail to corroborate a link between psychological adjustment and revictimization (Gidycz, Hanson & Layman, 1995; Sorenson, Seigel, Golding, & Stein, 1991). Similar inconsistencies exist in research examining a possible link between early victimization experiences and ability to recognize threatening dating situations (Breitenbecher, 1999;
More research is necessary in order to understand the link between the consequences associated with sexual victimization, risk perception and subsequent victimization.

**Alcohol Use**

Alcohol use is consistently associated with experience of sexual victimization, severity of victimization, and completed rape (Abbey, Ross, McDuffie, & McAuslan, 1996a; Koss et al., 1987; Ullman, Karabatsos, & Koss, 1999). For example, Ullman and colleagues (1999) reported that more severe assaults were associated with women who were frequent drinkers as opposed to women who consumed alcohol less frequently. Severity of alcohol use also appears to be associated with a history of victimization (Brener et al., 1999). In a recent prospective study of 372 undergraduate women, revictimization during a 2-month interim was moderated by alcohol use (Gidycz, Loh, Lobo, Rich, Lynn, & Pashdag, in press). For example, women with a history of severe sexual victimization who reported heavy drinking habits were more than ten times more likely to experience sexual victimization than women with no history that were light/non drinkers (Gidycz Loh et al., in press).

The precise nature of alcohol use as a risk factor, or ramification of sexual victimization remains unclear. It is also possible that alcohol use maintains a reciprocal relationship with sexual victimization. Testa and Livingston (2000) suggest that sexual victimization experiences do not predict future binge drinking. Conversely, research by Kilpatrick, Acierno, Resnick, Saunders and Best (1997) with a nationally representative sample of 3,006 community women found that sexual victimization increased alcohol and drug use among participants over a 2-year follow-up. However, in analyses exploring
the role of substance use in predicting future assault, Kilpatrick and colleagues (1997) found that drug use, but not alcohol abuse, increased the likelihood of sexual victimization over the 2-year period. As such, results indicated only a reciprocal relationship between drug use and sexual victimization (Kilpatrick et al., 1997).

Thus, although the precise relationship between alcohol use and sexual victimization remains unclear, there is a breadth of evidence to suggest that alcohol use places women at greater risk to experience sexual victimization. Alcohol’s association with sexual victimization may occur through a number of different pathways, such as altering women’s own perceptions of risk, heightening a woman’s risk to be targeted for victimization, or mediating her ability to effectively resist. Nurius (2000) posits that expectancies of reduced social inhibition when consuming alcohol lead to decreased risk perception of potentially risky situations and decreased intentions to respond assertively to threat. Alcohol use is also associated with decreased problem solving ability, making it less likely that a woman can act assertively in defense. Norris, Nurius and Dimeff (1996) reported that women often identified alcohol as a specific barrier to removing themselves from a sexually threatening situation. Moreover, women reported that they were less likely to use physical resistance or verbal assertiveness in response to sexual aggression when drinking (Norris et al., 1996). Norris and colleagues (1996) suggested that drinking may heighten a woman’s anxiety concerning rejection and general embarrassment over misunderstanding a coercive situation, in turn decreasing her likelihood of responding assertively to a perceived threat.

Despite alcohol’s known effects on physical coordination and problem-solving, it appears that women tend to believe that alcohol will not impair their cognitive abilities
when it comes to perceiving risky dating situations. Norris and Kerr (1993) reported that compared to sober women, women who consumed a moderate amount of alcohol perceived themselves as more likely *not to resist* when presented with a vignette scenario of sexually aggressive behavior. Further, in a study of undergraduate women, participants *consistently failed* to identify alcohol consumption as a risk factor for sexual victimization for themselves or their peers (Cue, George, & Norris, 1996). Moreover, women displayed optimistic bias regarding the effects of alcohol in decreasing their own inhibition as compared to their peers. Even when women reported alcohol as a mediator of social inhibition in their peers, they are unlikely to report alcohol as decreasing their own inhibition (Cue et al., 1996). It appears that when using alcohol, women maintain a false sense of security that they will still be aware of risky cues and be able to maintain control of their surroundings (Norris et al., 1996). These results suggest that discussion of alcohol use as mediators of decreased capacity for both risk perception and active resistance is an important component of sexual assault risk reduction programs.

Alcohol use may also make women more likely to be considered as a target for sexual victimization by potential perpetrators. First, women’s interests are more likely to be misperceived by a man when she is drinking (Abbey, Ross, McDuffie & McAuslan, 1996b). Often a woman’s use of alcohol is perceived by men as a cue that she is interested in sex, increasing the likelihood that a man will wrongly perceive signs of sexual intent (Abbey, McAuslan, & Ross, 1998; George, Stoner, Norris, Lopez, & Lehman, 2000). Similarly, research suggests that women are more likely to be perceived as willing to initiate sexual intercourse after consuming alcohol (Corcoran & Thomas, 1991). Research also suggests that women who drink in bars may also be considered
legitimate targets for sexual victimization, and more responsible for the attack (Norris & Cubbins, 1992). Thus, women who socialize in settings where drinking occurs are more likely to be in close proximity to perpetrators, and as a result, are more likely to be targets for sexually aggressive behavior (Parks & Zetes-Zanatta, 1999; Testa & Parks, 1996).

Several studies have also found evidence of the tactical use of alcohol by perpetrators. Kanin (1985) found that 76% of rapists, compared to 23% of men without a history of sexual aggression, reported attempting to intoxicate a female with alcohol in order to have sex with her. Alcohol use may also facilitate sexually aggressive behavior by weakening men’s own self-control (Muehlenhard, Goggins, Jones & Satterfield, 1991). Thus, alcohol may be used as a tactic to lessen a potential victim’s inhibition and increase the aggressor’s chances of obtaining sex.

It is clear that alcohol use has overwhelmingly important implications for the development of risk-reduction programming. Although it is overly optimistic to expect that risk-reduction programs will reduce the amount of alcohol consumed by college women, it is necessary to educate women on how to drink responsibly, and how alcohol will alter their capacity to perceive risk and react assertively. Moreover, women’s awareness of responsible drinking behaviors, intentions to drink responsibly, and practice of safe drinking behaviors can be used as measures of program effectiveness.

Situational Variables

Several situational variables in dating scenarios have been researched as potential risk factors for sexual assault. These variables include who initiates the date, which individual pays for the date, style of dress worn and location of activity after a date.
Evidence related to the importance of who initiates the date is inconclusive. Although Koss (1985) suggested that initiating a date increases a woman’s risk for victimization, Muehlenhard and Linton (1987) observed that the initiation of the date by the male, his status as the driver and his role in paying for the date were all factors associated with increased sexual aggression.

Generally, research among college populations suggested that undergraduates see sexual coercion as more justifiable when women ask men out, go to their apartments, or allow them to pay for the date (Muehlenhard, 1988). Likewise, potential perpetrators may view women who wear revealing clothing as more sexually provocative and more interested in engaging in sexual activity than those who dress more modestly (Abbey, Cozzarelli, McLaughlin, & Harnish, 1987).

The location of the assault also appears to be an important situational variable. The majority of sexual assaults take place in private locations, where the victim is more likely to be isolated and less likely to receive help (Miller & Marshall, 1987). Victimization is likely to occur while parked in a car or at a man’s residence—both locations where privacy and a sense of control may empower a man to become sexually aggressive (Muehlenhard & Linton, 1987). Miller and Marshall (1987) found that perpetrators reported sexual assaults taking place in a private house or apartment (60%), dormitory (20%), parked car (10%), or fraternity house (7%).

Researchers have also examined variation in contextual factors between stranger and acquaintance rapes. While victimization by a stranger is likely to occur when a women engages in outdoor activities with delinquent peers late at night (Lauritsen, Laub, & Sampson, 1992), acquaintance rape occurs with a perpetrator whom the victim knows
for a long period of time, and is not likely to happen on the first date (Muehlenhard & Linton, 1987). In addition, many sexual assaults occur between two individuals after they previously engage in consensual sexual activity (Ullman et al., 1999).

Given the wide range of situational variables implicated in sexual victimization, it is necessary to specifically educate women on specific scenarios that are more risky for sexual victimization. The knowledge of how situational variables contribute to a woman’s risk for sexual victimization may be the most effective area in which we can hope to see change and behavior modification among program participants. Whereas drinking behaviors may be more difficult to influence, we can give women specific knowledge on the above risk factors to enable improved perception of risk and encourage assertive responses to potential threats.

**Attitudinal and Personality Factors**

Although various studies focus on the personality or attitudes of the victim as they relate to subsequent sexual victimization, thus far, research suggests that victim attributes do not predict future victimization. Factors such as sexually conservative attitudes, low self-esteem, acceptance of adversarial beliefs or endorsement of rape myths have been suggested as possible predictive variables for sexual victimization, yet research has failed to establish a relationship between these attitudes and sexual assault (Amick & Calhoun, 1987; Forbes & Adams-Curtis, 2001; Koss & Dinero, 1989).

Whereas there may be little reason to include a discussion of the personality characteristics of women into risk-reduction programming, it is essential that women be aware of the common personality characteristics of perpetrators (Gidycz et al., 2002). A review of common characteristics of rapists by Gidycz and colleagues (2002) suggests
that perpetrators of sexual aggression display adversarial views about heterosexual relationships, endorse rape myths, support traditional sex roles, condone the use of violence against women and are more tolerant of sexual violence than men who do not perpetrate sexual aggression. In addition, research suggests that men who endorse traditional male sex role stereotypes are more likely to engage in sexual aggression than men who do not endorse such beliefs (Koss, Leonard, Beezley, & Oros, 1985). Recent prospective research by Loh, Gidycz, Lobo and Luthra (2005) examined characteristics of perpetrators of sexual aggression over a 3-month and 7-month follow-up. Results suggested that fraternity membership, adherence to adversarial beliefs about relationships, and previous perpetration of sexual violence predicted subsequent perpetration over the follow-up periods. Although not all men who hold such beliefs will perpetrate sexual assault, women may reduce their risk of sexual victimization by being aware of the common characteristics of perpetrators.

Further, the severity of sexual victimization also varies as a function of the relationship to the victim. Although sexual victimization is traditionally assumed to be committed by strangers, acquaintances or dates perpetrate the majority of sexual assaults occurring on college campuses (Koss et al., 1987). Specifically, both attempted rape and rape tend to be more violent than other forms of sexual victimization (Koss, 1989), however, steady dating partners are more likely to perpetrate acts of sexual coercion, strangers or acquaintances are more likely to perpetrate rape (Abbey, Ross, McDuffie & McAuslan, 1996).
Health-risk behaviors also appear to be associated with both the incidence and consequence of sexual victimization among women. Researchers have studied the link between sexual victimization and health behaviors such as alcohol use, drug use, age of first sexual intercourse, number of sexual partners, weapon possession and seat belt use; however, these studies lack the temporal design necessary to establish a causal link (e.g., Brener et al., 1999).

Despite the drawbacks of retrospective research designs, studies suggest that health-risk behaviors may be associated with sexual victimization. In a national survey of 2,823 college women, Brener and colleagues (1999) reported that women with single or repeated experiences of victimization were more likely to engage in health-risk behaviors than women without a history of victimization. Specifically, victims of sexual assault were twice as likely to have been in a physical fight with a spouse or boyfriend (6% vs. 3%), 1.5 times as likely to engage in drinking and driving in the 3 months prior to the survey (28% vs. 22%), twice as likely to consider suicide in the 12 months preceding the survey (19% vs. 8%), and twice as likely to smoke cigarettes (39% vs. 25%). Victims were twice as likely to have had sexual intercourse before the age of 15 (21% vs. 9%), use alcohol before the last time they engaged in sexual intercourse (22% vs. 12%), and have multiple sexual partners in the 3 months prior to the survey (Brener et al., 1999). Although these results suggested a high correlation between sexual victimization and health-risk behaviors, a prospective longitudinal design is necessary to understand the temporal relationship between victimization and health-risk behaviors (Brener et al., 1999).
Research conducted by Gidycz, Orchowski, King and Rich (manuscript under review) extended Brener and her colleagues’ (1999) methodology by assessing the relationship between a wider array of health-risk behaviors and sexual victimization over 3-month and 6-month follow-up periods. Retrospectively, a history of sexual victimization was associated with increased likelihood of a range of health risk behaviors, including heavy episodic drinking, marijuana use, suicidal ideation, the experience of physical violence, and use of diet pills, vomiting or laxatives to lose weight. In prospective analyses, health-risk behaviors failed to predict new experiences of sexual victimization, after controlling for past history of victimization and demographic characteristics. Further, prospective analyses also suggested that incidence of sexual victimization over the 3-month follow-up was not associated with increased engagement in health-risk behaviors over the 6-month follow-up.

*The Ohio University Sexual Assault Risk Reduction Program*

Over the past decade, research conducted by The Laboratory for the Study and Prevention of Sexual Assault at Ohio University has worked toward developing effective methods for reducing women’s risk for sexual assault. The development of The Ohio University Sexual Assault Risk Reduction Program (SARR) began in the early 1990’s, and has undergone study evaluation and revision on several occasions. The program aims to reduce college women’s risk for sexual victimization through the application of theoretical models of behavior and attitude change in an interactive, didactic and multimedia protocol.

Initial evaluation found the program effective in decreasing sexual assault among women without a history of sexual victimization; however, the program was not effective
for women with a history of sexual victimization (Hanson & Gidycz, 1993). The program was next modified and evaluated with information specifically relevant to survivors of sexual victimization. However, the revised program was found ineffective for women with and without a history of sexual assault (Breitenbecher & Gidycz, 1998). Through a grant from the Ohio Department of Health, the program was revised to improve the personal relevancy of the information to program participants (Gidycz, Lynn et al., 2001). Multi-site program evaluation revealed no significant differences in preventing sexual victimization at the 2-month follow-up. However, program participants who were victimized during the 2-month follow-up period were less likely to be revictimized during the 6-month follow-up than were women who did not participate in the risk reduction program (Gidycz, Lynn et al., 2001).

Through a grant from the Ohio Department of Health, the length and intensity of the program was expanded to include a self-defense component, booster session and additional multimedia presentations (Gidycz et al., in press). Specific objectives of the revised program included the addition of a feminist self-defense class, enhancement of the cognitive elaboration of program protocol, as well as the addition of an additional Booster Session for review of program material. Whereas the findings suggested that the enhanced program was not effective in decreasing a woman’s chances of being sexually assaulted over the 3-month or 6-month follow-up period, the program did appear to increase participants’ use of self-protective dating behaviors (Gidycz et al., in press).

**Program Protocol**

The Ohio University Sexual Assault Risk Reduction Program begins with a discussion of general information on the objectives of a sexual assault risk reduction
program. The rationale of the program is discussed, and women are reminded that risk reduction interventions for women are meant to reduce blame. Societal factors that foster sexual violence are also discussed.

Next, the program provides definitions of rape and sexual assault. Both national and local statistics on the frequency of sexual assault are provided. The program next moves into a discussion of the risk factors for experiencing sexual victimization. A video entitled, “I Thought it Would Never Happen to Me” (Gidycz, 1997), is shown, in which sexual assault survivors discuss their experiences. Following the video, participants are asked to discuss their reactions to the tape, focusing on the characteristics of the perpetrators and situations that might enhance risk. Large group discussion of risk factors follows. The facilitator next discusses recovery issues for victims of sexual assault.

The program continues with a facilitated discussion of strategies to employ when confronted with potentially threatening dating situation. The role of alcohol as a specific risk factor for sexual victimization is discussed. A video is shown, entitled “Keep your options open: Alternative solutions for stressful social situations” (Gidycz, 2000) and participants are asked to discuss and model risk reduction strategies. The program concludes by thanking the participants for their time and asking participants if there are any other questions they would like to discuss.

New Directions for Risk Reduction Programming

The current study aims to clarify questions raised by previous evaluation of the Ohio University Sexual Assault Risk Reduction program (Gidycz et al., in press). Considering the program’s effectiveness in increasing self-protective behaviors, it is
hypothesized that implementation of a feminist self-defense workshop was a critical component in raising women’s awareness of self-protective strategies. Although previous evaluation succeeded in providing an understanding of the program’s influence on self-efficacy and assertive sexual communication, it is unclear how the program influenced more subtle indicators of behavior change. As a result, the current study includes specific modifications to the existing risk-reduction program based on a more comprehensive and theoretically driven array of behavioral, attitudinal and cognitive variables.

Following a literature review of theories of behavior change and risk perception, two theoretical models were incorporated in the protocol: 1) theory of planned behavior (Ajzen, 1985, 1987); and 2) the transtheoretical model of change (Prochaska et al., 1992). These theories also fit well with the use of the socio-cognitive model (Bandura, 1977; Nurius, 2000) to understand processes of risk perception for sexual victimization. A brief discussion will illustrate how each of these theories attends to necessary cognitive variables and decision-making processes—both critical aspects of any behavior change program.

Theory of planned behavior. The theory of planned behavior (Ajzen, 1985, 1987) asserts that action is influenced by three factors, including: 1) beliefs about the outcome of behavior; 2) beliefs about normative expectations for a behavior; 3) and perceived control over the outcome of a behavior. Ajzen (1985, 1987) suggests that these three factors (i.e., one’s attitudes toward the behavior, the subjective norm and one’s perceived behavioral control) act together to formulate behavioral intentions, which in turn, are associated with the subsequent performance of an action. Thus, the perceived social
acceptability of a behavior, as well as one’s perceptions of the negative or positive consequences associated with performing an action, influences an individual’s decision to perform a behavior. In addition, the extent to which individuals believe they have the resources and abilities necessary to perform a given behavior will also influence their likelihood to perform a task. Given the usefulness of these concepts in understanding factors that influence the likelihood of an action, the theoretical components of the theory of planned behavior have already been utilized in preventative programming.

For example, Gray, Lesser, Quinn and Bound (1990) found that in a prevention program specifically designed to reduce risk taking intentions in college women, that behavioral intentions were significantly related to later risk-taking behaviors. Likewise, Combs-Lane and Smith (2002) used a prospective analysis to measure intention of risk-behaviors, victimization and actual engagement in risk-taking behaviors over a 6-month period. In this study, the participants’ initial intentions of engaging in risky behaviors predicted engagement in heavy drinking, illicit drug use, risky sex and exposure to potential perpetrators (Combs-Lane & Smith, 2002). Victimization experiences over the interim were significantly and positively correlated with alcohol use ($r = .46$), expected involvement in heavy drinking ($r = .27$), expected involvement in risky sex ($r = .29$) and expected exposure to potential perpetrators at initial assessment (Combs-Lane & Smith, 2002). There were no significant correlations between sexual victimization over the interim and cognitive appraisals of the positive and negative consequences of engaging in risky activities. Yet, intentions of risk-taking behavior significantly predicted sexual victimization 6-months later.
These results suggest that prospective analysis of women’s intentions of engaging in risky situations, as well as their intentions of acting assertively once in potentially threatening situations are important variables for assessing the efficacy of sexual assault risk reduction programs (Combs-Lane & Smith, 2002). Interventions must identify not just risk factors, but also the variables that affect risk perception, threat recognition and assertive response (Nurius, 2000). As intention to respond assertively may also be relative to risk perception and threat recognition, the current study updates the existing SARR program protocol to include a facilitated discussion of the importance of behavioral intent in decision making.

Cognitive appraisals are hypothesized to be important mediating factors in the process of risk detection, perception of the severity of the threat, and the decision to respond assertively. Even when women are aware of situational risk factors for sexual victimization by an acquaintance, the decision to react assertively is complicated by an array of social and cognitive variables. Researchers suggest that women often fail to react assertively in threatening situations due to cognitive appraisal processes, wherein beliefs about potential drawbacks to reacting assertively may seem to outweigh the importance of reacting assertively to potential risk cues.

For example, responding assertively to a known potential perpetrator may hold undesirable social consequences—such as rejection or embarrassment—if the potential threat is ungrounded (Cook, 1995; Nurius, 2000). According to this model, the decision to act protectively induces a cost/benefit analysis wherein the benefits must be perceived to be greater than the costs in order for the risk-reducing action to be implemented.
As a result, the SARR program was modified to include a facilitated discussion of the potential costs and benefits of self-protective behaviors. By making women more aware of their own cognitive processes of cost/benefit analysis, we hope to encourage participants to better understand their behaviors, vigilantly monitor their surroundings, question normalized dating and social scripts, trust their intuition, and engage in proactive behavior when faced with potential threats. The current study will also utilize an array of outcome measures corresponding to various areas of the theory of planned behavior, including measure of intention, actual engagement in self-protective behaviors, as well as the negative/positive consequences associated with various protective behaviors.

*Transtheoretical model of change.* As opposed to discrete models of behavior change, the transtheoretical model views change as a temporal process evolving through a series of five stages: 1) precontemplation; 2) contemplation; 3) preparation; 4) action and; 5) maintenance (Prochaska & Di Clemente, 1983; Prochaska, Di Clemente, & Norcross, 1992; Prochaska & Velicer, 1997). As a fluid model of behavior change, the transtheoretical model assumes that not all individuals are equally ready to enact program objectives. Rather, individuals’ readiness for behavior change appears to be differentially distributed across each level of change. In a study of smoking cessation, the majority of participants fell in the first three stages of change, with 40% of the smokers in the precontemplation stage, 40% in the contemplation stage and 20% in the preparation stage (Velicer, Fava, Prochaska, Abrams, Emmons, & Pierce, 1995). These distributions appear to differ across countries (Etter, Perneger, & Ronchi, 1997), and are hypothesized to differ among various other health behaviors as well.
Moreover, programs of behavior change are frequently differentially effective based on the pretreatment stage of change (Prochaska & DiClemente, 1992; Prochaska, Norcross, Fowler, Follick, & Abrams, 1992). According to researchers, stage-matched therapy interventions can have a greater impact than protocol that is orientated towards all individuals, where it is assumed that all individuals are equally ready to change (Levesque et al., 2000). Moreover, a stage-matched approach considers behavior change to be an ongoing process.

Just as many behavior change programs realize that participants may be at different stages of readiness to adopt program protocol; it is likely that women may be at different stages of readiness to enact risk-reduction strategies. This theoretical approach has two main implications for risk reduction programming: 1) acknowledging different stages of change within programming (i.e., women may be hesitant to enact self-protective strategies that are new to them) and 2) presenting self-protective strategies as a lifestyle change (i.e., maintaining vigilance in risk detection requires continual self-monitoring and is an ongoing process). For example, it is necessary for risk reduction programs to inform women that different reactions to program material are normal, and that the use of self-protective strategies might not come naturally at first. Further, risk reduction programming must encourage women to introduce risk reduction strategies into their daily routine in order to progress toward a more self-protective lifestyle. As such, the current study will employ a discussion of a moving towards a self-protective lifestyle, and will evaluate program effectiveness as a function of participants’ initial openness to enact program objectives. By exploring how personal variables and readiness to enact
program objectives interacts with program efficacy, this project will also explore possibilities for future development of stage-matched risk reduction programming.

To be clear, this stance toward identifying a woman’s readiness to enact program objectives is in no way meant to incur blame or responsibility to the victim for preventing victimization. However, while we are waiting for effective prevention programs to be developed for male-audiences, it is necessary for risk reduction programs to address ways that women can utilize self-protective strategies and reduce their risk for sexual victimization. The stage-matched approach, like current models of risk perception, acknowledges that the use of self-protective strategies and assertive responses to threat requires complex decision making processes and social vigilance. It is hypothesized that risk reduction programming can be more effective when the use of self-protective behavior is presented as a lifestyle, rather than specific strategies to employ only after detection of threat.

The use of the transtheoretical model in presenting change as an ongoing process requiring continual maintenance aligns well with recent literature addressing women’s perceptions of risk for sexual victimization. The theory of planned behavior also contains components similar to many concepts currently discussed within risk reduction literature. Specifically, these two concepts mirror Nurius’ (2000) use of the socio-cognitive model to describe the process by which women’s optimistic bias and sense of vulnerability hinders use of risk reduction behaviors. Specifically, according to a socio-cognitive model, one’s beliefs about their susceptibility to harm influence not only what that individual anticipates, but also what they later perceive as threatening and warranting active resistance (Nurius, 2000). Thus, due to this optimistic bias, women who perceive
themselves at low risk for harm may fail to reduce their exposure to potentially
dangerous situations. This concept is also utilized by Hickman and Muehlenhard (1997),
who suggest that women who the underestimate their risks for sexual victimization by an
acquaintance are less fearful of acquaintance assault, and are therefore less prepared to
prevent or protect against sexual advances if they occur. Such research is particularly
concerning given that women are more likely to experience victimization by an
acquaintance than by a stranger (Koss et al., 1987).

Further, cultural dating norms while on a date make it less likely a woman will
retrieve information on threatening cues from her long-term memory when necessary
(Nurius, 2000). Women in socializing situations are apt to be involved in cognitive
processing schemes of “entertainment” or “friendship” rather than a vigilant mode of
self-protection (Nurius, 2000). Threatening dating situations are likely to be subtle,
normalized, ambiguous and therefore ignored, it is likely that women misperceive many
of the cues that are necessary to detect the escalation of a date from casual conversation
to sexually threatening behavior.

Taken together, women’s tendency to underestimate their risk for acquaintance
assault, adhering to social scripts and dating expectations often outweigh the importance
of maintaining personal safety (Nurius, 2000). Thus, Nurius (2000) suggests it is helpful
to present the use of self-protective behaviors as a lifestyle in order to encourage
continual social vigilance as opposed to considering using self-protective strategies only
after specific detection of threat.

For example, Nurius (2000) compares vigilant threat detection and assertive
response to the task of maintaining a low calorie diet. Although an individual might
know the importance and consequences of regulating their diet, they may discard this knowledge and act in unhealthy ways—such as eating a brownie—due to the seeming harmlessness of the “offender” as well as the continual hardship of constant dieting. According to Nurius, detecting risky dating situations and in turn deciding to react assertively requires a commitment to vigilance and self-monitoring. Yet, maintaining social vigilance may require women to reevaluate their current behaviors and reshape their social habits—a task many young women may find difficult to do (Nurius, 2000). As such, it is necessary for prevention programming to stress the subtly of situational variables that lead to threatening dating situations, and reiterate the need to trust one’s intuition even when in seemingly “familiar” situations.

This research was incorporated into the current program’s use of the transtheoretical model in presenting risk detection as an ongoing lifestyle change. Using concepts from Nurius’ (2000) research within the transtheoretical model, program revisions not only acknowledged women’s hesitancy to utilize new self-protective behaviors, but also discussed the various social barriers that limit the use of protective tactics and resistance strategies. In doing so, the program protocol attempted to avoid instilling too much fear in participants so that women’s self-efficacy in utilizing an assertive response was diminished.

*Rationale for the Current Study*

Although focusing such preventative programming with women—who are the overwhelmingly majority of victims of sexual assault—will not prevent the demonstration of sexually aggression by men; it is necessary to provide women with effective strategies to respond to potential threats. Given this attention to the two
aforementioned models—*theory of planned behavior* and the *transtheoretical model of change*—the modified program includes discussion of the role of intentions of engaging in risky and self-protective behaviors, as well as discussion of the role of positive/negative appraisals in decision making. Likewise, the modified program addresses the concept that not all individuals may be equally ready to enact program objectives (Levesque et al., 2000), and encourages women to gradually integrate program objectives into their daily lives, so that assertive communication and self-protective behaviors can become a part of their lifestyle.

**Focus Groups**

Two series of focus groups were utilized to evaluate potential revisions to the Ohio University Sexual Assault Risk Reduction Program. The first sets of focus groups were used to gather information on potential improvements to program protocol, and the appropriateness of proposed measures. The second series of focus groups was utilized to gather information on proposed instruments. All focus group sessions were held in classrooms in the Department of Psychology and were conducted in groups with a minimum of 4 women, but no larger than 10 women. All participants were given one experimental credit point for participation. Demographic characteristics of participants are provided in Table 1. Focus group protocols are provided in Appendix F-1 and Appendix F-2.

**Phase I: Measure development and discussion of program protocol.** Two focus groups were conducted during phase one of program revision. The focus group discussed three topics. First, the group provided feedback on the appropriateness of including the transtheoretical model in the program. Specifically, participants discussed
their reactions to talking about “readiness for change” within a sexual assault risk reduction program. Participants also provided feedback on a measure designed to identify stages of change in their own use of self-protective behaviors.

Second, the group discussed the pros and cons of reacting assertively to risky dating situations (see Nurius, 2000). This feedback was used to revise program protocol to include a facilitated discussion of the pros and cons of reacting assertively to potentially risky dating scenarios. Feedback on pros and cons of assertive response was also used to create a measure for later use in program evaluation.

Finally, participants were asked to view a video utilized in previous sessions of the Ohio University Sexual Assault Risk Reduction Program, entitled "Keep Your Options Open: Alternative Solutions for Stressful Social Situations" produced and directed by Christine A. Gidycz & Colleagues. The film depicts several types of risky dating scenarios and options for assertive response. In the risk reduction program the video is introduced by asking participants to think about what they say when they come face to face with a man who is engaging in behaviors that make them feel uncomfortable. During each scenario, the tape is stopped at various points, and participants are asked to discuss ways to handle the situation, and to brainstorm options and strategies they might use if they found themselves in an uncomfortable situation.

Focus group participants viewed each scenario, and were then asked to discuss the strengths and weakness of the video, and provide feedback on how these scenarios can be made into a series of vignettes. Participants were asked to note any features of the scenario that would be important to include in a vignette. Following this exercise, participants also discussed the appropriateness of using vignettes in the revised program.
Overwhelmingly, participants noted that the video was preferred to vignettes. While watching the video, participants also commented on the pros and cons of each strategy used, and provided feedback on whether or not it was helpful to talk about what might prevent them from using various self-protective strategies.

Following completion of the focus groups, participants’ responses were analyzed for any trends. Because this was an exploratory study, no specific hypotheses were tested. Instead, content analysis was used to develop themes that informed revision of the program protocol and development of the measures.

**Phase II: Piloting of the measures and revised program evaluation.** During phase two of program revision, participants’ feedback from phase one of program revision was utilized to create a series of measures corresponding to the theory of planned behavior and the transtheoretical model of change. Following creation of the instruments and protocol, a second series of focus groups were run to assess the validity of the measures and revised program protocol. Next, the second set of focus groups were introduced to the revised program protocol, and asked for feedback regarding the clarity of the material, its appropriateness and its personal relevancy. Following completion of the focus groups, participants’ responses were analyzed for any trends. Because this was an exploratory study, no specific hypotheses were tested. Instead, content analysis was used to develop themes that informed revision of the program protocol and development of the measures.

**Conclusions.** The following conclusions were drawn from the focus groups and were utilized in specific revisions of the program: 1) discussion of concepts associated with the theory of planned behavior and the transtheoretical model of change are
appropriate for discussion in the program as long as theoretical terminology is avoided (i.e., integration should be subtle and should utilize basic terminology); 2) measures should expand the definition of “dating partner” to include other various social situations in which college students encounter potential partners; 3) the scenarios in the video, “Keep Your Options Open: Alternative Solutions for Stressful Social Situations” mirror the ambiguity in many risky dating situations. Creation of vignettes would not allow for such subtlety (i.e., the video should remain in the program with future studies focusing on how to update the video); 4) discussion of pros and cons should be incorporated into the video in order to plan potential responses to threatening situations; 5) discussion of “readiness” to enact program protocol should be at the end of the program in order to decrease likelihood that students who are hesitant to enact the protocol feel uncomfortable.
## Table 1

**Focus Group Participant Demographics**

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Specific Program Revisions

Revisions to program protocol included statements regarding participants’ intentions, considerations for inhibiting factors for self-protective behavior, motivating factors to engage in self-protective behaviors, the consideration of a stage-matched approach to risk-reduction, as well as statements regarding self-protective behavior as a lifestyle.

According to the theory of planned behavior, the modified program protocol incorporated various statements encouraging participants to consider behavioral intentions for both engaging in risky as well as self-protective behaviors. To introduce the idea of the role of cognitive processes in decision-making, the program notes, “It is important that we think about how we might respond in these situations, and what factors might prevent us from following our instincts. By understanding our own thought processes and behaviors, we are more likely to identify potentially risky situations, and react with confidence.” Given the complex cognitive and social variables involved in making the decision to engage in assertive and self-protective behaviors, the program also addressed the ambiguity of dating scenarios in order to encourage a more ongoing sense of risk detection. For example, the revised program notes: “Risky dating scenarios are rarely clear-cut. The cues may be very ambiguous that a dating situation is moving from friendly to dangerous. Because the cues in a potentially threatening dating situation are often quite ambiguous, women may often decide not to react assertively, and disregard potential warning signs.” The modified program also incorporates more general statements regarding the importance of behavioral intention, such as “Understanding how you intend to act can help prevent from second guessing yourself.”
when faced with a potentially risky situation”, or statements such as, “Often when you have a plan for how you might react in a potentially threatening situation, you can be confident in your response.”

Another component of the theory of planed behavior is the consideration of the pros and cons of engaging in a behavior. As such, participants were encouraged to brainstorm factors that might inhibit them from engaging in self-protective behaviors. For example, the modified program notes: “There may also be perceived drawbacks to reacting assertively. For example, some worry that they will feel embarrassed if they respond assertively to a potential perpetrator if the threat is ungrounded. Women may be especially reluctant to acting assertively when the situation involves someone they know. Can anyone think of other factors that might inhibit you from responding assertively in this situation?” Each self-protective strategy presented in the video, “Keep Your Options Open: Alternative Solutions for Stressful Social Situations” produced and directed by Christine A. Gidycz & Colleagues” was followed with a discussion of the potential benefits and drawbacks to each strategy. For example, the program facilitator asked participants, “What do you have to lose in this situation? Take a minute and think how you might be feeling in this situation, and how you might react. What are some of the benefits to using each of the strategies? What might be a reason that would inhibit you from reacting assertively in this situation?” The program also reinforces the importance of a cost/benefit analysis of the pros and cons in decision-making at the end of the video discussion by stating, “Understanding the benefits to reacting assertively helps us to take the warning signs of a potentially threatening dating situation”. 
The revised protocol also incorporated statements grounded in the transtheoretical model of change that discussed how some individuals may feel reluctant to enact program suggestions depending on their particular “stage of change.” Participants are informed that some of the information that they hear in the program may be unfamiliar or shocking to them, and that they may have strong emotions or resistance to the information. The stage-matched model also encouraged participants to think of the adoption of self-protective behavior as an ongoing process. As such, the modified program concludes with a brief statement regarding the process of utilizing self-protective strategies in a daily routine: “We’ve covered a lot of material today. Some of the information may have been new to you. However, it is likely that some of you may have been thinking about the various risk factors and ways to react assertively when faced with a potentially threatening situation. Some of you may already be trying to implement self-protective behaviors in your daily routine.” The discussion of different levels of readiness to enact program objectives continues by stating, “Using these self-protective strategies isn’t easy or simple. Like any part of our life-style, engaging in self-protective behaviors and utilizing an assertive communication style are behaviors that might not come naturally at first. So, it is normal if you feel hesitant to engage in some of the strategies we talked about today.” Similarly, the program suggests, “Adopting these protective strategies will be an ongoing process.” For example, the modified protocol reminds participants: “We encourage you to think about how best to introduce the program material into your lifestyle. When individuals plan ahead and intend to engage in certain behaviors, they are more likely to react quickly and confidently in risky situations.”
Another component relating to women’s readiness to change was their current perception of vulnerability to sexual victimization. To address optimistic bias, which may prevent women from responding assertively to potential threats the modified program states, “Before we go on, we should note that women often tend to underestimate their risks for experiencing unwanted sexual advances by someone she knows. Therefore, women may be less prepared to protect against sexual advances if they occur. However, women are more likely to experience sexual victimization by an acquaintance than by a stranger. It is important to trust your intuition, even during situations that may seem familiar to you.” It is notable, that program revisions most often incorporated components of a stage-matched approach as well as discussion of behavioral intent. The objective of such statements was to encourage participants to plan ahead and anticipate potentially risky scenarios in order to feel more confident using resistance tactics if necessary.

**Control Group Intervention**

The control group protocol is entitled “Evaluation of Health Interventions for Women: A Peer-Based Vaccine Preventable Disease Education and Awareness Program” (VPD). A team of undergraduate researchers with specific interests and experience in the development of peer-based educational health programming was recruited to design and implement the control group program. Holly Raffle, a part time instructor in Ohio University’s Department of Psychology and a doctoral student in the Department of Education, supervised the group.

Due to the association of sexual victimization with a variety of health risk behaviors, it is vital that the control group intervention share no overlapping features or
content areas similar to the sexual assault risk reduction program protocol. For example, due to the role of alcohol as a significant risk factor for sexual victimization, a health intervention on alcohol awareness would threaten the validity of any conclusions made on the efficacy of the sexual assault risk reduction program on reducing incidence of sexual victimization. Thus, the VPD program was an ideal intervention to compare the SARR intervention against, because its subject area in no way overlaps with the content of the SARR program.

In addition, a literature revealed a dearth of health interventions on vaccine preventable diseases specifically tailored to college women or college students in general. For example, several peer oriented programs for college students exist focusing on HIV/STI (Bauman, 1993; Dark, 1996; Nokes, 1996; Reeder, Pryor, & Harsh, 1997; Ritchie & Getty, 1994), rape awareness (Caron, 1993), nutrition (Gates & Kennedy, 1989; Kessler, Gilham, & Vickers, 1992; Kunkel, Bell, & Luccia, 2001) general wellness (Carey, 1984), and breast self-examination (Maurer, 1997); however no peer-oriented VPD educational programs existed in the literature. Other studies exist for training immunization recruitment programs for the general population (Brimberry, 1988; Cates, 1990; Dickey & Petitti, 1992; Hutchison & Shannon, 1991; Lukasik & Pratt, 1987). Moreover, several programs exist for general training on vaccine preventable diseases for clinicians (Bluffington, Bell & LaForce, 1991; CDC, 2000; Crouse, Nichol, Peterson, & Grimm, 1994; Klein & Adachi, 1986; Margolis, Lofgren & Korn, 1988), the elderly (Bloom, Bloom, Krasnoff, & Frank, 1988; Nicholson, Wiskella, & May, 1987; Rodriguez & Baraff, 1993), and nurses (Black, Ploeg, Walter, Hutchinson, Scott, & Chambers,
taiored to college students was located during the literature review.

Given the importance of students being aware of VPD’s and the vaccines available to them, the control group intervention served to fill an important gap in existing health education programming. Overall, the VPD educational program is designed to help students make more informed choices concerning vaccination. Objectives of the VPD program included 1) participants will identify the complications of the different vaccine preventable diseases; 2) participants will describe how vaccines work; 3) participants will distinguish between the positive and negative effects of a vaccine; 4) participants will describe how different diseases are transferred; 5) participants will name methods of general disease prevention; 6) participants will define immunity; 7) participants will recall the names of vaccine preventable diseases.

The VPD intervention was evaluated through focus groups in the spring and summer of 2004. This pilot study consisted of a formative evaluation (Tuckman, 1999) of the program, in which participant performance on the program’s objectives was collected and evaluated. The results of the focus groups provided insight into necessary changes in the wording of measures, as well as potential areas of question for program content. Participant feedback was utilized in the formulation of the finalized VPD program.

Specific Aims

The current research implements revision to the Ohio University Sexual Assault Risk Reduction Program according to two theoretical models of behavior change. One objective of the current research was to examine how these updates influenced the effectiveness of the program compared to the previous risk reduction program. Beyond
the specific modifications of the existing program, the aims of the current research also included gaining a more comprehensive analysis of behavior and attitude change among program participants through several updates to evaluation methodology. Through the use of a wide range of measures corresponding to the program’s theoretical models of behavior and attitude change, this study aims to gain a better understanding of the more subtle effects of sexual assault risk reduction programming. Second, through a summative evaluation process, the current study compares the efficacy of the sexual assault risk reduction program to another theoretically-driven health intervention for college women. Finally, through the use of a survey manipulation design during the assessment of experience of sexual victimization, the current study aimed to tease out the influence of increased knowledge of the definition of sexual victimization on reporting behaviors. Specific aims and hypotheses of the current research are listed in Figure 1 and Figure 2, respectively.
Specific Aims of the Current Study

**Aim 1:** To extend and enhance the risk-reduction program developed in The Laboratory for the Study and Prevention of Sexual Assault at Ohio University as determined by feedback from participants, outcome analyses, and theoretical concepts.

**Aim 2:** To determine, in a prospective design, the effectiveness of the risk reduction program relative to another health intervention in reducing rates of victimization in the program group over a 2-month and 4-month follow-up period.

**Aim 3:** To determine the modified program’s impact on self-efficacy, assertive sexual communication and self-protective behaviors relative to the previous program.

**Aim 4:** To extend the measurement of program effectiveness to include more subtle indicators of change according to the socio-cognitive theory, transtheoretical model of change, and theory of reasoned action.

**Aim 5:** To assess program efficacy as a result of participant readiness to enact program objectives in order to conceptualize future research in stage-matched risk-reduction programming.

**Aim 6:** To determine the program’s impact on reporting incidence of sexual victimization on a survey and to the police.
Specific Hypotheses of the Current Study

**Hypothesis 1:** It is hypothesized that the risk reduction group will evidence lower rates of sexual victimization after the intervention relative to the control group.

**Hypothesis 2:** It is hypothesized that the risk reduction group will evidence greater self-protective behaviors and increased assertive communication after the intervention compared to the control group.

**Hypothesis 3:** It is hypothesized that the modified program will evidence greater self-protective behaviors and increased assertive communication relative to previous implementation of The Ohio University Sexual Assault Risk Reduction Program (Gidycz et al., in press).

**Hypothesis 4:** It is hypothesized that the risk reduction group will evidence progression in readiness to enact program objectives relative to the control group.

**Hypothesis 5:** It is hypothesized that the risk reduction group will evidence greater positive appraisals of self-protective behaviors and fewer negative appraisals of self-protective strategies following program participation, over a 2-month and 4-month interim, relative to the control group.

**Hypothesis 6:** It is hypothesized that the risk reduction group will evidence increased rates of reporting incidence of sexual victimization on a survey and to the police, over a 2-month and 4-month interim, relative to the control group.
Participants

Participants in this study consisted of 279 women undergraduate students at Ohio University. Data from 1 participant was incomplete, and excluded from analyses. As such, results included data from a total of 278 participants. Of the 278 women who completed the first survey, 89.9% (N= 250) returned for the 2-month follow up. Of these 250 women, 129 returned for the 4-month follow-up (51.6%). Logistic regression analyses suggested that group membership or history of adolescent sexual victimization did not predict return rates at the 2-month follow-up. A second logistic regression suggested that group membership, history of adolescent victimization, or sexual victimization over the 2-month interim did not predict return rates at the 4-month follow-up.

Participants were enrolled in psychology courses and had the choice of volunteering to participate in psychology experiments or write a brief summary of a journal article in exchange for credit applied toward their course grade. Students volunteered for participation through the online experiment scheduling system. Participants were recruited in the Fall of 2004 and the Winter 2005. Chi-square analyses revealed no significant differences between treatment and control conditions in the participants’ age, academic rank, race or ethnicity, family income, past participation in a self-defense program, past participation in a risk reduction program, or history of adolescent sexual victimization. A series of independent measures t-tests revealed no significant differences between treatment and control conditions in the participants’ baseline scores on outcome measures, with the exception of baseline measures of self-
protective behavior, as reported on the Dating Self-Protection Against Rape Scale. Specifically, participants in the Vaccine Preventable Disease Peer Education and Awareness Program group reported less use of self-protective behaviors ($M=47.70$, $SD=10.58$) compared to women in the Sexual Assault Risk Reduction Program group ($M=51.25$, $SD=10.79$).

The vast majority of participants were 18- to 19-years old (92.4%, $N=257$), first or second year students (95.3%, $N=255$), and heterosexual (98.9%, $N=275$). The vast majority of participants self-identified as Caucasian (95.7%, $N=266$), 3.2% self-identified as African American ($N=9$), 0.4% self-identified as Asian ($N=1$) and 0.7% listed their race as “other” ($N=2$). All participants noted that they had never been married.

Experiences of childhood sexual victimization were reported by 16.8% ($N=47$) of respondents. Of those women reporting childhood sexual victimization, 41.3% ($N=19$) reported the most severe experience as another person showing his/her sexual organs to them against their will, 19.6% ($N=9$) reported the most severe experience as being requested to do something sexual by someone older than them against their will, 8.7% ($N=4$) reported the most experience as being coerced to show their own sexual organs to someone, 4.3% ($N=2$) and 6.5% ($N=3$) reported being fondled or touched sexually, respectively, against their will. Additionally, 10.9% ($N=5$) of the women reporting childhood sexual victimization listed their most severe experience as being coerced or
forced to touch someone else sexually, 4.3% \((N=2)\) reported experiencing attempted sexual intercourse, and 4.3% \((N=2)\) reported completed acts of forced sexual intercourse.

With regards to experiences of adolescent sexual victimization, experiences of moderate adolescent sexual victimization (i.e., unwanted sexual experiences other than rape, including forced sexual contact, sexual coercion, and attempted rape) were reported by 27.8% \((N = 77)\) of participants at pretest assessment and experiences of severe adolescent sexual victimization (i.e., rape) were reported by 12.3% \((N=34)\) of participants at pretest assessment.
Table 2

**Participant Demographics**

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<td>6</td>
<td>2.2</td>
</tr>
</tbody>
</table>
Table 2: Continued

<table>
<thead>
<tr>
<th>Number of Sexual Partners</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Zero partners</td>
<td>81</td>
<td>29.1</td>
</tr>
<tr>
<td>1 or 2 partners</td>
<td>112</td>
<td>40.3</td>
</tr>
<tr>
<td>3 or 4 partners</td>
<td>46</td>
<td>16.5</td>
</tr>
<tr>
<td>5 or 6 partners</td>
<td>14</td>
<td>5.0</td>
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<tr>
<td>7 or 8 partners</td>
<td>12</td>
<td>4.3</td>
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<tr>
<td>9 or 10 partners</td>
<td>6</td>
<td>2.2</td>
</tr>
<tr>
<td>11 or more partners</td>
<td>7</td>
<td>2.5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Number of Partners (Sexual Behavior)</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Zero partners</td>
<td>112</td>
<td>40.3</td>
</tr>
<tr>
<td>1 or 2 partners</td>
<td>112</td>
<td>40.3</td>
</tr>
<tr>
<td>3 or 4 partners</td>
<td>46</td>
<td>16.5</td>
</tr>
<tr>
<td>5 or 6 partners</td>
<td>14</td>
<td>5.0</td>
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<tr>
<td>7 or 8 partners</td>
<td>12</td>
<td>4.3</td>
</tr>
<tr>
<td>9 or 10 partners</td>
<td>6</td>
<td>2.2</td>
</tr>
<tr>
<td>11 or more partners</td>
<td>7</td>
<td>2.5</td>
</tr>
</tbody>
</table>
**Procedure**

Sessions were held in classrooms in the Department of Psychology. Session groups included no more than 20 participants. Upon arrival at the classroom, participants received a randomly ordered index card to assign them to either the control or intervention group. Participants in the SARR program participated in a total of four sessions, and participants in the VPD program participated in a total of three sessions. Experimental credit points towards general psychology research requirements were awarded for participation in the pretest assessment and program administration as well as the 2-month follow-up. Participation in the 4-month follow-up was voluntary.

Similar to previous program administration, during Session I, all program participants engaged in a 3-hour intervention program. Participants in the SARR group returned to complete a 2-hour self-defense course approximately 1-2 weeks following participation in the initial intervention (Session II- SARR). Participants in both the SARR and VPD intervention returned for a 2-month follow-up session to complete outcome measures and participate in a short “booster session” review of program material (Session III-SARR, Session II-VPD). At the 2-month follow-up all participants reported incidence of sexual victimization over the interim, changes in their vaccination status, and completed outcome measures of attitude and behavior change, allowing for the prospective assessment of program effectiveness. All participants were asked to return for a 4-month follow-up (Session III – VPD, Session IV – SARR), during which they reported incidence of sexual victimization over the interim, changes in vaccination status, and completed outcome measure of attitude and behavior change. The intervention schedule is summarized in Figure 3.
### Intervention Schedule

<table>
<thead>
<tr>
<th>Session</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Session I – SARR</strong></td>
<td>3 hours</td>
</tr>
<tr>
<td><em>Initial Session</em></td>
<td></td>
</tr>
<tr>
<td>Sexual Assault Risk-Reduction Program and pre-test assessment</td>
<td></td>
</tr>
<tr>
<td>Experimental Credit Points Received</td>
<td></td>
</tr>
<tr>
<td><strong>Session II – SARR</strong></td>
<td>2 hours</td>
</tr>
<tr>
<td><em>Self-Defense Workshop (1-2 weeks after Session 1)</em></td>
<td></td>
</tr>
<tr>
<td>Self-Defense Workshop and program assessment</td>
<td></td>
</tr>
<tr>
<td>Experimental Credit Points Received</td>
<td></td>
</tr>
<tr>
<td><strong>Session III - SARR</strong></td>
<td>2 hours</td>
</tr>
<tr>
<td><em>2-Month Follow-Up</em></td>
<td></td>
</tr>
<tr>
<td>SARR booster session and 2-month assessment questionnaires</td>
<td></td>
</tr>
<tr>
<td>Experimental Credit Points Received</td>
<td></td>
</tr>
<tr>
<td><strong>Session IV – SARR</strong></td>
<td>1 hour</td>
</tr>
<tr>
<td><em>4-Month Follow-Up</em></td>
<td></td>
</tr>
<tr>
<td>4-month assessment questionnaires</td>
<td></td>
</tr>
<tr>
<td>Participation Voluntary</td>
<td></td>
</tr>
<tr>
<td><strong>Session I - VPD</strong></td>
<td>3 hours</td>
</tr>
<tr>
<td><em>Initial Session</em></td>
<td></td>
</tr>
<tr>
<td>VPD educational program and pre-test assessment</td>
<td></td>
</tr>
<tr>
<td>Experimental Credit Points Received</td>
<td></td>
</tr>
<tr>
<td><strong>Session II – VPD</strong></td>
<td>2 hours</td>
</tr>
<tr>
<td><em>2-Month Follow-Up</em></td>
<td></td>
</tr>
<tr>
<td>VPD booster session and 2-month assessment questionnaires</td>
<td></td>
</tr>
<tr>
<td>Experimental Credit Points Received</td>
<td></td>
</tr>
<tr>
<td><strong>Session III – VPD</strong></td>
<td>1 hour</td>
</tr>
<tr>
<td><em>4-Month Follow-Up</em></td>
<td></td>
</tr>
<tr>
<td>4-month assessment questionnaires</td>
<td></td>
</tr>
<tr>
<td>Participation Voluntary</td>
<td></td>
</tr>
</tbody>
</table>

*Note. For the VPD educational program, participation involves three sessions—there is not a similar component to the self-defense seminar in the VPD program.*
Pre-test and program facilitation. At the pretest assessment the facilitator passed out the consent form (see Appendix A-1). To protect the participants’ identity, subjects identified themselves through a number attained using the Subject Number Calculation Form (see Appendix B), which cannot be linked to the participants’ identities in any way. The facilitator informed the participants of the coding procedure for the Subject Number Calculation Form and provided an example of how to complete it. Further, given the group discussion format of the program, participants were asked to sign a confidentiality statement (see Appendix A-5), ascertaining that they understood that the confidentiality their responses during group discussions could not be guaranteed.

As per previous evaluation of the SARR program, 20% of sessions were videotaped and reviewed by trained undergraduate researchers. The VPD program sustained a similar fidelity check procedure. The program facilitator informed participants when the session was being videotaped, and reminded participants that the camera would be focused only on the facilitator. Participants next completed packets of questionnaires. Following the program, videotapes were viewed by an undergraduate researcher and rated regarding the consistency of the program (see Appendix E-1, Appendix E-2). To protect the identity of the participant, participants were given a manila envelope in which to return their packet to the facilitator. Notably, a survey manipulation procedure was implemented for a random sample of pretest assessments. Specifically, approximately 50% of the sessions completed the packets as usual. The other assessment sessions utilized two separate packets of questionnaires. All attitude and knowledge measures were completed prior to program facilitation; however, assessment of experiences of sexual victimization and other behaviors was conducted following
program facilitation. This procedure was utilized to explore the association between increased understanding of the definition of sexual victimization and women’s reports of victimization experiences.

Participants in both SARR and VPD received the same packets of questionnaires at pre-test, 2-month and 4-month follow-ups. Because the SARR participants engaged in a self-defense course, they were also given follow-up assessments of the self-defense program at 2-month and 4-month follow-ups.

After completing all questionnaires, women participated in a 3-hour intervention session. Following the intervention, participants in the SARR program chose a time to attend the self-defense course. All participants were provided with a debriefing form listing campus and community resources (see Appendix A-6). The facilitator remained present in the facility for 30 minutes following the intervention to address potential concerns and the project supervisor, Dr. Christine Gidycz was available by phone during all active data collection.

Self-defense workshop. Participants in the SARR intervention group returned for a self-defense workshop approximately 2-weeks following initial pretest assessment and program facilitation. Notably, there was not a similar component for the VPD intervention. Similar processes of informed consent, and subject number calculation occurred prior to participation in the self-defense workshop (see protocol of Session I, Appendix A-2, Appendix B and Appendix A-6). Sessions were not videotaped. The principal investigator participated in the self-defense sessions, and assisted the facilitator when necessary.
The self-defense course was taught by Cheryl Cesta, who has been teaching women, children and special populations self-defense for over 20 years. Ms. Cesta also taught the self-defense workshops during previous evaluation of the Ohio University Sexual Assault Risk Reduction Program (Gidycz et al., in press). She has presented many two-hour long workshops to Colleges, groups and schools throughout Ohio, including Athens, Hocking, Washington and Pike counties. She is specially trained regarding cultural issues, individuals with special needs, individuals challenged with disabilities, and survivors of sexual abuse and assault. Cheryl holds a masters degree in community counseling from Ohio University and has counseled survivors of incest, sexual assault and domestic violence.

The self-defense workshop aims to develop the awareness and capabilities to protect oneself from unwanted sexual advances and harassment by introducing women to practical skills for effective response to strangers and acquaintances when in threatening dating situations. Five central topics are covered in the self-defense seminar: 1) awareness and body language; 2) trusting your intuition; 3) verbal responses to deter assault; 4) immediate resistance strategies (e.g. running or yelling); 5) physical self-defense techniques and vulnerable target areas. Specifically, the prevalence of acquaintance sexual assault is discussed and the facilitator addresses the need for women to be prepared to resist when in a threatening situation. Various options for assertive response when one’s safety is threatened or consent is not expressed are modeled. Women are instructed that safety, risk-reduction and self-defense include several factors: trusting one’s intuition, awareness of home, car and street safety, and utilizing assertive verbal skills and physical techniques.
Following the course, participants completed a program evaluation survey, and were provided with a debriefing text listing campus and community resources. The facilitator remained in the facility for 30 minutes following the session to address any concerns or questions. The project supervisor, Dr. Christine Gidycz was in the building or immediately available via phone during all active data collection.

**Two-month follow-up and booster session.** Similar processes of informed consent and subject number calculation occurred before participation in the 2-month follow-up session (see protocol of Session I, Appendix A-1, and Appendix B). The SARR/VPD booster program was videotaped to ensure the integrity and the consistency of the programs. As per previous evaluation of the SARR program, 20% of sessions were videotaped and reviewed by trained undergraduate researchers. The program facilitator informed participants when the session was being videotaped, and reminded participants that the camera would be focused only on the facilitator. An undergraduate researcher viewed the tapes and completed a fidelity check form rating the consistency of the program (See Appendix E-3 and Appendix E-4).

Participants in the VPD and SARR program received the same packets of questionnaires; however, only participants in the SARR program received questionnaires to evaluate the self-defense program. Following completion of the questionnaires, participants in both the SARR and VPD program participated in a short booster session (See Appendix D-3 and Appendix D-4). The booster session consists of facilitated discussion of program material, similar to previous program implementation (Gidycz et al., in press). Three questions were asked regarding the use of risk reduction and self-
defense skills over the interim, and participants were given a handout upon which to list their answers.

At the end of the booster session, all participants were given a debriefing form that lists campus and community resources in case concerns arise (Appendix A-6). The program facilitator remained in the facility for 30 minutes following the session to address any concerns or questions and the project supervisor Dr. Christine Gidycz remained in the building or was available by phone during all active data collection. Two experimental credit points were provided to participants for completing the booster session.

*Four-month follow-up assessment.* Due to the time-period of the 4-month follow-up, participants’ were not eligible to receive experimental credit points. As such, participation in the 4-month follow-up was voluntary. Similar processes of informed consent, and subject number calculation occurred before participation in the follow-up (see Session I, Appendix A-4, Appendix B). Participants did not complete a confidentiality agreement at the assessment session. Following completing the questionnaires, participants received a debriefing form, and left their contact information if they were willing to be contacted to participate in follow-up studies in the future (See Appendix A-7, Appendix A-8). See Figure 4 for a summary of the timeline of the proposed study.
Figure 4

**Timeline**

<table>
<thead>
<tr>
<th>Time Period</th>
<th>Conduct Ratings of Program Facilitation</th>
<th>Data Entry and Analysis</th>
<th>Cohort 1</th>
<th>Cohort 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beginning of Fall Term 2004</td>
<td>X</td>
<td>X</td>
<td>Pretest and Intervention</td>
<td>Pretest and Intervention</td>
</tr>
<tr>
<td>End of Fall Term 2004</td>
<td>X</td>
<td>X</td>
<td>2-month follow-up and booster session</td>
<td>2-month follow-up and booster session</td>
</tr>
<tr>
<td>Beginning of Winter Term 2004</td>
<td>X</td>
<td>X</td>
<td>4-month follow-up</td>
<td>4-month follow-up</td>
</tr>
<tr>
<td>End of Winter Term 2004</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Beginning of Spring Term 2004</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>End of Spring Term 2004</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Note: Participants were randomly assigned to either the Risk Reduction Group or the Vaccine Preventable Disease Intervention group in each cohort.*
Measures

Measures utilized in this study correspond to those previously implemented in evaluation of the Ohio University Sexual Assault Risk Reduction Program (e.g., Gidycz et al., in press), exploratory measures corresponding to theories utilized in program revisions, and measures corresponding to evaluation of the control group intervention. See Table 3 for a list of all variables and measures.

Demographics Questionnaire (Appendix C-1). This is a brief questionnaire used to collect relevant personal information regarding basic participant characteristics such as age, ethnicity and race, religious background, and sexual orientation.

Drinking and Drug Habits Questionnaire (Collins, Parks & Marlatt, 1985; Appendix C-2). This questionnaire was taken from a general information questionnaire used by Collins, Parks and Marlatt (1985), and it is used to measure the quantity and frequency of substance use behaviors. Only a select amount of questions were used to capture a sum of weekly drinking behaviors, history of problem drinking behaviors and patterns of drug usage. The average daily alcohol consumption subscale of this questionnaire demonstrates good reliability when compared to a daily self-report measure of alcohol use (r = .86; Collins, Koutsky, Morsheimer, & MacLean, 2001). The problem drinking substance of this questionnaire is significantly correlated to another measure of problem drinking behavior (r = .61, Collins & Lapp, 1992).

Childhood Sexual Victimization Questionnaire (Finkelhor, 1979; Koss & Risin, 1987; CSVQ; Appendix C-3). This self-report measure consists of 13 items designed to assess childhood sexual victimization experiences. Participants answer “yes” or “no” to indicate whether they have had certain sexual experiences. Participants who indicated
that they had any of these sexual experiences completed a series of three questions, which ascertain relationship to the people involved, the age of the other person involved and the main reason why the woman participated in the experience. Sexual abuse is classified based on the criteria utilized by Risin and Koss (1987). For the purpose of this study, any participant noting a sexual experience before the age of 14, with a person 5 years or older than the individual, and/or where some form of coercion was used to obtain participation of the individual (e.g., use of power or authority, physical force, gifts, threats); and/or the other person was a caregiver or authority figure (e.g., parent, uncle, grandparent, babysitter) will be classified as sexually victimized in childhood. This definition is consistent with other researchers of childhood sexual victimization (e.g., Briere & Runtz, 1987; 1988). Evidence for the concurrent validity of the Childhood Sexual Victimization Questionnaire is demonstrated in research by Risin and Koss (1987). In this study, 15 males completed the CSVQ and were interviewed regarding their victimization experiences. Results indicated that 93% of the participants provided the same description of childhood sexual experiences during the interview as was indicated by self-report.

*Sexual Experiences Survey (Koss & Oros, 1982; SES; Appendix C-4).* The Sexual Experiences Survey is designed to identify the victims of sexual assault through a series of 10 sexually explicit questions, in which the respondent assesses her past sexual behavior along a variety of dimensions. The participant simply responded “Yes” or “No” to the items in a self-report format. This measure is used to acknowledge sexual assault experiences, even if the victim is unaware that the experience may be classified as sexual victimization. Experiences of sexual victimization from the age of 14 on are assessed
using the Sexual Experiences Survey as well as experiences of subsequent sexual victimization over the follow-up periods. Several questions were added following each item on the Sexual Experiences Survey for the purposes of the current study. Frequency of experiences of sexual victimization was assessed, as well as the offender’s relationship to the victim before the most recent event. Finally, drug and alcohol use by both the perpetrator and the victim was determined.

Because sexual victimization exists along a spectrum of behaviors, the Sexual Experiences Survey was used to classify individuals into categories of sexual victimization history, according to the most severe experience reported. The five levels of sexual assault, in order from least to most severe, are defined as follows: (a) no history of sexual victimization (no items were endorsed), (b) unwanted sexual contact (items 1, 2, or 3): the use of continual arguments, authority, or physical force was used to coerce the woman into sex play, including fondling, kissing or petting, but not sexual intercourse, (c) attempted rape (items 4 or 5): physical force, alcohol, or drugs was used to attempt sexual intercourse with the woman, but intercourse did not occur, (d) sexual coercion (items 6 or 7): authority, continual arguments and pressure was used to compel the woman into sexual intercourse, and (e) rape (items 8, 9, or 10): alcohol, drugs, or physical force was used to coerce the woman into sexual intercourse, including anal and oral sex. Similar to prior evaluation of the Ohio Sexual Assault Risk Reduction Program (e.g., Gidycz et al., in press), the five levels of sexual victimization as identified by Koss and Oros (1982) were collapsed into three levels in order to allow for more statistical power. These levels included none (i.e., no items were endorsed), moderate (i.e., sexually aggressive contact, attempted rape or coercion), or severe (i.e., a rape experience).
The Sexual Experiences Survey demonstrates good reliability and validity, and is frequently used in research of sexual assault (Koss & Gidycz, 1985). Research by Gylys and McNamara (1996) suggested that the Sexual Experiences Survey adequately captures the legal definitions of attempted rape and rape. Koss and Gidycz (1985) provide support for the construct validity of the scale. In their study, self-report responses on the survey were found to correlate with information provided in an interview \( r = .73, p < .001; \) Koss & Gidycz, 1985). The Sexual Experiences Survey also demonstrated good internal consistency \( (\alpha = .74) \) and an excellent 2-week test-retest reliability \( (r = .93) \) (Koss & Gidycz, 1985).

**Dating Self-Protection Against Rape Scale (Moore & Waterman, 1999; Appendix C-5).** The Dating Self Protection Against Rape Scale is an index of 15 potential behaviors women may perform in order to protect themselves from situations that may put them at risk for sexual victimization. Individual questionnaire items reflect situational factors that have been shown in the literature to be related to an acquaintance rape. Participants responded via a 6-point rating scale, ranging from never to always. The survey demonstrated good reliability (Cronbach’s alpha = .86) and good split half reliability (Spearman-Brown= .81) (Moore & Waterman, 1999). Use of this scale in previous evaluation of the Ohio University Sexual Assault Risk Reduction Program (Gidycz, et al., in press) found that participants evidenced significant increases in self-protective behaviors over the interim compared to a non-treatment control group.

**Sexual Communication Scale (Hanson & Gidycz, 1993; Appendix C-6).** This measure assesses a woman’s likelihood of open sexual communication with her partner, and as an outcome measure of program effectiveness. It includes questions regarding
communication that one might engage in concerning sexual concerns, and one’s history of expressing these concerns. Research by Breitenbecher and Gidycz (1998) reported a Cronbach’s alpha for the scale of .99 and a 2-month test-retest reliability of .60.

**Sexual Assertiveness Scale (Morokoff et al., 1997).** The Sexual Assertiveness Scale is an 18-item measure which assesses the frequency on engaging in assertive behaviors during intimate situations. Higher scores indicate a greater willingness to assert one’s sexual desires and limits. There are three subscales to the Sexual Assertiveness Scale: 1) initiation; 2) refusal; and 3) pregnancy-STD prevention. Each subscale demonstrates moderately stable test-retest reliability over a 6-month and one-year interim. The correlation values between sub-scales range from .59 to .77. Construct validity is demonstrated in significant shared variance with other measures of global sexual assertiveness (Morokoff et al., 1997).

**Self-Efficacy Scale (Marx et al., 2001, Ozer & Bandura, 1990; Appendix C-7).** The Self-Efficacy Scale provides an index of an individual’s confidence that she can perform various assertive responses to threatening dating situations. The scale consists of 7 items scored on a 7-point scale ranging from “not at all confident” to “very confident” such that higher scores indicate a greater sense of self-efficacy. Internal consistency reliability of this scale was reported to be high, with a coefficient alpha of .97 (Ozer & Bandura, 1990), and the scale has been utilized to evaluate the effectiveness of other sexual assault interventions in increasing participants’ confidence in responding assertively to unwanted sexual advances (Calhoun et al., 2001).
Global Perceptions of Risk Scale (Norris, 1999: Appendix C-8). This 16-item measure is based on global perceptions of victimization and it is frequently used with women in assessing risk for sexual victimization (i.e., Breitenbecher & Scare, 2001). To be consistent with the array of sexual experiences that were defined as sexual victimization the measure was adapted to better reflect some of the behaviors targeted with the Sexual Experiences Survey (Koss & Oros, 1982). Norris’ (1999) research has assessed perception of risk for sexual victimization for the self, and in relation to other women. The current survey was modeled according to Norris’ design, and asked participants to rate if their risk for experiencing various sexual behaviors is greater than, less than, or the same as their friends. Thus, by comparing one’s perception of risk to that of their peers, a measure of optimistic bias is obtained.

Rape Attribution Questionnaire (Frazier 2002; Frazier & Seales, 1997; Appendix C-9). The Rape Attribution Questionnaire contains 25 items that assess the various attributions that victims make regarding sexual assault experience. The questionnaire pertains only to victims of sexual assault; however, it has been adapted to allow all individuals to complete the measure regardless of history of sexual victimization. The questionnaire begins with the prompt: “How often have you thought: An unwanted sexual experience would occur because...”. Individuals responded along a 5-point continuum of “never “to “very often” such that higher total scores indicate higher levels of blame. Five subscales are also utilized to explore various domains of attributions of blame, including: 1) societal blame (items: 1, 6, 11, 16, 21); 2) behavioral self-blame (items: 2, 7, 12, 17, 22); 3) characterological self-blame (items: 3, 8, 13, 18, 23); 4) chance (items: 4, 9, 14, 19, 24); 5) and rapist blame (items: 5, 10, 15, 20, 25). Early research of the subscales
revealed adequate internal consistency ($\alpha = .84$) (Frazier, 1990). Two subscales of the measure demonstrated good reliability when Frazier (2002) conducted a survey of 135 survivors of sexual victimization (behavioral self-blame = .87, rapist blame, $\alpha = .88$).

*Reporting Behavior Scale (Appendix C-10).* This measure was adapted from questions utilized in previous Ohio University Sexual Assault Risk Reduction Program (Gidycz et al., in press) to include more options for reporting behaviors (i.e., reporting to a resident advisor). This measure was utilized to assess women’s likelihood of reporting sexual victimization to various off-campus and on-campus agencies.

*Transtheoretical Measure (Nigg et al., 1998; Appendix C-11).* This measure uses a series of self-report questions assessing the 4 main program objectives of the Ohio University Sexual Assault Risk-Reduction Program: responsible alcohol use, assertive response to threatening dating situations, the utilization of self-protective behaviors, and use of open sexual communication. The structure was adapted from a standard stage of change measure developed by Nigg and colleagues (1998), consistent with Prochaska’s Transtheoretical model. This measure was intended to be exploratory in nature, and was piloted in focus groups. Individuals in the focus groups reviewed the measure for clarity, and wording was modified according to participant feedback.

Individuals were classified into one of four stage categories, according to the highest level of behavior identified. Precontemplation stage included individuals who did not intend to engage in the behavior in the next six months. Contemplation included those individuals who were not actively trying to implement program objectives, but who are seriously considering doing so in the next six months. Action stage included individuals who were actively trying to implement program material, or had done so for
less than six months. Maintenance stage included individuals who had successfully maintained program objectives for at least six months. Consistent with other measures of behavior change, piloting of the measure revealed participants in all four of the possible stages.

*Cognitive Appraisals of Self-Protective Strategies Questionnaire (Katz et al, 2000; Moore & Waterman, 1999; Appendix C-12).* This measure is adapted from the Dating Self-Protection Against Rape Scale and the Cognitive Appraisals of Risk Questionnaire (Katz et al., 2000; Moore & Waterman, 1999). Participants were asked to indicate the level of positive or negative consequences resulting from enacting each strategy. This measure was intended to be exploratory in nature, and was piloted in focus groups. Individuals in the focus groups reviewed the measure for clarity, and wording was modified according to participant feedback. Scores were summed to reflect total level of negative and positive appraisals of self-protective behavior as noted by the questions from the Dating Self-Protection Against Rape Scale. According to baseline assessments, Cronbach’s alpha for participants’ positive appraisals of self-protective behavior was .86, and Cronbach’s alpha for participants’ negative appraisals of self-protective behavior was .79.

*Behavioral Intent Measure (Katz et al, 2000; Moore & Waterman, 1999; Appendix C-13).* This instrument contains questions from the Dating Self-Protection Against Rape Scale (Moore & Waterman, 1999) and additional questions from the Cognitive Appraisals of Risk Questionnaire (Katz et al., 2000). It is intended to assess participants’ intentions to enact self-protective strategies, and alcohol use. Its format was modeled after the Cognitive Appraisals of Risk Questionnaire (Katz et al., 2000). Focus
groups reviewed the measure for clarity and the current use of the questionnaire is exploratory in nature. Scores were summed to reflect the total level of intending to engage in self-protective behaviors according to the questions from the Dating Self-Protection Against Rape Scale. According to baseline assessment, Cronbach’s alpha for participants’ intentions to engage in self-protective behavior was .82.

*Behavioral Frequency Measure (Katz et al, 2000; Moore & Waterman, 1999; Appendix C-14).* This instrument contains questions from the Self-Protective Strategies Against Rape Scale (Moore & Waterman, 1999), and additional questions from the Cognitive Appraisals of Risk Questionnaire (CARE; Katz et al., 2000). It is intended to assess frequencies of enacting self-protective strategies and alcohol use. Its format was modeled after the Cognitive Appraisals of Risk Questionnaire (Katz et al., 2000). Focus groups reviewed the measure for clarity and the current use of the questionnaire is exploratory in nature. Scores were summed to reflect the total frequency of engaging in self-protective behaviors according to the questions from the Dating Self-Protection Against Rape Scale. According to baseline assessment, Cronbach’s alpha for participants’ frequency of engaging in self-protective behavior was .99.

*Knowledge Measure: Sexual Assault Risk Reduction Program (Gidycz, et al, in press; Appendix C-15).* This measure includes information directly related to program protocol, and is designed to assess participants’ knowledge of program material. This instrument assessed baseline knowledge pertaining to sexual victimization, the learning of program material, and retention of program information over time. The instrument was not modified from prior use in program evaluation of the Ohio University Sexual Assault Risk Reduction Program (Gidycz et al., in press).
VPD Knowledge Instrument (Glencoe Mc-Graw Hill Company; Payne & Hahn, 2002; Appendix C-16). This instrument contains items designed to assess participants’ knowledge of: (a) VPD, (b) how vaccines work, (c) vaccine side effects, and (d) indications and contraindications for vaccination. This instrument established the participants’ prior knowledge of VPD and vaccination, and also assessed learning and retention over the follow-up period. Focus groups were utilized to pilot the measure. Survey items were extracted from test banks (Glencoe McGraw-Hill, Payne & Hahn, 2002).

Vaccine Preventable Disease Perceptions and Attitudes Measure (Gellin et al., 2000; Ritvo et al., 2003; Appendix C-17). This instrument contains items designed to assess participants’ perceptions and attitudes regarding VPD and vaccination. The instrument is based on the Expanded Health Belief Model (Stretcher & Rosenstock, 1997). Participants were asked to answer “yes”/ “no”/ “don’t know” to items to assess perceived susceptibility as well as indicate the level of seriousness of specific VPDs and the likelihood of contracting specific VPDs to assess perceived severity. Participants were asked to indicate their level of agreement with statements about VPDs and vaccinations to assess perceived benefits, perceived barriers, cues to action, and self-efficacy in preventing VPDs. This measure was adapted, with permission, from surveys published by Gellin et al. (2000) and Ritvo et al. (2003).

Elaboration Likelihood Model Questionnaire (Post-Program Evaluation) (ELMQ; Heppner, Humphrey, Hillenbrand-Gunn & Debord, 1995; Heppner, Neville, Smith, Kivlighan & Gershuny, 1999). The Elaboration Likelihood Model Questionnaire measures central route attitude change during program participation. The questionnaire
consists of 12 items, measured on a 5-point scale, where higher scores indicate increased central route processing. An open-ended response item was added to the questionnaire. The scale contains two factor loadings, Presentation Quality (3 items; alpha=.61), and Cognitive Involvement (8 items; alpha=.81) as noted by Heppner et al., 1999. For the purpose of the current study, two questions were revised (question #9 and question #11) to allow for more specific item analyses. One additional question was added to the survey, asking women to indicate their likelihood of recommending the program to other women. Two qualitative questions were also added to the survey to evaluate what women learned from the program, and what recommendations they had to improve the program in the future. Given the exploratory nature of the updated survey design, analyses of program evaluation utilized only the original questions provided by Heppner et al., 1999.

*Post-Self Defense Evaluation (Gidycz et al., in press; Appendix C-19).* This series of questions were used to evaluate the cognitive processing of the self-defense session.

*Follow-up Evaluation: Self-Defense (Gidycz et al., in press; Appendix C-20).* This series of questions were utilized to follow the participants’ utilization of program material from the self-defense course.
Table 3

*Proposed Variables and Measures*

<table>
<thead>
<tr>
<th>Variable</th>
<th>Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sexual Victimization in Childhood</td>
<td>Child Sexual Victimization Survey**</td>
</tr>
<tr>
<td>History of Sexual Victimization</td>
<td>Sexual Experiences Survey***</td>
</tr>
<tr>
<td>Sexual Victimization over the interim</td>
<td>Sexual Experiences Survey***</td>
</tr>
<tr>
<td>Perceived Vulnerability of Victimization</td>
<td>Global Appraisals of Risk Questionnaire***</td>
</tr>
<tr>
<td>Drinking Habits</td>
<td>Drinking and Drug Habits Questionnaire***</td>
</tr>
<tr>
<td>Vaccination History</td>
<td>Demographic Questionnaire***</td>
</tr>
<tr>
<td>Vaccine Preventable Disease Attitudes and Perceptions and Knowledge</td>
<td>Vaccine Preventable Disease Attitudes and Perceptions Instrument ***</td>
</tr>
<tr>
<td>Likelihood to Report</td>
<td>Reporting Behaviors Questionnaire***</td>
</tr>
<tr>
<td>Self-Protective Behaviors</td>
<td>Dating Self-Protective Strategies Against Rape Questionnaire ***</td>
</tr>
<tr>
<td>Assertive Sexual Communication</td>
<td>Sexual Communication Survey***</td>
</tr>
<tr>
<td>Assertive Behaviors</td>
<td>Sexual Assertiveness Questionnaire</td>
</tr>
<tr>
<td>Self-blame or Offender-blame</td>
<td>Rape Attribution Scale***</td>
</tr>
<tr>
<td>Positive/Negative Appraisals of Behavior</td>
<td>Cognitive Appraisal Questionnaire ***</td>
</tr>
<tr>
<td>Intent of Behaviors</td>
<td>Behavioral Intent Questionnaire ***</td>
</tr>
<tr>
<td>Frequency of Behaviors</td>
<td>Behavioral Frequency Questionnaire***</td>
</tr>
<tr>
<td>Readiness to Enact Program Objectives</td>
<td>Transtheoretical Measure***</td>
</tr>
<tr>
<td>Learning/Retention of Program Material</td>
<td>Learning Measure ***</td>
</tr>
<tr>
<td>Central Route Possessing</td>
<td>ELM Questionnaire *</td>
</tr>
<tr>
<td>Use of Self-Defense Strategies</td>
<td>Self-Defense Follow-up Evaluation ****</td>
</tr>
</tbody>
</table>

*Note.* *Given after Session I (VPD and SARR), **Given only at Session I (VPD and SARR) Pretest, ***Given at Session I (VPD and SARR) Pretest and Follow-ups (VPD Sessions II and III, SARR Sessions III and IV), ****Given at SARR Follow-Ups (SARR Sessions III and IV).
Results

**Dropout rates and group membership**

A hierarchical logistic regression assessed the relationship between the interaction between group membership, risk perception, engagement in risky behaviors, and return rates at the 2-month and 4-month follow-up. To predict return at the 2-month follow-up, the sum pretest score on the Global Perception of Risk Scale, adolescent sexual victimization, childhood sexual victimization, sum scores of “readiness to change” as indicated by pretest scores on the subscales of the Transtheoretical Model Measure, and group membership were entered as predictor variables in the first block. All two-way interactions between these risk variables and group were entered in the second block of predictors. Return rate at the 2-month follow-up was entered as the criterion variable. In the full model, none of the predictors significantly predicted return at the 2-month follow-up. However, the reduced model, including only the first block of predictors variables, significantly predicted return at the 2-month follow-up, $X^2(8, N = 273) = 17.47, p < .05$. In the presence of the other risk variables, group was significantly related to return rate at the 2-month follow-up, Wald $X^2(1, N = 273) = 4.69, p < .05$. Such that participants in the risk reduction program were 2.77 times more likely to drop-out of the study compared to participants in the alternative health intervention. In the presence of the other predictors, participants level of readiness to take action to reduce their risk of sexual assault was also associated with return rate at the 2-month follow-up, Wald $X^2(1, N = 273) = 6.68, p < .01$. Participants with lower levels of readiness to enact risk reduction strategies, regardless of group, were less likely to return for the 2-month follow-up than participants with higher levels of readiness to enact risk reduction strategies.
A second hierarchical logistic regression assessed the relationship between risk perception, risky behaviors, group membership, and return rates at the 4-month follow-up. To predict return at the 4-month follow-up, the sum score on the Global Perception of Risk Scale at the 2-month follow-up, adolescent sexual victimization, childhood sexual victimization, new experiences of sexual victimization over the 2-month interim, sum score of “readiness to change” as indicated by scores on the Transtheoretical Model Measure at the 2-month follow-up, and group membership were entered as predictor variables in the first block of predictors. All possible 2-way interactions between group membership and risk variables were entered as the second block of predictors. Return rate at the 4-month follow-up was entered as the criterion variable. None of the predictors significantly predicted return at the 4-month follow-up.

**Evaluation of Program Consistency**

Analyses of the process evaluation measures suggested that the program was facilitated consistently over time, from session to session as well as from fall to winter cohorts. Session I of the Sexual Assault Risk Reduction Program was facilitated 14 times. Of these, 8 sessions were evaluated according to the fidelity check form. Of the total 53 points that were evaluated on the fidelity check form, on average, the 8 sessions “hit” 51 of these points ($SD=2.82$). The total number of points “hit” during the sessions ranged from 46 to 53 points. No points were consistently missed during the facilitation of the program.

The Sexual Assault Risk Reduction Program booster session was facilitated 7 times. Of these, 4 sessions were evaluated according to the fidelity check form. Of the total 24 points that were evaluated on the fidelity check form, on average, the 4 sessions
“hit” 20.25 points in the session ($SD=0.96$). The total number of points “hit” during the sessions ranged from 19 to 21 points. No points were consistently missed during the facilitation of the program.

Session I of the Vaccine Preventable Diseases Peer Education and Awareness Program was facilitated 17 times. Of these, 10 programs were evaluated according to the fidelity check form. Of the total 55 points that were evaluated on the fidelity check form, on average, the 10 sessions “hit” 51.6 of these points ($SD=1.07$). The total number of points “hit” in the sessions ranged from 50 to 53 points. No points were consistently missed during the facilitation of the program.

The Vaccine Preventable Diseases Peer Education and Awareness Program booster session was facilitated 13 times. Of these, 6 programs were evaluated according to the fidelity check form. Of the total 42 points that were evaluated on the fidelity check form, on average, the 6 sessions “hit” 36 of these points ($SD=1.55$). The total number of points “hit” in the sessions ranged from 35 to 38. Of note, there were two points in the program that were consistently missed throughout the evaluation (Program Introduction, point 2; Program Introduction, point 16).

*Survey Manipulation*

One chi-square analysis explored the association between completing the Sexual Experiences Survey before/after program participation and subsequent reports of adolescent sexual victimization among women in the Vaccine Preventable Disease Peer-Education and Awareness Program group. A second chi-square analysis explored the association between completing the Sexual Experiences Survey before/after program participation and subsequent reports of adolescent sexual victimization for women in the
Sexual Assault Risk Reduction Program group. It was hypothesized that women in the Sexual Assault Risk Reduction group who completed the survey following the program would report higher levels of adolescent sexual victimization than those women who completed the survey before program participation. Results indicated that completing the Sexual Experiences before or after the interventions did not influence rates of reporting experiences of adolescent sexual victimization for participants in either the Vaccine Preventable Diseases Peer-Education and Awareness Program group or the Sexual Assault Risk Reduction Program group.

**Impact of the Program on Sexual Victimization and Revictimization**

*Sexual victimization during the two2-month interim as a function of participation in the risk reduction program.* A backward elimination log-linear analysis was conducted to examine the interactions between history of adolescent sexual victimization, program participation, and victimization experiences over the 2-month follow-up period. No distinction is made between independent and dependent variables in a log-linear model, allowing for the exploration of multiple possible associations between program participation, history of sexual victimization and victimization over the interim. In the backward hierarchical log-linear procedure, all potential associations between variables were included in the first model. Those associations that did not significantly degrade the model when removed were eliminated from the model. This procedure continued until the final model contained only the significant associations between variables. Subsequent chi-square analyses were utilized to explore any significant associations between variables.
With regards to the association between program participation, past experiences of sexual victimization and subsequent victimization over the 2-month interim, the best fitting model included one significant two way interaction between history of adolescent sexual victimization and sexual victimization over the 2-month interim, \( G^2 (4, N = 250) = 115.84, p < .001 \). As a significant two-way interaction was not revealed between program participation and victimization over the 2-month interim, results suggested that the program was ineffective in reducing incidence of sexual victimization during the follow-up period. Further, as no significant three-way interaction was revealed between history of adolescent sexual victimization, program participation, and victimization over the 2-month interim, results further indicated that the program was not differentially effective for women with a history of sexual victimization.

Chi-square analyses were conducted to investigate the nature of the interaction between history of adolescent sexual victimization and victimization during the 2-month follow-up period, \( \chi^2 (4, N = 250) = 136.234, p < .001 \). Approximately 12.2 \( (N = 18) \) of the women without a history of adolescent sexual victimization were victimized during the 2-month follow-up period. The majority (83.39\%, \( N = 15 \)) of those victimized reported experiences classified as moderate sexual victimization. However, of the women with a history of moderate or severe sexual victimization during adolescence (\( N = 98 \)) approximately, 69.2\% and 72.7\% respectively, were victimized during the 2-month follow up period.

Frequencies of moderate sexual victimization and severe sexual victimization among program and control group participants during the 2-month interim are listed in Table 4. Specifically, 35.2\% (\( N = 44 \)) of the control group and 34.4\% (\( N = 43 \)) of the
program group experienced moderate or severe victimization over the 2-month follow-up period.

*Sexual victimization during the four-month follow-up period as a function of participation in the risk reduction program.* A second backward elimination log-linear analysis was conducted with the women who attended the 4-month follow-up to explore the relationship between history of adolescent sexual victimization, victimization over the 2-month interim, victimization over the 4-month interim and program participation. The best fitting model included 2 two-way interactions. Significant interactions included history of adolescent sexual victimization and experience of sexual victimization during the 2-month interim, \( G^2 (4, N = 119) = 64.55, p < .001 \), and experience of sexual victimization during the 2-month interim and experience of sexual victimization during the 4-month interim, \( G^2 (4, N = 119) = 22.55, p < .01 \).

The failure to find a significant two-way interaction between group membership and sexual victimization during the 4-month interim suggested that the program was ineffective in reducing rates of sexual victimization over the 4-month follow-up period. Additionally, the failure to find a three-way interaction between history of sexual victimization, program participation, and sexual victimization over the 4-month interim, or a significant three-way interaction between sexual victimization over the 2-month interim, program participation, and sexual victimization over the 4-month interim suggested that the program was not differentially effective for women with a history of sexual victimization during adolescence or who experienced victimization during the 2-month interim.
Chi-square analyses were also conducted to explore the association between sexual victimization during the 2-month follow-up and victimization during the 4-month follow-up, $\chi^2 (4, N = 119) = 32.18, p<.001$. Of the women who experienced either moderate or severe sexual victimization during the 2-month follow-up ($N = 39$), 20.5% experienced moderate sexual victimization during the 4-month follow-up ($N = 8$), and 15.4% experienced severe sexual victimization during the 4-month follow-up ($N=6$). Of those without victimization experiences during the 2-month follow-up ($N = 80$), 7.5% experienced moderate sexual victimization during the 4-month follow-up ($N= 6$) and 1.3% experienced severe sexual victimization over the 4-month follow-up ($N = 1$).

Frequencies of moderate sexual victimization and severe sexual victimization among program and control group participants during the 4-month interim are listed in Table 4. Specifically, 20.9% ($N=14$) of the control group and 16.1% ($N = 10$) of the program group experienced moderate or severe victimization over the 4-month follow-up period.
Table 4

*Sexual Victimization Experiences as a Function of Treatment Group*

<table>
<thead>
<tr>
<th>Victimization Level and group</th>
<th>None</th>
<th>Moderate</th>
<th>Severe</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
<td>N</td>
</tr>
<tr>
<td>Adolescent Sexual Victimization</td>
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<td></td>
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<tr>
<td>Exp (N=145)</td>
<td>90</td>
<td>62.1</td>
<td>39</td>
</tr>
<tr>
<td>Con (N= 132)</td>
<td>76</td>
<td>57.6</td>
<td>38</td>
</tr>
<tr>
<td>2-month Victimization Status</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exp (N=125)</td>
<td>82</td>
<td>65.6</td>
<td>35</td>
</tr>
<tr>
<td>Con (N=125)</td>
<td>81</td>
<td>64.8</td>
<td>27</td>
</tr>
<tr>
<td>4-month Victimization Status</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exp (N=62)</td>
<td>52</td>
<td>83.9</td>
<td>7</td>
</tr>
<tr>
<td>Con (N=67)</td>
<td>53</td>
<td>79.1</td>
<td>9</td>
</tr>
</tbody>
</table>

*Note: Sexual Assault Risk Reduction Program group is noted as “Exp” and Vaccine Preventable Disease Peer-Education and Awareness Program group is noted as “Con”.*
Impact of program on Attitudes and Behaviors

A series of eleven 2 x 3 x 3 (Group x Victimization Status at the 2-Month Follow-up x Time) repeated measures analyses of variance were conducted to assess whether group participation was related to changes in attitudes and behaviors over the course of the follow-up periods. (See Table 4 for descriptive statistics, including means and standard deviations of all outcome variables). A depiction of the ANOVA design is provided in Figure 5. The between-subjects factors were program group and incidence of sexual victimization over the 2-month interim. Victimization status at the 2-month follow-up was included as an independent variable in analyses of outcome measures to account for the possibility that outcome measures might be influenced by victimization experiences that occurred during the course of the study. The within-subjects factor was time period (i.e., pre-test, 2-month and 4-month assessment). In this design, each outcome measure acted as a “multiple measure” dependent variable, nested within the within-subject factor of time period. The eleven dependent variables were measured at pre-test, 2-month and 4-month follow-up periods.

According to Barcikowski and Robey (1994), the analyses of such a two-between one within ANOVA design with multiple measures nested within the within-subject factor uses contrasts at each cell of the within-subjects factor (time-period) to consider each multiple-measure individually. As such, this two-between factor, one-within factor with multiple measures design allowed for prospective analyses of each outcome measure across time and between conditions, while taking into account the possible influence of experience of sexual victimization during the course of the study (i.e., during 2-month interim). Tukey’s Highest Significant Differences analyses were used to determine
which individual differences between means contributed to any significant main effects for time-period or sexual victimization over the 2-month interim. Cicchetti’s extension of Tukey’s Least Significant Difference test (Cicchetti, 1972) was used to examine the significant interactions involving between-subject factors and outcome measures over time. Given the number of dependent variables, the use of this post-hoc analysis strategy accounted for the possibility of inflated Type I error within the multiple comparisons.

Prior to ANOVA analyses, tests of statistical assumptions—including Mauchley’s test of sphericity and Box’s M test were performed. When necessary, in order to control for inflated F-test values, the critical degrees of freedom for the omnibus tests, planned comparisons, and posttests were adjusted according to a Hyun-Feldt correction. However, the adjustment had no effect upon the results of the omnibus, planned comparisons and post-tests, and as such, all test statistics are currently reported using the unadjusted degrees of freedom.
**Figure 5**

**ANOVA Design**

<table>
<thead>
<tr>
<th>Health Intervention and Victimization Status over the 2-month Interim</th>
<th>Time One/Pretest Multiple Measures:</th>
<th>2-Month Follow-up Multiple Measures:</th>
<th>4-Month Follow-up Multiple Measures:</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) Self-Protective Behaviors</td>
<td>(1) Self-Protective Behaviors</td>
<td>(1) Self-Protective Behaviors</td>
<td></td>
</tr>
<tr>
<td>(2) Sexual Communication</td>
<td>(2) Sexual Communication</td>
<td>(2) Sexual Communication</td>
<td></td>
</tr>
<tr>
<td>(3 &amp; 4) Assertive Behaviors</td>
<td>(3 &amp; 4) Assertive Behaviors</td>
<td>(3 &amp; 4) Assertive Behaviors</td>
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<tr>
<td>(5) Behavioral Intent</td>
<td>(5) Behavioral Intent</td>
<td>(5) Behavioral Intent</td>
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</tr>
<tr>
<td>(6) Behavioral Frequency</td>
<td>(6) Behavioral Frequency</td>
<td>(6) Behavioral Frequency</td>
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</tr>
<tr>
<td>(7) Positive Appraisals of Risk</td>
<td>(7) Positive Appraisals of Risk</td>
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</tr>
<tr>
<td>(8) Negative Appraisals of Risk</td>
<td>(8) Negative Appraisals of Risk</td>
<td>(8) Negative Appraisals of Risk</td>
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</tr>
<tr>
<td>(10) Perceived Vulnerability</td>
<td>(10) Perceived Vulnerability</td>
<td>(10) Perceived Vulnerability</td>
<td></td>
</tr>
<tr>
<td>(11) Knowledge</td>
<td>(11) Knowledge</td>
<td>(11) Knowledge</td>
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<table>
<thead>
<tr>
<th>SARR Participants</th>
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<th>Severe</th>
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<td>This cell would include the “multiple measures” for each subject.</td>
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</table>

<table>
<thead>
<tr>
<th>VPD Participants (Control Group)</th>
<th>None</th>
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<th>Severe</th>
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<tr>
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<td>This cell would include the “multiple measures” for each subject.</td>
<td>This cell would include the “multiple measures” for each subject.</td>
<td></td>
</tr>
</tbody>
</table>
Self-protective strategies. Analyses of the Self-Protective Strategies Against Rape Scale revealed a significant main effect for group, $F(1, 100) = 9.09, p < .01$. Specifically, participants in the Vaccine Preventable Disease Peer Education and Awareness Program group reported overall, lower levels of self-protective behaviors ($M = 44.82, SE = 1.48$) compared to participants in the Sexual Assault Risk Reduction Program group ($M = 52.59, SE = 2.11$). However, this main effect is best understood through interpretation of the significant group by time interaction, $F(2, 218) = 4.54, p < .05$. Overall, control group participants evidenced decreases in self-protective behaviors from pre-test ($M = 47.23, SE = 1.54$) to the 4-month follow-up assessment ($M = 42.64, SE = 1.77$). Analysis of treatment group participants revealed that levels of self-protective behaviors remained stable between pre-test ($M = 50.89, SE = 2.19$), the 2-month follow-up ($M = 53.78, SE = 2.46$) and the 4-month follow-up ($M = 53.09, SE = 2.52$). Participants in the treatment group demonstrated significantly higher levels of self-protective behaviors than participants in the control group at all three assessment periods.

Assertive sexual communication. An analysis of the Sexual Communication Survey revealed a significant time by group interaction, $F(2, 204) = 3.77, p < .05$. Analyses of control group participants suggested that sexual communication remained stable from pretest ($M = 124.69, SE = 1.98$) to the 2-month follow-up ($M = 123.85, SE = 1.86$) and to the 4-month follow-up ($M = 122.74, SE = 2.62$). Analyses of treatment group participants revealed that levels of sexual communication were maintained between pre-test ($M = 121.69, SE = 2.85$) and the 2-month follow-up ($M = 122.95, SE = 2.69$) and increased over the 4-month interim ($M = 129.63, SE = 3.77$). No differences in levels of assertive
sexual communication were revealed between the treatment and control group at pre-
test, 2-month or 4-month assessment.

Sexual assertiveness. An analysis of the total score on the Sexual Assertiveness
Scale revealed a significant main effect for sexual victimization over the 2-month
interim, $F(2, 111) = 3.70$, $p < .05$. Specifically, women who did not experience sexual
victimization over the 2-month interim ($M=51.55$, $SE=0.93$) reported significantly more
sexual assertiveness than women who experienced moderate sexual victimization over
the 2-month interim ($M=47.10$, $SE=1.71$).

Analyses of the individual subscales of the Sexual Assertiveness Scale revealed a
slightly different pattern. Analyses of the Refusal Subscale of the Sexual Assertiveness
Scale revealed a significant main effect for sexual victimization over the 2-month follow-
up period, $F(2, 111) = 3.70$, $p < .05$. Specifically, women who did not experience sexual
victimization over the 2-month interim reported more use of behaviors relating to the
refusal of sexual behaviors ($M=19.62$, $SE=0.39$) compared to women who experienced
severe sexual victimization over the 2-month interim ($M=16.92$, $SE=1.15$).

Analyses of the Initiation Subscale of the Sexual Assertiveness Scale revealed a
significant main effect for time, $F(2, 222) = 3.72$, $p < .05$. Analyses suggested that
women’s initial levels of initiating sexual activity were increased from pretest ($M =
11.34$, $SE = 0.64$) to the 4-month follow-up ($M = 12.90$, $SE = 0.60$).

Analyses of the Sexually Transmitted Disease Subscale of the Sexual Assertiveness
Scale revealed a significant main effect for time, $F(2, 222) = 5.70$, $p < .01$. Analyses
suggested that women’s protective behavior against sexually transmitted diseases
demonstrated decreases from initial assessment ($M = 19.46$, $SE = 0.76$) to the 4-month
follow-up ($M = 17.07, SE = 0.80$). A significant interaction between time and sexual victimization over the 2-month interim was also revealed on the Sexually Transmitted Diseases Subscale, $F(4, 222) = 2.88, p <.05$. The significant interaction was related to differences in levels of self-protective behavior against sexually transmitted diseases at the 4-month follow-up. Here, although women who experienced none, moderate or severe sexual victimization over the 2-month interim failed to report differences in self-protective behaviors against sexually transmitted diseases over time, when assessed at the 4-month follow-up, women who did not experience sexual victimization reported significantly more protective behaviors against sexually transmitted diseases ($M = 19.70, SE = 0.67$) than women who experienced either moderate ($M = 15.71, SE = 1.24$) or severe ($M = 15.79, SE = 1.95$) sexual victimization over the 2-month follow-up.

**Self-efficacy.** An analysis of the Self-Efficacy Scale revealed a significant time by group interaction, $F(2, 226) = 3.16, p <.05$. Overall, control group participants maintained levels of self-efficacy from pre-test ($M = 36.06, SE = 1.00$), 2-month follow-up ($M = 36.31, SE = 0.90$) and 4-month follow-up ($M = 35.41, SD = 0.91$). Analysis of treatment group participants revealed significant increases in self-efficacy between pre-test ($M = 36.22, SE = 1.45$) to the 4-month follow-up ($M = 39.31, SE = 1.32$). Overall, at pre-test and 2-month follow-up, no differences were observed in the treatment group and the control group reports of self-efficacy. However, at the 4-month follow-up, participants in the Sexual Assault Risk Reduction Program reported significantly higher levels of self-efficacy compared to participants in the Vaccine Preventable Disease Peer Education and Awareness Program.
Analyses also revealed a significant three way interaction between time, group and sexual victimization over the 2-month interim, \( F(4, 226) = 3.85, p < .01 \). Given the complex nature of examining such a three way interaction, results will be presented by discussing each of the three levels of unconfounded comparisons: 1) given that treatment group and victimization status were held constant, what was the difference over time periods?; 2) given that treatment group and time period were held constant, what was the difference between each level of sexual victimization?; 3) and given that level of sexual victimization and time period were held constant, what was the difference between treatment groups?

Among treatment group participants, no differences across time in levels of self-efficacy were reported for women who experienced none or severe experiences of sexual victimization over the 2-month follow-up. However, among treatment group participants, women who experienced moderate levels of sexual victimization over the 2-month follow-up reported significantly lower levels of self-efficacy at pre-test (\( M=34.71, SE= 1.77 \)) compared to the 4-month follow-up (\( M= 41.29, SE= 1.61 \)). Among control group participants, no differences across time in levels of self-efficacy were reported for women who experienced none, moderate or severe experiences of sexual victimization.

Among treatment or control group participants, no differences in levels of self-efficacy were revealed between women who experienced none, moderate or severe sexual victimization over the 2-month interim were revealed within the pre-test, 2-month or 4-month follow-up period.

At the 2-month assessment, women in the Sexual Assault Risk Reduction Program group who experienced no experiences of sexual victimization during the 2-month
interim reported higher levels of self-efficacy ($M=40.13$, $SE=0.96$) compared to women in the Vaccine Preventable Disease Peer Education and Awareness Program group who reported no experiences of sexual victimization during the 2-month interim ($M=36.52$, $SE=0.91$). At the 4-month assessment, women in the Sexual Assault Risk Reduction Program group who experienced moderate levels of sexual victimization over the 2-month interim reported higher levels of self-efficacy ($M=41.29$, $SE=11.61$) compared to women in the Vaccine Preventable Disease Peer Education and Awareness Program group who experienced moderate levels of sexual victimization over the 2-month interim ($M=32.60$, $SE=1.90$).

*Intent to engage in self-protective behaviors.* An analysis of the Behavioral Intent Questionnaire revealed a significant interaction between time and level of sexual victimization over the 2-month interim, $F(4, 224) = 2.96, p < .05$. No differences in intentions to engage in self-protective behaviors at pre-test, the 2-month follow-up, or the 4-month follow-up were revealed among women who reported no experiences of sexual victimization at the 2-month follow-up. Women who experienced moderate or severe sexual victimization over the 2-month interim evidenced a similar pattern of results, such that no differences were evidenced in reports of intentions to engage in self-protective behavior from pre-test, to the 2-month or 4-month follow-up. Notably, however, at pre-test assessment, women who experienced moderate sexual victimization over the 2-month interim reported higher intentions to engage in self-protective behaviors ($M = 46.79$, $SE = 2.60$) compared to women who experienced severe sexual victimization over the 2-month interim ($M = 39.21$, $SE = 4.06$).
Frequency of self-protective behaviors. An analysis of the Behavioral Frequency Questionnaire revealed no significant main effects or interactions among time, group membership, or sexual victimization over the follow-up period.

Positive appraisals of self-protective strategies. An analysis of the Cognitive Appraisals of Risk Scale relating to positive appraisals of self-protective strategies as noted on the Dating Self-Protection Against Rape Scale revealed a significant main effect for time, $F(2, 226) = 4.67, p = .01$. Analyses of this main effect suggested that women’s positive appraisals of protective behavior showed a significant increase from initial assessment ($M = 78.13, SE = 1.74$) to the 4-month follow-up ($M = 82.94, SE = 1.55$).

Negative appraisals of self-protective strategies. An analysis of the Cognitive Appraisals of Risk Scale relating to negative appraisals of self-protective strategies as noted on the Dating Self-Protection Against Rape Scale revealed a significant main effect for time, $F(2, 226) = 8.05, p < .001$. Pairwise comparisons of the main effect revealed that women’s negative appraisals of self-protective strategies showed significant decrease from initial assessment ($M = 40.44, SE = 1.56$) to the 2-month follow-up ($M = 35.19, SE = 1.43$) which was maintained over the 4-month follow-up ($M = 34.79, SE = 1.41$).

A significant interaction between time and experience of sexual victimization over the 2-month interim was also revealed, $F(4, 226) = 3.80, p < .01$. At pre-test, 2-month assessment, and 4-month assessment, reports of negative appraisals of self-protective behaviors did not differ between women reporting none, moderate or severe experiences of sexual victimization during the 2-month interim. Women who experienced either moderate or severe sexual victimization during the 2-month interim failed to evidence
differences in reports of negative appraisals of self-protective behavior over time. Women who reported no experiences of sexual victimization during the 2-month interim reported more negative appraisals of self-protective behaviors at pre-test ($M=42.42$, $SE=1.31$) compared to their report at the 4-month follow-up ($M=32.40$, $SE=1.19$).

**Likelihood to report sexual aggression.** An analysis of the Reporting Behaviors Questionnaire revealed a main effect for sexual victimization over the follow-up period, $F(2, 110) = 4.99, p = .01$. Pairwise comparisons revealed that, women who did not experience sexual victimization over the 2-month interim were significantly more likely to indicate recognizing or reporting sexual victimization ($M=27.72$, $SE=0.67$) than women who experienced moderate sexual victimization over the 2-month interim ($M=23.72$, $SE=1.24$). No significant differences were revealed between women who did not experience sexual victimization over the 2-month interim or women who experienced moderate sexual victimization over the 2-month interim and women who experienced severe sexual victimization over the 2-month interim ($M=24.02$, $SE=1.90$).

**Perceived vulnerability and risk.** An analysis of the sum score of risk as noted on the Global/Situational Appraisal of Risk questionnaire revealed a significant main effect for level of sexual victimization over the 2-month interim, $F(2, 109) = 4.70, p < .05$. Analyses suggested that women who did not experience sexual victimization over the 2-month interim reported lower levels of risk ($M = 7.79$, $SE = 0.74$) than women who experienced moderate ($M = 10.93$, $SE = 1.37$) or severe ($M = 13.11$, $SE = 2.12$) sexual victimization over the 2-month interim.

**Knowledge.** Analyses of the learning measure for the Ohio University Risk Reduction Program revealed a main effect for time, $F(2, 226) = 4.67, p < .05$. Analyses
of this main effect suggested that women’s knowledge of risk factors for sexual
victimization revealed significant increase from initial assessment ($M = 23.58, SE = 0.28$)
to the 2-month assessment ($M = 24.61, SE = 0.29$). However, knowledge scores as
indicated at the 4-month follow-up ($M = 23.80, SE = 0.48$) were not significantly
different from pretest or 2-month follow-up scores.
Table 5

*Means for Outcome Measures as a Function of Treatment Group and Victimization over the 2-Month Follow-up*

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<td></td>
<td></td>
</tr>
<tr>
<td>Exp ($N=3$)</td>
<td>43.33</td>
<td>13.80</td>
<td>28.67</td>
</tr>
<tr>
<td>Con ($N=12$)</td>
<td>41.83</td>
<td>12.76</td>
<td>41.25</td>
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<tr>
<td>Total Perceived Vulnerability to Sexual Victimization</td>
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<tr>
<td>No Victimization</td>
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<td></td>
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<tr>
<td>Exp ($N=37$)</td>
<td>6.51</td>
<td>5.42</td>
<td>9.19</td>
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<tr>
<td>Con ($N=41$)</td>
<td>8.15</td>
<td>6.76</td>
<td>7.71</td>
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<tr>
<td>Moderate</td>
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<td></td>
</tr>
<tr>
<td>Exp ($N=13$)</td>
<td>8.69</td>
<td>9.29</td>
<td>10.08</td>
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<tr>
<td>Con ($N=10$)</td>
<td>12.10</td>
<td>6.76</td>
<td>11.80</td>
</tr>
<tr>
<td>Severe</td>
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<td></td>
<td></td>
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<tr>
<td>Exp ($N=3$)</td>
<td>22.33</td>
<td>12.90</td>
<td>17.67</td>
</tr>
<tr>
<td>Con ($N=11$)</td>
<td>8.36</td>
<td>9.84</td>
<td>7.55</td>
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### Table 5: Continued

<table>
<thead>
<tr>
<th>Victimization Level</th>
<th>Pre-test</th>
<th>2-month</th>
<th>4-month</th>
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<tr>
<td></td>
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<tr>
<td>and group</td>
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<tr>
<td>Knowledge of Sexual Victimization</td>
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<td></td>
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<tr>
<td>No Victimization</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exp (N=38)</td>
<td>23.52</td>
<td>24.79</td>
<td>24.95</td>
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<tr>
<td>Con (N=42)</td>
<td>23.60</td>
<td>24.74</td>
<td>23.57</td>
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<tr>
<td>Moderate</td>
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<tr>
<td>Exp (N=14)</td>
<td>23.71</td>
<td>24.57</td>
<td>24.85</td>
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<tr>
<td>Con (N=10)</td>
<td>22.00</td>
<td>24.30</td>
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<tr>
<td>Severe</td>
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<td></td>
<td></td>
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<tr>
<td>Exp (N=3)</td>
<td>24.67</td>
<td>25.67</td>
<td>21.33</td>
</tr>
<tr>
<td>Con (N=12)</td>
<td>24.00</td>
<td>24.58</td>
<td>24.08</td>
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</table>
Assessment of Readiness to Change as a Function of Program Participation

A series of chi-square analyses were conducted to evaluate the effectiveness of the program in influencing participants’ readiness to enact self-protective strategies against sexual victimization. Three chi-square analyses were conducted for each subscale of the measure, which included: 1) readiness to utilize assertive behaviors; 2) readiness to take actions to reduce risk for sexual victimization; 3) readiness to utilize open sexual communication; 4) and readiness to maintain awareness of alcohol use. For each subscale, the first chi-square analysis examined differences between groups on initial levels of readiness to change as indicated at the pretest assessment. A second chi-square analysis examined differences between groups on readiness to change as indicated at the 2-month follow-up. A third chi-square analysis examined differences on readiness to change as indicated at the 4-month follow-up.

Readiness to utilize assertive behaviors. Chi-square analyses indicated that participants’ readiness to utilize assertive behaviors did not differ as a function of program group at pre-test, or 4-month follow-up assessment. However, results suggested that group membership was associated with varying levels of readiness to utilize assertive behaviors at the 2-month follow-up, $\chi^2 (3, N = 250) = 12.67$, p<.01. Specifically, 30.4% (N=38) of control group members compared to 12.0% of program group members (N=15) were classified in the precontemplation stage at the 2-month follow-up, suggesting that women in the control group were more likely than women in the program group to not be thinking about utilizing assertive behaviors.

Readiness to take actions to reduce risk for sexual victimization. Chi-square analyses indicated that participants’ readiness to take actions to reduce risk for sexual
victimization did not differ as a function of program group at pre-test, 2-month or 4-month follow-up assessment.

*Readiness to utilize open sexual communication.* Chi-square analyses indicated that participants’ readiness to utilize open sexual communication did not differ as a function of program group at pre-test, 2-month follow-up assessment. However, results suggested that group membership was associated with varying levels of readiness to utilize open sexual communication at the 4-month follow-up, \( \chi^2 (3, N = 128) = 8.61, p < .05 \). Specifically, 14.9% \((N=10)\) of control group members compared to 3.3% of program group members \((N=2)\) were classified in the precontemplation stage at the 4-month follow-up. In addition, 3.0% \((N=2)\) of control group members compared to 11.5% of program members were classified in the action stage, suggesting that women in the treatment group were more likely to identify themselves as currently taking measures to utilize open sexual communication.

*Readiness to maintain awareness of alcohol use.* Chi-square analyses indicated that participants’ readiness to maintain awareness of alcohol use behaviors did not differ as a function of program group at pre-test, 2-month or 4-month follow-up assessment.

*Assessment of Potential Negative Ramifications of Program Participation*

The total blame score and the five subscales of The Rape Attribution Scale regarding victim and offender blame were used to screen for any potential negative effects of the program (i.e., increased behavioral self-blame) as well as evidence of favorable changes in hypothesized blame for sexual victimization among program participants (i.e., increased rapist blame). A series of six 2 x 3 x 3 \((\text{Group} \times \text{Victimization Status at the 2-Month Follow-up} \times \text{Time})\) repeated measures analyses of
variance were conducted to assess whether group participation was related to changes in blame over the course of the follow-up periods. As with previous analyses, the between-subjects factors were program group and incidence of sexual victimization over the 2-month interim. The within-subjects factor was time period (i.e., pre-test, 2-month and 4-month assessment).

Analyses of the total score on the Rape Attribution Scale revealed a significant main effect for level of sexual victimization over the 2-month interim, $F(2, 112) = 3.99$, $p < .05$. Analyses suggested that women who did not experience sexual victimization over the 2-month interim reported lower levels of total blame ($M = 27.87, SE = 1.73$) than women who experienced severe ($M = 40.63, SE = 4.95$) sexual victimization over the 2-month interim. Separate analyses of subscales of the questionnaire were utilized to provide a more comprehensive analysis of blame.

Analyses of the Self-Blame Subscale, the Chance Blame Subscale or the Rapist Blame Subscale failed to reveal any significant main effects or interactions between time, group or level of sexual victimization over the 2-month interim.

Analyses of the Behavioral Self-Blame Subscale revealed a significant main effect for level of sexual victimization over the 2-month interim, $F(2, 112) = 5.34$, $p < .01$. Women who did not experience sexual victimization over the 2-month interim reported lower levels of behavioral self-blame ($M = 6.39, SE = 0.52$) than women who experienced severe ($M = 11.10, SE = 1.49$) sexual victimization over the 2-month interim.

Analyses of the Characterological Self-Blame Subscale revealed a significant main effect for level of sexual victimization over the 2-month interim, $F(2, 112) = 5.05$, $p = .008$, such that women who did not experience sexual victimization over the 2-month
interim reported lower levels of characterological self-blame \((M = 3.84, SE = 0.35)\) than women who experienced moderate \((M = 5.64, SE = 0.64)\) or severe \((M = 6.45, SE = 1.00)\) sexual victimization over the 2-month interim.

**Post-Program Evaluation**

*Cognitive Processing.* Analyses of variance were utilized to explore differences in cognitive processing of program material among groups. Results suggested that participants in the Sexual Assault Risk Reduction Program reported higher levels of cognitive involvement and more favorable perceptions of program presentation compared to participants in the Vaccine Preventable Disease Peer-Education and Awareness Program, \(F(1, 270) = 12.39, p < .01; F(1, 272) = 5.45, p < .05.\)

A similar pattern of results was reported for involvement in the booster session. Participants in the Sexual Assault Risk Reduction Program booster session reported higher levels of cognitive involvement and more favorable perceptions of program presentation compared to participants in the Vaccine Preventable Disease Peer-Education and Awareness Program booster session, \(F(1, 242) = 79.52, p < .001; F(1, 242) = 34.71, p < .001.\)

Overall, however, participants in both groups reported high levels of cognitive involvement and a generally favorable perception of program presentation. Evaluation of cognitive involvement and perceptions of program presentation in the booster session was also high in both program groups. Means and standard deviations of measures of program evaluation are presented in table 6.
### Table 6

**Means for Evaluation of Program Material as a Function of Program Group**

<table>
<thead>
<tr>
<th>Group</th>
<th>Pre-test</th>
<th>Booster Session</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$M$</td>
<td>$SD$</td>
</tr>
<tr>
<td></td>
<td>$M$</td>
<td>$SD$</td>
</tr>
<tr>
<td><strong>Cognitive Elaboration of Program Material</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exp</td>
<td>42.62</td>
<td>4.54</td>
</tr>
<tr>
<td></td>
<td>43.35</td>
<td>4.39</td>
</tr>
<tr>
<td>Con</td>
<td>40.50</td>
<td>5.38</td>
</tr>
<tr>
<td></td>
<td>37.84</td>
<td>5.20</td>
</tr>
<tr>
<td><strong>Presentation of Program Material</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exp</td>
<td>12.88</td>
<td>1.46</td>
</tr>
<tr>
<td></td>
<td>13.09</td>
<td>1.43</td>
</tr>
<tr>
<td>Con</td>
<td>12.44</td>
<td>1.67</td>
</tr>
<tr>
<td></td>
<td>12.06</td>
<td>1.32</td>
</tr>
</tbody>
</table>

_Note: Sexual Assault Risk Reduction Program group noted as “Exp” and Vaccine Preventable Disease Peer Education and Awareness Program group noted as “Con”._
Qualitative Analyses. Content analyses were used to assess reoccurring themes in open-ended response questions on the Elaboration Likelihood Questionnaire. Several themes emerged in participants’ reports of what they learned in the sexual assault risk reduction program. These themes included: 1) definitions of sexual assault; 2) frequency of sexual victimization; 3) assertiveness and self-defense strategies; 4) a greater awareness of the role of perpetrators to stop sexual aggression; 5) characteristics of perpetrators; 6) risk factors for sexual victimization; and 7) available campus resources.

Several themes also emerged in participants’ reports of suggestions for future program revisions, relating to both program content as well as study methodology. Specifically, these themes included: 1) no revisions necessary; 2) more time for group involvement; 3) shorter program length; 4) provide the personal experiences of a woman with a history of sexual victimization; 5) updated video materials; 6) changes to the questionnaires (i.e., wording of questions); 7) more time for self-defense techniques; 8) more times to participate in the program (i.e., during the day); 9) larger rooms for the self-defense program; and 10) that the program should be offered to more women on campus. Although these themes regard the possible changes to the program, it should be noted that many women either left the qualitative portion of the questionnaire blank, or noted that they had no recommendations for potential improvements to the program.

Discussion

The current study represents a systematic effort to modify an existing and previously evaluated sexual assault risk reduction program for college women. The most notable enhancements to the program included the utilization of two models of behavior
change throughout program protocol and evaluation, including the theory of planned behavior and the transtheoretical model of change. Modifications were also implemented to the methodology of the research design, such that an alternative health intervention was implemented within the control group of the study.

As Rozee and Koss (2001) suggested, although some sexual assault situations certainly may not be avoided, it is beneficial for women to be provided with strategies to more effectively confront potentially violent dating partners. Such a skill base would include enhanced abilities to initially detect potentially risky detecting scenarios, overcome potential barriers to resistance, and utilize a range of verbal and physical resistance strategies (Rozee & Koss, 2001). The current program revisions incorporate Rozee and Koss’ (2001) suggestions through specific attention to the positive and negative consequences of assertive behavior that may influence women’s barriers to resistance, as well as specific attention to viewing self-protective behaviors as a life-style, requiring continual vigilance and awareness of risk cues for potentially threatening dating scenarios.

Results suggested that the current program influenced women’s self-protective behaviors, open sexual communication, and self-efficacy in utilizing self-protecting behaviors compared to participants in an alternative health intervention. Specifically, women who participated in the revised sexual assault risk reduction program were more likely to evidenced stable levels of self-protective behaviors against sexual victimization, whereas levels of self-protective behaviors among control group participants evidenced decreases over the course of the study. A different pattern was noted in participants’ level of open sexual communication and self-efficacy; such that program participants
evidenced increases in open sexual communication and self-efficacy from pretest to the 4-month interim, whereas control group participants maintained stable levels of open sexual communication and self-efficacy over time. It must be noted, however, given current research on optimistic bias in risk perception for sexual victimization, it is unclear if such increases in self-efficacy may increase or decrease women’s vulnerability to sexual aggression. Future research is needed to better understand the relationship between self-efficacy and successfully resisting against sexual aggression.

Notably, the three above outcome measures were also utilized in previous evaluation of the Ohio University Sexual Assault Risk Reduction Program (Gidycz et al., in press). Whereas participants in both the original and revised risk reduction programs evidenced increases in self-efficacy, the current results diverge from past program evaluation by noting that program participants did not improve—but instead maintain—levels of self-protective behaviors in relation to control group participants—who, in this study, evidenced declines over time. The revised program, however, revealed significant increases in open sexual communication among program participants, which was not revealed in evaluation of the previous risk reduction program (i.e. Gidycz et al., in press).

Several exploratory measures were also implemented in the current study to provide enhanced evaluation of program revisions. Specifically, participants completed measures of negative appraisals of self-protective behaviors, positive appraisals of self-protective behaviors, intentions to utilize self-protective behaviors and frequency of self-protective behaviors over the interim. While it is surprising that program participation did not influence women’s positive or negative appraisals of self-protective behavior, or intention to engage in such behavior, the current study begins the process of measure
development for new avenues of evaluating risk reduction skills among college women. It is expected that future studies will continue the process of measure development and evaluation in order to increase the array of measure available to researchers of risk factors for sexual violence.

A further hypothesis was that the program might be differentially effective for women who experience sexual victimization over the course of the 2-month interim. Ideally, three-way interactions would be evidenced between group membership, sexual victimization over the 2-month interim, and measures of program effectiveness. One three-way interaction was revealed between program participation, sexual victimization during the 2-month interim, and levels of self-efficacy in self-protection against sexual victimization. Among program participants, it appears that among women with moderate sexual victimization over the 2-month interim, levels of self-efficacy in deterring an assault increased over the course of the study. Specifically, at the 4-month assessment, program group women with moderate sexual victimization reported higher levels of self-efficacy than women in the control group who experienced moderate sexual victimization over the 2-month interim. One explanation for higher levels of self-efficacy among women who experienced moderate sexual victimization in the program group may be that women classified in the moderate sexual victimization category may have experienced an attempted sexual assault, and successfully thwarted an attack through the use of resistance strategies.

It is notable, however, that several main effects for sexual victimization were revealed, suggesting that women’s scores on outcome measures was associated with their experiences with sexual victimization over the course of the study. These effects would
be expected, however, given that outcome measures assess factors relating to women’s risk to experience sexual victimization. Specifically, women who experienced moderate sexual victimization over the 2-month interim reported higher levels of risk for sexual victimization, a lower likelihood to recognize or report sexual victimization, lower levels of overall sexual assertiveness compared to women who did not experience sexual victimization over the 2-month interim. In addition, women who experienced severe sexual victimization over the 2-month interim reported higher levels of risk for sexual victimization and a lower likelihood to refuse sexual behaviors compared to women who did not experience sexual victimization over the 2-month interim.

Some two-way interactions also emerged between participants’ experiences of sexual victimization over the 2-month interim and measures of program effectiveness. Specifically, a 2-way interaction between sexual victimization over the 2-month interim and participants negative appraisals of self-protective behaviors was also noted. Women who experienced moderate or severe sexual victimization over the 2-month follow-up maintained their level of negative appraisals of self-protective behavior over the course of the study. Rather, women who did not experience sexual victimization over the 2-month follow-up noted decreases in their barriers to resistance from pre-test to 4-month assessment, as noted in fewer negative appraisals of engaging in self-protective behaviors.

In addition, when assessed at the 4-month follow-up women who experienced moderate or severe sexual victimization over the 2-month follow-up were less likely to protect against STD’s compared to women who did not experience sexual victimization over the 2-month follow-up. Such a result suggests that women who were victimized
over the course of the 2-month interim were more likely to engage in this risky sexual behavior at the subsequent follow-up assessment.

Another notable 2-way interaction was noted in women’s intentions to engage in self-protective behaviors, such that at pretest, women who experienced moderate sexual victimization over the 2-month interim were more likely to intend to engage in self-protective behaviors than women who experienced severe sexual victimization over the 2-month interim, suggesting that intentions to engage in protective behaviors may be associated with an increased ability to deter or thwart sexual victimization, or decrease the severity of sexual victimization by thwarting the perpetration of an attempted rape from progressing into a complete rape experience.

Perhaps most notably, as with past studies of sexual victimization, previous experiences of sexual victimization, or experiences of sexual victimization over the interim remained the strongest predictor of future victimization. Such data underscores the need for continued risk reduction campaigns and programming efforts specifically tailored to women with a history of sexual victimization.

Further, whereas analyses of outcome measures suggests that the revised program enhances women’s use of a range of risk reduction behaviors compared to the existing program, it was surprising that the revised program did not evidence decreases in incidence of sexual victimization as a function of program participation. A similar result was evidenced in past evaluation of the Ohio University Sexual Assault Risk Reduction Program (Gidycz et al., in press).

There are several possible explanations for this finding. First, it is arguable that sexual assault risk reduction program, such as the current 7-hour program, cannot
significantly reduce the incidence of sexual victimization over such a short interim. Some sexual assaults are simply unavoidable regardless of the preventative measures employed by women. From this perspective, it is truly the responsibility of the perpetrators of sexual violence to end sexually aggressive behavior. Until societal structures no longer support the perpetration of sexual violence, and perpetrators chose to stop violence, it is arguable that no sexual assault risk reduction program can be responsible for significantly reducing the incidence of sexual victimization.

Second, it is also possible that risk reduction programs for women may also not be powerful enough, unless facilitated over a longer period of time, to evidence meaningful changes in the incidence of sexual victimization. Further, given the relatively short follow-up period in the current study, it is unclear how the risk reduction strategies learned in the program may aide women in resisting future sexual victimization. Continued evaluation of the current program, utilizing a larger more representative sample across a longer follow-up period may, in fact, display notable decreases in the incidence of sexual victimization over time.

A third possibility is that the relatively small number of women who experience sexual victimization over a follow-up period makes it difficult to garner the statistical power to detect differences in the incidence of sexual violence. It should be noted that while more statistical power may be garnered in the current study by collapsing the number of women who experience moderate or severe sexual victimization, such analysis strategies gloss over important conceptual differences in the varying levels of sexual victimization experienced by women. The current study thus sacrifices some statistical power in order to maintain a conceptual framework that acknowledges the differences
between various experiences of sexual victimization. Indeed, as noted in description of the main effects and two-way interactions between measures of program effectiveness and experience of sexual victimization over the 2-month interim, the pattern of results for women who experienced moderate sexual victimization over the 2-month interim often differed from the pattern of results for women who experienced severe sexual victimization over the 2-month interim. Collapsing over these different types of sexual victimization would obscure these notable differences.

Overall, however, the current study adds to our understanding of the evaluation of sexual assault risk reduction programs by following up on many of the hypotheses and questions posed in Gidycz and her colleagues’ (in press) most recent program evaluation. Specifically, Gidycz and her colleagues (in press) hypothesized “there is some evidence to suggest that program group women may have been better able to detect and label sexual assault experiences, increasing the likelihood that they would respond “yes” to the Sexual Experiences Survey items that assessed sexual victimization”. To explore this possibility, the current study used a survey manipulation designed to explore how increased awareness of the definition of sexual assault was associated with increased reporting of past history of sexual victimization. Analyses of the survey manipulation suggested that there was no difference in reports of women’s history of adolescent sexual victimization between women who completed the Sexual Experiences Survey prior to the program compared to women who completed the Sexual Experiences Survey after the program.

One factor which was not explored in this survey design, however, was the possibility that over time, women in the sexual assault risk reduction program group
gained an increased awareness of threatening dating scenarios and experiences that classify as sexual victimization. As such, it is possible that women in the risk reduction group developed a greater awareness of experiences that meet the definition of sexual victimization over the 2-month interim, subsequently influencing their response on later assessment of sexual victimization according to the Sexual Experiences Survey.

Another question that was raised in Gidycz and her colleagues’ (in press) previous program evaluation was the role of reporting sexual victimization to the police or other authorities. As the previous survey design failed to measure reporting behaviors at pre-test as well as follow-up assessments (only using a follow-up measure), it was unclear how such behaviors changed over time as a result of program participation. The current study addressed this methodological problem by implementing measures of reporting and recognizing threatening dating behaviors at pre-test, 2-month follow-up and 4-month follow-up assessments. Results suggested that women who participated in the revised risk reduction program did not differ in reports of recognizing or likelihood to report sexual victimization compared to women who participated in the alternative health intervention.

Finally, it should also be noted, however, that a number of outcome measures also indicated main effects over time, suggesting that women in both the treatment and control group evidenced changes in measures of risk reduction behaviors over the course of the study. For example, regardless of treatment group, women evidenced increases in measures of program effectiveness over time, including overall levels of initiating sexual activity, positive appraisals of self-protective behaviors. Women’s negative appraisals of self-protective behaviors also witnessed an overall decline over time. One concerning result, however, was that women’s overall protection against sexually transmitted
diseases decreased over the course of the study, suggesting that levels of risky sexual behavior may increase over time.

It is likely that the development of enhanced risk reduction skills over time among both groups of women is due to natural exposure over the course of their college experiences. Given that the majority of women in the present study were in their first year of college, women in both groups were likely exposed to additional information from both peer groups and educators, and evidenced increases in maturity over time associated with increases in assertiveness, self-confidence, and awareness of some risk factors for sexual victimization. Gidycz and her colleagues (in press) suggest another explanation for this surprising finding. Specifically, it is also possible that women in the program group shared information from the self-defense and risk reduction program with the women in the alternative health intervention. Even though women were randomly assigned to participate in either the risk reduction program or the alternative health intervention, given the use of the Psychology 101 subject pool, Gidycz and her colleagues (in press) have suggested that women in such experimental protocols often sign up for studies with groups of friends. As a similar trend in this study was noted as well, such that women who were randomly assigned to differing health interventions were noticeably disappointed when separated, or often waited for their friend outside of the building when program sessions did not end at exactly the same time. Thus, as Gidycz and her colleagues (in press) note, even when women are separated into program and control groups and asked not to share specific information with women in the control group, it is likely that some participants disclose information provided in the various intervention sessions.
Overall, the current study represents only the second controlled outcome study, which used random assignment, to evaluate the effectiveness of a sexual assault risk reduction program with a self-defense component. Overall, program evaluation suggests that additions to the program were a step towards increased risk reduction skills among women, and a positive step in the development of effective risk reduction programming to combat incidence of sexual violence. This study also represents the first effort to incorporate an alternative health intervention among control group participants into such a prospective study of risk reduction programming.

Results of the current study, while notable, are limited by the significant drop-out rates among program participants. Although an initial logistic regression suggested that group membership, history of adolescent victimization, or victimization during the follow-ups did not predict return rates at the 2-month or 4-month follow-up and expanded analysis of the role of readiness to change, risk variables, and group membership suggested that return rates were influenced by a few notable factors. Whereas none of the predictors influenced return rates at the 4-month follow-up, in the presence of other risk variables, participants in the risk reduction program were 2.77 times more likely to drop-out of the study at the 2-month follow-up than were participants in the alternative health intervention. Additionally, participants with lower levels of readiness to enact risk reduction strategies, regardless of group, were less likely to return for the 2-month follow-up than participants with higher levels of readiness to enact risk reduction strategies. While it is unclear why program participants were more likely to drop-out of the study at the 4-month follow-up (14.4%) as compared to control group participants (5.3%), it is likely that these differences in drop out rates may have biased the results of
outcome assessment at the 2-month follow-up. It is possible that women in the risk reduction group may have dropped out of the study at the 2-month follow-up after experiences of sexual victimization during the interim, desiring to avoid the discussion of topics relating to sexual victimization. However, conversely, such avoidance seems unlikely, given the program's previous discussion that survivors of sexual victimization are not to blame for the assaults. Of note, during the booster sessions, many women shared experiences where they were successfully able to deter sexual victimization over the course of the interim (i.e., using self-defense, noticing risk scenarios). Nonetheless, results comparing pretest to 2-month assessment on outcome variables must be tempered with the consideration that return rates for the 2-month follow-up, when risk variables were taken into account, were influenced by program participation.

Given that this pattern was not evidenced at the 4-month follow-up, where participation was voluntary, it is possible that participation in the additional self-defense session biased women from placing more time into subsequent portions of the study. Participants in the risk reduction program received a total of 4 experimental credit points following the self-defense session, and would have the minimum number points necessary for their Psychology 101 requirement. Pending that they participated in no other experiments, participants in the control group intervention would need to return for the 2-month follow-up in order to receive the minimum number of points required for their course. It will be important for future studies to maintain an equivalent incentive for participation between program and control groups in order to allow for a more valid exploration of potential biases in return rates.
Results are also limited by the reliance of self-report measures of behavioral and attitude change, which are frequently subject to a range of biases and distortions in reporting (Gidycz et al., 2002). Indeed, future research must continue to systematically evaluate and revise risk reduction programming, and develop more sensitive outcome measures with which to measure program effectiveness. A range of measures in the current study were exploratory in nature, and as such, the validity of these measures in assessing risk reduction strategies is unclear. Follow-up studies will evaluate and continue to develop these measures for future use in program evaluation.

The current study is also limited in its use of a relatively small college-aged sample with limited racial diversity. Although the sample was representative of the demographics of the university, certainly, program development must include a wider population, addressing women from a wider age range and a more diverse racial background. The short-term nature of the follow-up in the current study is also problematic (e.g., Breitenbecher, 2000). Given that previous evaluation of the Ohio University Sexual Assault Risk Reduction Program utilized 3-month and 6-month follow-up periods, it is possible that the short follow-up period in the current study underestimated program effectiveness. Further exploration of specific self-defense tactics (i.e., Ullman, 1998; Ullman & Knight, 1992), various situational variables, as well as the role of contextual variables—such as alcohol use and social norms—may also be useful in further development of risk reduction efforts.

Nonetheless, the results of this study also provide helpful directions for future program development. For example, no interaction was revealed between program participation, group membership and levels of blame over time. Such a result suggests
that the program did not result in increased levels of blame or feelings of responsibility among program participants, which is an important component to healing from sexual victimization (Frazier, 1990). However, such a result also suggests that the program did not have a differential effect on women’s responses perceptions of blame for sexual victimization either. Rather, women who experienced severe sexual victimization over the 2-month interim reported higher levels of total blame and behavioral self-blame than women who experienced no sexual victimization over the 2-month interim, regardless of program group. Similar results were witnessed in analyses of characterological self-blame, such that women who experienced moderate or severe sexual victimization over the 2-month interim, regardless of program group, reported higher levels of characterological self-blame than women who experienced no sexual victimization over the 2-month interim. Such results suggest that the program was not effective in decreasing the amount of blame experienced following experiences of sexual victimization over the 2-month interim.

Although the current program was developed for survivors of sexual victimization as well as women without a history of sexual victimization, it is also important to anticipate that program participants may experience sexual victimization following program participation. As such, it is important for risk reduction programming to provide women with information that may help them to process and heal from an experience of sexual victimization if such an event occurs in the future (i.e., Koss & Figueredo, 2004). It is also vital that risk reduction programming not result in increased levels of blame following program participation (i.e., Frazier, 1990). Given that levels of total, behavioral and characterological self-blame among women who experienced sexual
victimization during the course of this study did not differ as a function of treatment
group, elaborating upon the discussion of reactions to sexual victimization may prove to
be an efficacious avenue for future program revision.

Conclusion

Despite preventative and risk reduction efforts, incidence of sexual victimization
on college campuses remains alarmingly high. Whereas responsibility for stopping the
perpetration of sexual violence rests, ultimately, with the men who engage in sexual
aggressive behavior, it is vital for researchers and clinicians to continue to develop and
facilitate programming for women in order to reduce their risk of sexual victimization.
Until perpetrators take responsibility for ending violence against women, women must be
provided with skills to reduce their risk for sexual violence, as well as fight back against
potential perpetrators. Thus, in the meantime, efforts to develop risk reduction
programming must remain an ongoing and systematic process. As such, the current study
provides further exploration of the critical components of sexual assault risk reduction
programming, and serves as yet another step in the development of more effective risk
reduction programming for college women.
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Appendix A-1
Consent Form (Session I: SARR and VPD)

Title of Research: Evaluation of Health Interventions for Women
Principal Investigators: Lindsay M. Orchowski, Holly Raffle
Department: Psychology

I. Federal and university regulations require us to obtain signed consent for participation in research involving human participants. After reading the statement below, please indicate your consent by signing this form.

II. I agree to participate in the research study entitled “Evaluation of Health Interventions for Women”, which is being supervised by Christine A. Gidycz, Ph.D. of the Department of Psychology at Ohio University. I understand that my participation is entirely voluntary; I can withdraw my consent or stop responding at any time.

Statement of Procedure:
Purpose. The purpose of these procedures is to examine the utility of health interventions for undergraduate women and to examine to maintenance of these effects over time.

Procedure. This is a three-part experiment. By participating in this experiment, you will be randomly assigned to one of two health interventions. Participants in both Intervention “purple” and Intervention “green” will participate in a health intervention for a three-hour session. You will be asked to fill out questionnaires concerning sexual experiences, dating behaviors, and vaccine preventable diseases.

Please note that participants in Intervention “purple” will participate in a self-defense class that will consist of learning verbally assertive responses and demonstration of escape techniques. The self-defense component will be conducted by Cheryl Cesta who is a well-known expert in self-defense; however the session will not contain any physical contact for participants. Participants in Intervention “purple” will receive two additional experimental credit points for participating in the self-defense class, which will be awarded at the 2-month follow-up. You will be notified today if you are in Intervention “purple” or Intervention “green”.

All participants will be asked to return for a two-month and a four-month follow up. At the two-month follow-up you will be asked about whether you have been able to utilize the program information over the past two months, will be asked to fill out questionnaires. At the two-month follow-up, participants in Intervention “purple” and Intervention “green” will be given five credit points toward the research requirement in your psychology class. At session two, participants in Intervention “purple” will also be given an additional two credits for participation in the self-defense course.

Please note that all experimental credit points will be awarded after participation in the two-month follow-up. Participants will be asked to contact the experimenter to
receive their credit points for participation in earlier parts of the study if they are unable to participate in the two-month follow-up. Participants will be asked to return for a 4-month follow-up, however, experimental credit will not be awarded for participation.

Confidentiality. All questionnaires will be identified only by numerical codes that will be calculated by the participant, and only you will know this subject number. However, there will be a master list of names and phone numbers kept in a locked file cabinet and only accessible by the principal investigators. This master list of names will not contain subject numbers and will be destroyed following the completion of the project (approximately 1 year). Any information you provide to the experimenters will be completely confidential and anonymous, as there will be no way to link your identity to your survey responses.

Participants should also be aware that sensitive information that may include sexual issues, body image and disease transmission will be discussed during the intervention sessions. However, no participant is required to talk. All information during the sessions should not be discussed with others outside of the intervention sessions.

Please note however that participants' confidentiality in the group can only be protected as far as the other participants in the group do not repeat what is discussed in the group setting.

Participants should be aware that some sessions will be videotaped to insure the integrity and consistency of the program. If a session is taped, the camera will be focused on only the group leader and never on any participants. The videotapes will be viewed only by the research administrators and destroyed at the completion of the project.

Potential Risks. The primary risk associated with the procedure is transient anxiety associated with perceived competence and threats of disclosure of anonymity. There is also a risk that participants may experience discomfort in discussing personal or private information. However, any disclosure is completely voluntary. Every effort will be made by the researchers to protect the confidentiality of each individual concerning verbal and written information. Confidentiality of written responses will be protected by the private calculation of a personal subject number. You will be asked to recalculate this each time you participate. All raw data will be kept in a locked file cabinet. These procedures are implemented in order to protect your rights and privacy.

Potential Benefits. Potential benefits of participation in the program include a greater awareness of physical and emotional health risks. Although participation in the interventions may help you to avoid physical, sexual or emotional harm, participation cannot guarantee this result. As a research participant, you will be exposed to the conduct of scientific research and may gain insight into your own adjustment and life experiences.

The experimenter will be available for one half hour at the end of each session if you have any questions or concerns. In addition, you may feel free to call Lindsay Orchowski
at 593-1088 or e-mail her at lo305903@ohio.edu, Holly Raffle at 593-1076 or e-mail her at raffle@ohio.edu, or Dr. Christine Gidycz at 593-1092 or e-mail her at gidycz@ohiou.edu.

If you have any questions regarding your rights as a research participant, please contact Jo Ellen Sherow, Director of Research Compliance, Ohio University, (740) 593-0664.

I certify that I have read and understand this consent form and agree to participate as a subject in the research described. I agree that known risks to me have been explained to my satisfaction and I understand that no compensation is available from Ohio University and its employees for any injury resulting from my participation in this research. I certify that I am 18 years of age or older. My participation in this research is given voluntarily, without coercion or undue influence. I understand that I may discontinue participation at any time without penalty or loss of any benefits to which I may otherwise be entitled. I certify that I have been given a copy of this consent form to take with me.

Signature: _________________________________ Date: ____________
Print: ______________________________________
Title of Research: Evaluation of Health Interventions for Women
Principal Investigators: Lindsay M. Orchowski, Holly Raffle
Department: Psychology

I. Federal and university regulations require us to obtain signed consent for participation in research involving human participants. After reading the statement below, please indicate your consent by signing this form.

II. I agree to participate in the research study entitled “Evaluation of Health Interventions for Women”, which is being supervised by Christine A. Gidycz, Ph.D. of the Department of Psychology at Ohio University. I understand that my participation is entirely voluntary; I can withdraw my consent or stop responding at any time.

Statement of Procedure:
Purpose. The purpose of these procedures is to examine the utility of a health intervention for undergraduate women and to examine to maintenance of these effects over time.

Procedure. This is the second component of a risk reduction program. Today, you will participate in a self-defense class that will consist of learning verbally assertive responses and demonstration of escape techniques. The self-defense component will be conducted by Cheryl Cesta who is a well-known expert in self-defense, however the session will not contain any physical contact for participants. You will also be asked to fill out questionnaires.

All participants will be asked to return for a two-month and a four-month follow up. At the two-month follow-up you will be asked about whether you have been able to utilize the program information over the past two months, will be asked to fill out questionnaires. At the two-month follow-up, participants will be given a total of five credit points toward the research requirement in your psychology class. At this time, you will also be given an additional two credits for participation in the self-defense course.

Please note that all experimental credit points will be awarded after participation in the two-month follow-up. Participants will be asked to contact the experimenter to receive their credit points for participation in earlier parts of the study if they are unable to participate in the two-month follow-up.

Confidentiality. All questionnaires will be identified only by numerical codes that will be calculated by the participant, and only you will know this subject number. However, there will be a master list of names and phone numbers kept in a locked file cabinet and only accessible by the principal investigators. This master list of names will not contain subject numbers and will be destroyed following the completion of the project (approximately 1 year). Any information you provide to the experimenters will be completely confidential.
Participants should also be aware that self-protective strategies will be demonstrated during the self-defense course. However, no participant is required to participate, or to share information with the group.

**Potential Risks.** The primary risk associated with participation in the self-defense workshop is procedure is transient anxiety associated with the threats of disclosure of anonymity. Every effort will be made by the research to protect the confidentiality of each individual concerning written information. Confidentiality of written information will be protected by the private calculation of a personal subject number. You will be asked to recalculate this each time you participate. All raw data will be kept in a locked file cabinet. These procedures are implemented in order to protect your rights and privacy.

**Potential Benefits.** Potential benefits of participation in the program include a greater awareness of self-protective strategies, assertive verbal responses and escape techniques. Although participation in the interventions may help you to avoid physical, sexual or emotional harm, participation cannot guarantee this result. As a research participant, you will be exposed to the conduct of scientific research and may gain insight into your own adjustment and life experiences.

The experimenter will be available for one half hour at the end of each session if you have any questions or concerns. In addition, you may feel free to call Lindsay Orchowski at 593-1088 or e-mail her at lo305903@ohio.edu, Holly Raffle at 593-1076 or e-mail her at raffle@ohio.edu, or Dr. Christine Gidycz at 593-1092 or e-mail her at gidycz@ohiou.edu. If you have any questions regarding your rights as a research participant, please contact Jo Ellen Sherow, Director of Research Compliance, Ohio University, (740)593-0664.

I certify that I have read and understand this consent form and agree to participate as a subject in the research described. I agree that known risks to me have been explained to my satisfaction and I understand that no compensation is available from Ohio University and its employees for any injury resulting from my participation in this research. I certify that I am 18 years of age or older. My participation in this research is given voluntarily, without coercion or undue influence. I understand that I may discontinue participation at any time without penalty or loss of any benefits to which I may otherwise be entitled. I certify that I have been given a copy of this consent form to take with me.

Signature: ___________________________ Date: ____________
Print: ___________________________
Title of Research: Evaluation of Health Interventions for Women  
Principal Investigators: Lindsay M. Orchowski, Holly Raffle  
Department: Psychology  

I. Federal and university regulations require us to obtain signed consent for participation in research involving human participants. After reading the statement in II below, please indicate your consent by signing this form.

II. I agree to participate in the research study entitled “Evaluation of Health Interventions for Women”, which is being supervised by Christine A. Gidycz, Ph.D. of the Department of Psychology at Ohio University. I understand that my participation is entirely voluntary; I can withdraw my consent or stop responding at any time.

Statement of Procedure:
Purpose. The purpose of these procedures is to examine the utility of a health intervention for undergraduate women and to examine maintenance of these effects over time.

Procedure. This is a follow-up session for an ongoing experiment, where you will be asked to fill out questionnaires concerning your experiences over the past two-months, and discuss the usefulness of the initial program information that was provided. At this time, you will also receive your credit points for participating in previous sessions of this experiment. Participants in Intervention “purple” and Intervention “green” will receive 5 points for participating in the initial session, and the two-month follow-up. If you are in Intervention “purple”, and participated in the self-defense course, you will also be awarded 2 additional credit points at the two-month follow-up.

You will be asked to return in two-months to complete a similar follow-up session, however, experimental credit points will not be awarded.

Confidentiality. All questionnaires will be identified only by numerical codes that will be calculated by the participant, and only you will know this subject number. However, there will be a master list of names and phone numbers kept in a locked file cabinet and only accessible by the principal investigators. This master list of names will not contain subject numbers and will be destroyed following the completion of the project (approximately 1 year). Any information you provide to the experimenters will be completely confidential. Participants should also be aware that sensitive information that may include sexual issues, body image and disease transmission will be discussed during the intervention sessions. However, no participant is required to talk. All information during the sessions should not be discussed with others outside of the intervention sessions.
Please note however that participants' confidentiality in the group can only be protected as far as the other participants in the group do not repeat what is discussed in the group setting.

Potential Risks. The primary risk associated with the procedure is transient anxiety associated with perceived competence and threats of disclosure of anonymity. There is also a risk that participants may experience discomfort in discussing personal or private information. However, any disclosure is completely voluntary. Every effort will be made by the research to protect the confidentiality of each individual concerning verbal and written information. Confidentiality will be protected by the private calculation of a personal subject number. You will be asked to recalculate this each time you participate. All raw data will be kept in a locked file cabinet. These procedures are implemented in order to protect your rights and privacy.

Potential Benefits. Potential benefits of participation in the program include a greater awareness of physical and emotional health risks. Although participation in the interventions may help you to avoid physical, sexual or emotional harm, participation cannot guarantee this result. As a research participant, you will be exposed to the conduct of scientific research and may gain insight into your own adjustment and life experiences.

The experimenter will be available for one half hour at the end of each session if you have any questions or concerns. In addition, you may feel free to call Lindsay Orchowski at 593-1088 or e-mail her at lo305903@ohio.edu, Holly Raffle at 593-1076 or e-mail her at raffle@ohio.edu, or Dr. Christine Gidycz at 593-1092 or e-mail her at gidycz@ohiou.edu.

If you have any questions regarding your rights as a research participant, please contact Jo Ellen Sherow, Director of Research Compliance, Ohio University, (740)593-0664.

I certify that I have read and understand this consent form and agree to participate as a subject in the research described. I agree that known risks to me have been explained to my satisfaction and I understand that no compensation is available from Ohio University and its employees for any injury resulting from my participation in this research. I certify that I am 18 years of age or older. My participation in this research is given voluntarily, without coercion or undue influence. I understand that I may discontinue participation at any time without penalty or loss of any benefits to which I may otherwise be entitled. I certify that I have been given a copy of this consent form to take with me.

Signature: ______________________________ Date: ____________
Print: ______________________________
Title of Research: Evaluation of Health Interventions for Women
Principal Investigators: Lindsay M. Orchowski, Holly Raffle
Department: Psychology

I. Federal and university regulations require us to obtain signed consent for participation in research involving human participants. After reading the statement in II below, please indicate your consent by signing this form.

II. I agree to participate in the research study entitled “Evaluation of Health Interventions for Women”, which is being supervised by Christine A. Gidycz, Ph.D. of the Department of Psychology at Ohio University. I understand that my participation is entirely voluntary; I can withdraw my consent or stop responding at any time.

Statement of Procedure:
Purpose. The purpose of these procedures is to examine the utility of a health intervention for undergraduate women and to examine to maintenance of these effects over time.

Procedure. This is a follow-up session for an ongoing experiment, where you will be asked to fill out questionnaires concerning your experiences over the past two-months. Experimental credit points will not be awarded for participation. After completion of the questionnaires, you will be asked if you wish to provide contact information to be contacted for a long-term follow-up over the next year. This information will in no way be linked to your survey responses.

Confidentiality. All questionnaires will be identified only by numerical codes that will be calculated by the participant, and only you will know this subject number. However, there will be a master list of names and phone numbers kept in a locked file cabinet and only accessible by the principal investigators. This master list of names will not contain subject numbers and will be destroyed following the completion of the project (approximately 1 year). Any information you provide to the experimenters will be completely confidential. However, the principal investigators are required to notify proper individuals in the event that information regarding future plans for injury to self or others is disclosed by participants to the investigator or group leaders.

Potential Risks. The primary risk associated with the procedure is transient anxiety associated with perceived competence and threats of disclosure of anonymity. There is also a risk that participants may experience discomfort in discussing personal or private information. However, any disclosure is completely voluntary. Every effort will be made by the research to protect the confidentiality of each individual concerning verbal and written information. Confidentiality will be protected by the private calculation of a personal subject number. You will be asked to recalculate this each time you participate.
All raw data will be kept in a locked file cabinet. These procedures are implemented in order to protect your rights and privacy.

**Potential Benefits.** Potential benefits of participation in the program include a greater awareness of physical and emotional health risks. Although participation in the interventions may help you to avoid physical, sexual or emotional harm, participation cannot guarantee this result. As a research participant, you will be exposed to the conduct of scientific research and may gain insight into your own adjustment and life experiences.

The experimenter will be available for one half hour at the end of each session if you have any questions or concerns. In addition, you may feel free to call Lindsay Orchowski at 593-1088 or e-mail her at lo305903@ohio.edu, Holly Raffle at 593-1076 or e-mail her at raffle@ohio.edu, or Dr. Christine Gidyecz at 593-1092 or e-mail her at gidycz@ohiou.edu.

If you have any questions regarding your rights as a research participant, please contact Jo Ellen Sherow, Director of Research Compliance, Ohio University, (740)593-0664.

I certify that I have read and understand this consent form and agree to participate as a subject in the research described. I agree that known risks to me have been explained to my satisfaction and I understand that no compensation is available from Ohio University and its employees for any injury resulting from my participation in this research. I certify that I am 18 years of age or older. My participation in this research is given voluntarily, without coercion or undue influence. I understand that I may discontinue participation at any time without penalty or loss of any benefits to which I may otherwise be entitled. I certify that I have been given a copy of this consent form to take with me.

Signature: ___________________________ Date: ____________
Print: __________________________________________
Appendix A-5
Confidentiality Agreement

I, the undersigned, understand that I am participating in an experiment, “Evaluation of Health Interventions for Women”, which consists of group discussion. **I understand by participating in a discussion, I cannot guarantee the confidentiality of my responses.** I understand that disclosure is voluntary, and that I can discontinue participation at any time.

I understand that participants’ confidentiality in the group can only be protected as far as the other participants in the group **do not repeat what is discussed in the group setting.**

By signing this agreement, I agree to maintain the confidentiality of information discussed during this program group.

Signature: ________________________________ Date: ____________
Print: ____________________________________________
Debriefing Form (Session I & II: VPD, Session I, II, & III SARR)

Thank you for your participation in this research project. The study’s objective is to examine women’s personal and social life events, including psychological, physical and sexual experiences. As such, the current study utilized a larger number of questionnaires in order to assess a wide range of attitudinal, social and cognitive variables. The information provided by these questionnaires will help us in understanding how past, current, and future experiences are related to each other and to a variety of social, relationship and attitude factors.

This is a multi-part study. Therefore, you will be asked to return to participate in follow-up sessions at a later date. The survey administrator will contact you to schedule a follow-up session. If you are unable to participate in the two-month follow-up, please contact Lindsay Orchowski/Holly Raffle to receive your experimental credit points for participation in previous sessions.

As a reminder, all of your questionnaire responses will remain strictly confidential. If you have any further questions regarding the nature of this study, or would like to request details of the results of the study, please feel free to contact one of the following:

Graduate Researcher:            Lindsay M. Orchowski
Porter Hall – Office 44-P
593-1088

Part-time Faculty Researcher:   Holly Raffle
Porter Hall – Room 206
593-1076

Faculty Researcher:             Christine A. Gidycz
Porter Hall - Room 231
593-1092

In addition, if you are concerned about the study materials used or questions asked and wish to speak with a professional, or if you would like more information or reading material on this topic, please contact one of the following resources:

Ohio University Counseling and Psychological Services (CPS) 593-1616
• Campus Counseling and Psychological Services (CPS) 593-1616
• Tri-County Mental Health Services 592-3091
• Community agency that can provide assistance or information

Sexual Abuse Examiners Phone 593-4730
Hudson Health Center – Ohio University’s Student Health Service 593-1660

Operating Hours: Mon. through Fri. 8am - 4:30pm, except Thursday 9am - 4:30pm
Hours are slightly different in the summer and during winter and spring breaks. Closed on university holidays.

Hudson Health Center – Immunizations 593-4747
More information of self-defense programming can be found online at:
www.ohiou.edu/police/rad.htm
Appendix A-7  
Debriefing Form (Session IV: SARR)

Thank you for your participation in this research project. Coercive sexual behavior in dating relationships among college students is a serious problem. As a result of high numbers of women affected by sexual assault, researchers have tried to develop programs for preventing such experiences. Past results show that these programs are effective in preventing future sexual assault among women without a history of sexual victimization.

The purpose of this project is to examine the utility of sexual assault risk reduction program for college women, and to examine the maintenance of this program over time. Some participants may have participated in a program to prevent the sexual victimization of college women, while others have participated in an alternative intervention on vaccine preventable diseases. It is also the purpose of the study to assess the health risk factors associated with sexual victimization. As such, the current study utilized a large number of questionnaires in order to assess a wide range of attitudinal, social and cognitive variables. Women’s responses to the study’s questionnaires will be examined to identify important factors for the prevention of sexual assault in women. More information on self-defense programming can be found online at: www/ohiou.edu/police.rad.htm

As a reminder, all of your questionnaire responses will remain strictly confidential. If you have any further questions regarding the nature of this study, or would like to request details of the results of the study, please feel free to contact one of the following:

Graduate Researcher: Lindsay M. Orchowski, Porter Hall – Office 44-P, 593-1088
Part-time Faculty Researcher: Holly Raffle, Porter Hall – Room 206, 593-1076
Faculty Researcher: Christine A. Gidycz, Porter Hall - Room 231, 593-1092

In addition, if you are concerned about the study materials used or questions asked and wish to speak with a professional, or if you would like more information or reading material on this topic, please contact one of the following resources:

Ohio University Counseling and Psychological Services (CPS) 593-1616
• Campus Agency that can give further assistance or information
Tri-County Mental Health Services 592-3091
• Community agency that can provide assistance or information
Sexual Abuse Examiners Phone 593-4730

Hudson Health Center – Ohio University’s Student Health Service 593-1660

**Operating Hours:** Mon. through Fri. 8am - 4:30pm, except Thursday 9am - 4:30pm

Hours are slightly different in the summer and during winter and spring breaks. Closed on university holidays.

Hudson Health Center – Immunizations 593-4747
Appendix A-8
Debriefing Form (Session III: VPD)

Thank you for your participation in this research project. It is a common myth that vaccinations are just for children. However, many young adults do need vaccinations to prevent diseases such as hepatitis B, hepatitis A, flu, tetanus and/or meningococcal disease (bacterial meningitis). It is important to be aware of vaccine preventable diseases (VPD) in order to make informed choices with regards to vaccination.

The purpose of this project is to examine the utility of a program to increase knowledge and awareness of VPD and to examine the maintenance of the program effects over time. Some participants in this project have participated in the program, while others have participated in an alternative intervention to prevent the sexual victimization of college women. It is also the purpose of the study to assess knowledge, attitudes, and perceptions about VPD and vaccination. Women’s responses to the study’s questionnaires will be examined to identify important factors that encourage women to discuss vaccination with their health care providers.

As a reminder, all of your questionnaire responses will remain strictly confidential. If you have any further questions regarding the nature of this study, or would like to request details of the results of the study, please feel free to contact one of the following:

Part-time Faculty Researcher: Holly Raffle, Porter Hall – Room 206, 593-1076
Graduate Researcher: Lindsay M. Orchowski, Porter Hall – Office 44-P, 593-1088
Faculty Researcher: Christine A. Gidycz, Porter Hall - Room 231, 593-1092

In addition, if you are concerned about the study materials used or questions asked and wish to speak with a professional, or if you would like more information or reading material on this topic, please contact one of the following resources:

Hudson Health Center – Ohio University’s Student Health Service 593-1660
**Operating Hours:** Mon. through Fri. 8am - 4:30pm, except Thursday 9am - 4:30pm, Hours are slightly different in the summer and during winter and spring breaks. Closed on university holidays.
Hudson Health Center – Immunizations 593-4747
National Immunization Hotline (Phone) 1-800-232-2522
National Immunization Hotline (Email) NIPINFO@cdc.gov
Ohio University Counseling and Psychological Services (CPS) 593-1616

**Websites of Interest**
Ohio University’s Hudson Health Center
www.ohiou.edu/hudson/index.htm
Centers for Disease Control and Prevention www.cdc.gov
National Immunization Project Homepage www.cdc.gov/nip
Ohio Department of Health www.odh.state.oh.us/

More information on self-defense programming can be found online at:
www.ohiou.edu/polic.rad.htm
Appendix A-9
Contact Information Form

This is a multi-part study. Therefore, we will call you back for a two-month and a four-month follow-up. You will receive experimental credit points for your participation in earlier parts of the study after completion of the 2-month follow-up. Experimental credit points will not be received for participation in the 4-month follow-up.

Because students change their phone numbers, we would like a way to reach you if your number changes. If we lose contact, we will first attempt to reach you by email. The phone number of a parent or relative that is sure to know your new number would be preferable. If we call, we would simply say that we were calling from O.U. about an experiment that you participated in. We would not give any specifics about the study.

Your name:____________________________
Your current phone: ____________________
Your current email: _____________________
Your current home address:_______________
                                           ___________________________
                                           ___________________________

Contact name: ________________________
Contact phone: _______________________

Contact name:_________________________
Contact phone: ________________________
Appendix A-10
Program Participation Form - VPD

Thank you for your ongoing participation. The current study evaluated two health interventions for college women. You had the opportunity to participate in one of these interventions. This form indicates that you would like to be contacted to participate in the other health intervention. Participation is voluntary, and experimental credit points will not be given. During the course of this study, some women were given the opportunity to participate in a sexual assault risk reduction program. We would like to offer this program to all those who have not yet had the chance to participate. Please indicate your preference for participation and sign, print and date below.

___ Yes, I would like to participate in the Ohio University Sexual Assault Risk Reduction Program.

My Contact Information:
Telephone Number: ______________________        Email: ___________________
Local Address: __________________________

Because students change their phone numbers, we would like a way to reach you if your number changes. If we lose contact, we will first attempt to reach you by email. The phone number of a parent or relative that is sure to know your new number would be preferable. If we call, we would simply say that we were calling from O.U. about an experiment that you participated in. We would not give any specifics about the study.

Contact name: ________________________
Contact phone:_______________________
Signature_____________________             Date: _________________________
Print Name:___________________________

------------------------------------------------------------------------------------------------------------
Intervention Group: (circle one)  VPD     SARR     Term: (circle one)     Fall  Winter
Spring
Attempts to call: ____________________
Attempts to email: ____________________
Attempts to mail: ____________________
Date Scheduled: ____________________
No longer wants to participate? ___________
Appendix A-11  
Program Participation Form- SARR

Thank you for your ongoing participation. The current study evaluated two health interventions for college women. You had the opportunity to participate in one of these interventions.

This form indicates that you would like to be contacted to participate in the other health intervention. Participation is voluntary, and experimental credit points will not be given.

During the course of this study, some women were given the opportunity to participate in a peer-based vaccine preventable disease educational program. We would like to offer this program to all those who have not yet had the chance to participate. Please indicate your preference for participation and sign, print and date below.

___ Yes, I would like to participate in the Vaccine Preventable Diseases Educational Program.

My Contact Information:
Telephone Number: ______________________        Email: ___________________
Local Address: __________________________

Because students change their phone numbers, we would like a way to reach you if your number changes. If we lose contact, we will first attempt to reach you by email. The phone number of a parent or relative that is sure to know your new number would be preferable. If we call, we would simply say that we were calling from O.U. about an experiment that you participated in. We would not give any specifics about the study.

Contact name: ________________________
Contact phone: _________________________
Signature_____________________             Date: _________________________
Print Name:___________________________

----------------------------------------------------------------------------------------------------------------------------

Intervention Group: (circle one)  VPD   SARR   Term: (circle one)  Fall  Winter
Spring
Attempts to call:_______________________
Attempts to email:________________________
Attempts to mail:________________________
Date Scheduled:________________________
No longer wants to participate? ______________
Appendix B
Subject Number Calculation Form

Please write down the **last 4 digits**
of your social security number:

________ ________ ________ ________

Record the **month** and **day** of your birth date.
Add this **4 digit** figure to your SS # above.
If the month or day is only 1 digit, please put a '0'
in the first space. For example, if you were born on
January 1, you should record it as '01/01':

\[ + _____ / _____ ____ \]
\[ M \quad M \quad D \quad D \]

\[ ____________________________ \]

\[ = _____ _____ _____ _____ _____ \]

Add the number of letters in your mother's **FULL**
**FIRST** name. Do not use nicknames. For example, if
your mother's first name is Christine, but she goes by
the nickname Chris, you should record it as ‘09’, the
number of letters in CHRISTINE.:

\[ + _____ _____ \]

\[ _______________________________ \]

\[ = _____ _____ _____ _____ _____ \]

Please put this sheet back in the manila envelope provided. Fill out all questionnaire
sheets. If you have any questions, please ask the experimenter.
Appendix C-1
Demographics Questionnaire

1. What is your age?
   A. 18  D. 21  G. 24  J. Other (Write in) _______
   B. 19  E. 22  H. 25
   C. 20  F. 23  I. 26

2. What is your current year in school?
   A. First Year  D. Senior
   B. Sophomore  E. Graduate
   C. Junior      F. Other

3. What is your race?
   A. American Indian or Alaska Native  D. Native Hawaiian or Other Pacific Islander
   B. Asian  E. White
   C. Black or African American

4. What is your ethnicity?
   A. Hispanic or Latino
   B. Not Hispanic or Latino

5. In what religion were you raised?
   A. Catholic (Christian)  E. None
   B. Protestant (Christian)  F. Muslim
   C. Jewish  G. Other
   D. Nondenominational

6. What is your sexual orientation?
   A. Heterosexual
   B. Homosexual
   C. Bisexual

7. What is your current marital status?
   A. Never married  D. Divorced
   B. Cohabitating   E. Widowed
   C. Married

8. What is your current dating status?
   A. I do not date.
   B. I date casually
   C. I am involved in a long-term monogamous relationship (more than 6-months)
   D. I am engaged.
   E. I am married.
9. Are you currently involved in an exclusive romantic/dating relationship or marriage?
   A. Yes
   B. No

10. Approximately what is your parents’ yearly income?
    A. Unemployed or disabled
    B. $10,000-20,000
    C. $21,000-30,000
    D. $31,000-40,000
    E. $41,000-50,000
    F. $51,000-75,000
    G. $76,000-100,000
    H. Over $100,000
    I. Don’t Know

11. Have you ever taken a self-defense course?
    A. Yes
    B. No

12. Are you currently taking a self-defense course?
    A. Yes
    B. No

13. Have you ever participated in a sexual assault prevention program?
    A. Yes
    B. No

14. Have you ever willingly had sexual intercourse?
    A. Yes
    B. No

15. How old were you when you first willingly had sexual intercourse?
    A. I have never willingly had sexual intercourse
    B. 13 years or younger
    C. 14
    D. 15
    E. 16
    F. 17
    G. 18
    H. 19 years or older
16. How many consensual (not forced) sex partners have you had?
   A. 0
   B. 1 or 2
   C. 3 or 4
   D. 5 or 6
   E. 7 or 8
   F. 9 or 10
   G. 11 or more

17. How many consensual partners have you engaged in sexual behavior with (but not sexual intercourse)?
   A. 0
   B. 1 or 2
   C. 3 or 4
   D. 5 or 6
   E. 7 or 8
   F. 9 or 10
   G. 11 or more

18. My father’s occupation is:
   A. Executive, major professional
   B. Manager, minor professional
   C. Administrator, owner of a small business, semi-professional
   D. Clerical or sales worker
   E. Skilled worker
   F. Semi-skilled worker
   G. Unskilled worker
   H. Unemployed
   I. Homemaker
   J. Don’t know

19. My mother’s occupation is:
   A. Executive, major professional
   B. Manager, minor professional
   C. Administrator, owner of a small business, semi-professional
   D. Clerical or sales worker
   E. Skilled worker
   F. Semi-skilled worker
   G. Unskilled worker
   H. Unemployed
   I. Homemaker
   J. Don’t know
20. My father’s education is:
   A. Graduate of professional degree
   B. Partial graduate training
   C. College graduate
   D. Partial college training
   E. High school graduate (technical or training school)
   F. Partial high school (10th-12th grade)
   G. Partial Junior high school (7th or 9th grade)
   H. Elementary School (6th grade or lower)
   I. Don’t know

21. My mother’s education is:
   A. Graduate of professional degree
   B. Partial graduate training
   C. College graduate
   D. Partial college training
   E. High school graduate (technical or training school)
   F. Partial high school (10th-12th grade)
   G. Partial Junior high school (7th or 9th grade)
   H. Elementary School (6th grade or lower)
   I. Don’t know

22. Have you been vaccinated against Hepatitis B?
   A. Yes
   B. No
   C. Don’t know
   **If yes, write approximate date** Month________ Year________
   _____ I am unsure of the date (check if applicable)

23. Have you been vaccinated against meningococcal disease (meningococcal meningitis)?
   A. Yes
   B. No
   C. Don’t know
   **If yes, write approximate date** Month________ Year________
   _____ I am unsure of the date (check if applicable)

24. Have you been vaccinated against varicella (chicken pox)?
   A. Yes
   B. No
   C. Don’t know
   **If yes, write approximate date** Month________ Year________
   _____ I am unsure of the date (check if applicable)
25. Have you been vaccinated with measles, mumps, rubella (2 shots)?
   A. Yes
   B. No
   C. Don’t know
      **If yes, write approximate date**  Month________  Year___________
      _____ I am unsure of the date (check if applicable)

26. Have you been vaccinated against tetanus)?
   A. Yes
   B. No
   C. Don’t know
      **If yes, write approximate date**  Month________  Year___________
      _____ I am unsure of the date (check if applicable)

27. Have you been vaccinated against influenza (the flu) in the last year?
   A. Yes
   B. No
   C. Don’t know
      **If yes, write approximate date**  Month________  Year___________
      _____ I am unsure of the date (check if applicable)

28. Do you keep a current record of your vaccination status?
   A. Yes
   B. No

29. Have you ever participated in a vaccine preventable diseases educational program?
   A. Yes
   B. No

30. Do you live in on-campus housing (a residence hall)?
   A. Yes
   B. No
Appendix C-2
Drinking and Drug Habits Questionnaire

DIRECTIONS: Please answer all of the following questions. We ask that you answer each as honestly and thoughtfully as possible and remind you that all information you provide is strictly confidential. Please do not skip any of the following questions. Choose only one answer for each question, and circle your answer.

A Standard Drink is...

4 oz. glass of wine 12 oz. beer 1 oz. hard liquor 1 pitcher = 6 drinks
1 straight/mixed drink

1. My usual drinking practices are best described as:
   A. Having on average, 20 or more drinks per week
   B. Having on average, 12 drinks per week, but no more than 19 drinks per week
   C. On the average, 4 drinks per week, but no more than 11 drinks per week
   D. On the average, at least 1 drink per week but not more than 3 drinks per week
   E. On the average, less than 1 drink a month but more than 1 drink per year
   F. Having a drink less than 1 time per year
   G. I do not drink at all, though I used to drink in the past
   H. I do not drink at all, nor have I ever had a drink in the past.

The questions below are used to describe your drinking pattern during a typical week. Please choose the number for each day of the week indicating the average number of drinks you consumed on that day. For days you typically do not drink, choose zero. If you are a non-drinker, choose all zeros.

2. The average number of drinks you consume on Mondays:
   A. 0  D. 3  G. 6  J. 9
   B. 1  E. 4  H. 7  K. 10
   C. 2  F. 5  I. 8  L. 11 or more

3. The average number of drinks you consume on Tuesdays:
   A. 0  D. 3  G. 6  J. 9
   B. 1  E. 4  H. 7  K. 10
   C. 2  F. 5  I. 8  L. 11 or more
4. The average number of drinks you consume on **Wednesdays**:
   A. 0  D. 3  G. 6  J. 9  
   B. 1  E. 4  H. 7  K. 10  
   C. 2  F. 5  I. 8  L. 11 or more  

5. The average number of drinks you consume on **Thursdays**:
   A. 0  D. 3  G. 6  J. 9  
   B. 1  E. 4  H. 7  K. 10  
   C. 2  F. 5  I. 8  L. 11 or more  

6. The average number of drinks you consume on **Fridays**:
   A. 0  D. 3  G. 6  J. 9  
   B. 1  E. 4  H. 7  K. 10  
   C. 2  F. 5  I. 8  L. 11 or more  

7. The average number of drinks you consume on **Saturdays**:
   A. 0  D. 3  G. 6  J. 9  
   B. 1  E. 4  H. 7  K. 10  
   C. 2  F. 5  I. 8  L. 11 or more  

8. The average number of drinks you consume on **Sundays**:
   A. 0  D. 3  G. 6  J. 9  
   B. 1  E. 4  H. 7  K. 10  
   C. 2  F. 5  I. 8  L. 11 or more  

In terms of your experience **after drinking**, have you ever:

9. Been sick to your stomach?  
   A. Yes  B. No  

10. Had unusual flushing of the skin?  
    A. Yes  B. No  

11. Had a hangover (e.g., headaches, nausea)?  
    A. Yes  B. No  

12. Blacked out?  
    A. Yes  B. No  

13. Been arrested for driving while intoxicated (DWI)?  
    A. Yes  B. No  

14. Had problems with police not related to DWI (e.g., disturbing the peace, bar fights)?  A. Yes  B. No  

15. Injured yourself or someone else?  
    A. Yes  B. No  

16. Had an accident other than driving related?  
    A. Yes  B. No
17. Broken things or damaged property?
   A. Yes  B. No

Please indicate how often you have used each of the following substances. Please choose only one response for each substance and circle the number of your response. Please use the following definitions to help guide your responses.

1 = Never used
2 = Rarely use
3 = Occasionally use
4 = Regularly use

<table>
<thead>
<tr>
<th>Substance</th>
<th>Never used</th>
<th>Rarely use</th>
<th>Occasionally use</th>
<th>Regularly use</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALCOHOL</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>MARIJUANA (pot, grass, hashish):</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>OPIATES (heroin, morphine, demerol, codeine):</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>CAFFEINE (soda, coffee)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>BARBITURATES (downers, sleeping pills):</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>“CLUB” DRUGS (Ecstasy, GHB, Special K):</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>TOBACCO (cigarettes, cigars, chew):</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>TRANQUILIZERS (valium, Librium, xanax):</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>COCAINE (powder form):</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>CRACK</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>AMPHETAMINES (uppers, speed):</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>STEROIDS</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>
30. INHALENTS

31. PSYCHEDELICS
  (LSD, mescaline, peyote):
Appendix C-3
Childhood Sexual Victimization Questionnaire

DIRECTIONS: Many people have sexual experiences as children, either with friends or with people older than themselves. The following questions ask about any experiences you may have had before the age of 14. Answer no or yes to whether or not you have had each of these experiences before age 14. Then answer the questions below each experience referring to the most significant time you had the experience. Questions about sexual intercourse mean penetration of the vagina, no matter how slight, by a man's penis. Ejaculation is not required.

FOR EACH ITEM, PLEASE CIRCLE THE APPROPRIATE RESPONSE.

1. Another person showed his/her sex organs to you.
   A. No
   B. Yes

2. Who was involved? (Circle one letter) [If more than one person was involved, who was the oldest person?]
   A. I did not have this experience before age 14
   B. stranger
   C. older person you knew (neighbor, teacher, friend of your parents, etc.)
   D. friend of your brother or sister, or person about you age (not boyfriend)
   E. aunt, uncle, or grandparent
   F. brother, step-brother; sister, or step-sister
   G. step-father or step-mother
   H. father or mother
   I. boyfriend

3. Approximately how much older than you was the other person? [If more than one person was involved, how much older was the oldest person?]
   A. I did not have this experience before age 14
   B. The person was younger than me or about my same age
   C. The person was 1-4 years older than me
   D. The person was 5-9 years older than me
   E. The person was 10 or more years older than me
4. What is the main reason you participated?
   A. I did not have this experience before age 14
   B. Curiosity, it felt good, it made me feel loved or secure
   C. Other person used his/her authority
   D. Other person gave me gifts, money, candy, etc.
   E. Other person threatened to hurt or punish me
   F. Other person used physical force
   G. I did not willingly participate

5. Someone older than you requested you to do something sexual.
   A. No
   B. Yes

6. Who was involved? (Circle one letter) [If more than one person was involved, who was the oldest person?]
   A. I did not have this experience before age 14
   B. stranger
   C. older person you knew (neighbor, teacher, friend of your parents, etc.)
   D. friend of your brother or sister, or person about you age (not boyfriend)
   E. aunt, uncle, or grandparent
   F. brother, step-brother; sister, or step-sister
   G. step-father or step-mother
   H. father or mother
   I. boyfriend

7. Approximately how much older than you was the other person? [If more than one person was involved, how much older was the oldest person?]
   A. I did not have this experience before age 14
   B. The person was younger than me or about my same age
   C. The person was 1-4 years older than me
   D. The person was 5-9 years older than me
   E. The person was 10 or more years older than me
   F. 

8. What was the strategy used to request that you participate?
   A. I did not have this experience before age 14
   B. Curiosity, it felt good, it made me feel loved or secure
   C. Other person used his/her authority
   D. Other person gave me gifts, money, candy, etc.
   E. Other person threatened to hurt or punish me
   F. Other person used physical force
   G. I did not willingly participate
9. You showed your sex organs to another person at his/her request.
   A. No
   B. Yes

10. Who was involved? (Circle one letter) [If more than one person was involved, who was the oldest person?]
    A. I did not have this experience before age 14
    B. stranger
    C. older person you knew (neighbor, teacher, friend of your parents, etc.)
    D. friend of your brother or sister, or person about you age (not boyfriend)
    E. aunt, uncle, or grandparent
    F. brother, step-brother; sister, or step-sister
    G. step-father or step-mother
    H. father or mother
    I. boyfriend

11. Approximately how much older than you was the other person? [If more than one person was involved, how much older was the oldest person?]
    A. I did not have this experience before age 14
    B. The person was younger than me or about my same age
    C. The person was 1-4 years older than me
    D. The person was 5-9 years older than me
    E. The person was 10 or more years older than me

12. What is the main reason you participated?
    A. I did not have this experience before age 14
    B. Curiosity, it felt good, it made me feel loved or secure
    C. Other person used his/her authority
    D. Other person gave me gifts, money, candy, etc.
    E. Other person threatened to hurt or punish me
    F. Other person used physical force

13. Another person fondled you in a sexual way.
    A. No
    B. Yes
14. Who was involved? (Circle one letter) [If more than one person was involved, who was the oldest person?]
   A. I did not have this experience before age 14
   B. stranger
   C. older person you knew (neighbor, teacher, friend of your parents, etc.)
   D. friend of your brother or sister, or person about you age (not boyfriend)
   E. aunt, uncle, or grandparent
   F. brother, step-brother; sister, or step-sister
   G. step-father or step-mother
   H. father or mother
   I. boyfriend

15. Approximately how much older than you was the other person? [If more than one person was involved, how much older was the oldest person?]
   A. I did not have this experience before age 14
   B. The person was younger than me or about my same age
   C. The person was 1-4 years older than me
   D. The person was 5-9 years older than me
   E. The person was 10 or more years older than me

16. What is the main reason you participated?
   A. I did not have this experience before age 14
   B. Curiosity, it felt good, it made me feel loved or secure
   C. Other person used his/her authority
   D. Other person gave me gifts, money, candy, etc.
   E. Other person threatened to hurt or punish me
   F. Other person used physical force

17. Another person touched or stroked your sex organs.
   A. No
   B. Yes
18. Who was involved? (Circle one letter) [If more than one person was involved, who was the oldest person?]
   A. I did not have this experience before age 14
   B. stranger
   C. older person you knew (neighbor, teacher, friend of your parents, etc.)
   D. friend of your brother or sister, or person about your age (not boyfriend)
   E. aunt, uncle, or grandparent
   F. brother, step-brother; sister, or step-sister
   G. step-father or step-mother
   H. father or mother
   I. boyfriend

19. Approximately how much older than you was the other person? [If more than one person was involved, how much older was the oldest person?]
   A. I did not have this experience before age 14
   B. The person was younger than me or about my same age
   C. The person was 1-4 years older than me
   D. The person was 5-9 years older than me
   E. The person was 10 or more years older than me

20. What is the main reason you participated?
   A. I did not have this experience before age 14
   B. Curiosity, it felt good, it made me feel loved or secure
   C. Other person used his/her authority
   D. Other person gave me gifts, money, candy, etc.
   E. Other person threatened to hurt or punish me
   F. Other person used physical force

21. You touched or stroked another person's sex organs at his/her request.
   A. No
   B. Yes
22. Who was involved? (Circle one letter) [If more than one person was involved, who was the oldest person?]
   A. I did not have this experience before age 14
   B. stranger
   C. older person you knew (neighbor, teacher, friend of your parents, etc.)
   D. friend of your brother or sister, or person about you age (not boyfriend)
   E. aunt, uncle, or grandparent
   F. brother, step-brother; sister, or step-sister
   G. step-father or step-mother
   H. father or mother
   I. boyfriend

23. Approximately how much older than you was the other person? [If more than one person was involved, how much older was the oldest person?]
   A. I did not have this experience before age 14
   B. The person was younger than me or about my same age
   C. The person was 1-4 years older than me
   D. The person was 5-9 years older than me
   E. The person was 10 or more years older than me

24. What is the main reason you participated?
   A. I did not have this experience before age 14
   B. Curiosity, it felt good, it made me feel loved or secure
   C. Other person used his/her authority
   D. Other person gave me gifts, money, candy, etc.
   E. Other person threatened to hurt or punish me
   F. Other person used physical force

25. Another person attempted intercourse (Got on top of you, attempted to insert penis but penetration did not occur).
   A. No
   B. Yes
26. Who was involved? (Circle one letter) [If more than one person was involved, who was the oldest person?]
   A. I did not have this experience before age 14
   B. stranger
   C. older person you knew (neighbor, teacher, friend of your parents, etc.)
   D. friend of your brother or sister, or person about you age (not boyfriend)
   E. aunt, uncle, or grandparent
   F. brother, step-brother; sister, or step-sister
   G. step-father or step-mother
   H. father or mother
   I. boyfriend

27. Approximately how much older than you was the other person? [If more than one person was involved, how much older was the oldest person?]
   A. I did not have this experience before age 14
   B. The person was younger than me or about my same age
   C. The person was 1-4 years older than me
   D. The person was 5-9 years older than me
   E. The person was 10 or more years older than me

28. What was the strategy used to request that you participate?
   A. I did not have this experience before age 14
   B. Curiosity, it felt good, it made me feel loved or secure
   C. Other person used his/her authority
   D. Other person gave me gifts, money, candy, etc.
   E. Other person threatened to hurt or punish me
   F. Other person used physical force

29. Another person had intercourse (oral, vaginal or anal) with you, (any amount of penetration -- ejaculation not necessary)
   A. No
   B. Yes
30. Who was involved? (Circle one letter) [If more than one person was involved, who was the oldest person?]
   A. I did not have this experience before age 14
   B. stranger
   C. older person you knew (neighbor, teacher, friend of your parents, etc.)
   D. friend of your brother or sister, or person about you age (not boyfriend)
   E. aunt, uncle, or grandparent
   F. brother, step-brother; sister, or step-sister
   G. step-father or step-mother
   H. father or mother
   I. boyfriend

31. Approximately how much older than you was the other person? [If more than one person was involved, how much older was the oldest person?]
   A. I did not have this experience before age 14
   B. The person was younger than me or about my same age
   C. The person was 1-4 years older than me
   D. The person was 5-9 years older than me
   E. The person was 10 or more years older than me

32. What is the main reason you participated?
   A. I did not have this experience before age 14
   B. Curiosity, it felt good, it made me feel loved or secure
   C. Other person used his/her authority
   D. Other person gave me gifts, money, candy, etc.
   E. Other person threatened to hurt or punish me
   F. Other person used physical force
Appendix C-4
Sexual Experiences Survey

DIRECTIONS: The following questions ask about your sexual experiences since the age of 14. Questions about sexual intercourse mean penetration of a woman's vagina, no matter how slight, by a man's penis. Ejaculation is not required. Whenever you see the words sexual intercourse, please use this definition.

1. Have you ever given in to sex play (fondling, kissing, or petting, but not, intercourse) when you didn't want to because you were overwhelmed by a man's continual arguments and pressure
   A. No
   B. Yes

2. Have you had sex play (fondling, kissing, or petting, but not, intercourse) when you didn't want to because a man used his authority (boss, teacher, camp counselor, supervisor) to make you?
   A. No
   B. Yes

3. Have you had sex play (fondling, kissing, or petting, but not, intercourse) when you didn't want to because a man threatened or used some degree of physical force (twisting your arm, holding you down, etc.).
   A. No
   B. Yes

4. Have you had a man attempt sexual intercourse (get on top of you and insert his penis) when you didn't want to by threatening or using some degree of force (twisting your arm, holding you down, etc.) but intercourse did not occur?
   A. No
   B. Yes

5. Have you had a man attempt sexual intercourse (get on top of you and insert his penis) with you by giving you alcohol or drugs, but intercourse did not occur?
   A. No
   B. Yes

6. Have you given in to sexual intercourse when you didn't want to because you were overwhelmed by a man's continual arguments and pressure?
   A. No
   B. Yes
7. Have you had sexual intercourse when you didn't want to because a man used his position of authority (boss, teacher, counselor, supervisor)?
   A. No
   B. Yes

8. Have you had sexual intercourse when you didn't want to because a man gave you alcohol or drugs?
   A. No
   B. Yes

9. Have you had sexual intercourse when you didn't want to because a man threatened or used some degree of physical force (twisting your arm, holding you down, etc.) to make you?
   A. No
   B. Yes

10. Have you had sexual acts (anal or oral intercourse or penetration by objects other than the penis) when you didn't want to because a man threatened or used some degree of physical force (twisting your arm, holding you down, etc.)?
    A. No
    B. Yes

Look back at questions 1-10. For the following questions, refer to the highest question number to which you answered “yes”. If you have had this experience more with more than one person on different occasions, refer to the most significant time this occurred. If you did not answer yes to any of the previous questions, then answer Not applicable to the following questions

11. What was your relationship to the man/men at that time? (choose one) (If more than one man was involved, what was your relationship to the oldest?)
    a. Not applicable
    b. Stranger
    c. Non-romantic acquaintance (friend, neighbor, etc)
    d. Casual/first date or romantic acquaintance
    e. Relative (father, stepfather, uncle brother)

12. How well did you know him?
    a. Not applicable
    b. Didn’t know at all
    c. Slightly/moderately acquainted
    d. Very well acquainted
    e. Extremely well acquainted
13. Was the man/men using intoxicants on this occasion?
   a. Not applicable
   b. Alcohol
   c. Drugs
   d. Both
   e. None

14. Were you using any intoxicants on this occasion?
   a. Not applicable
   b. Alcohol
   c. Drugs
   d. Both
   e. None

15. Did you discuss the experience with anyone?
   a. Not applicable
   b. No
   c. Yes

16. Did you press charges?
   a. Not applicable
   b. No
   c. Yes

17. Do you think you might press charges at any future time?
   a. Not applicable
   b. No
   c. Yes

18. How responsible is he/are they for what happened?
   a. Not applicable
   b. Not at all or a little
   c. Somewhat
   d. Quite a bit
   e. Very much

19. Looking back on the experience, how would you describe the situation?
   (remember this is confidential)
   a. Not applicable
   b. I don’t feel that I was victimized
   c. I believe I was a victim of a serious miscommunication
   d. I believe I was a victim of sexual assault
   e. I believe I was a victim of rape or date rape
   f. I believe I was a victim of a crime other than sexual assault or rape
Appendix C-5
Dating Self Protection Against Rape Scale

DIRECTIONS: For each of the following questions please circle how often you feel that you do the following in dating situations.

<table>
<thead>
<tr>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>Almost never</td>
<td>Sometimes</td>
<td>Most of the time</td>
<td>Frequently</td>
<td>Always</td>
</tr>
</tbody>
</table>

How often do you:

1. Plan for what self-protective measure you would take if you were alone with your partner and he/she becomes sexually aggressive?

2. Have trusted friends(s) be with you and your dating partner?

3. Abstain or limit your alcohol intake to three drinks or less?

4. Let a friend or family member know where you are and whom you are with?

5. Speak directly and assertively?

6. Try to be alone with your dating partner?

7. Talk to people who know your dating partner to find out what he/she is like?

8. Pay attention to your dating partner’s drug/alcohol intake?
9. Provide your own transportation so you do not have to depend on your dating partner for transportation?

   A        B           C  D  E  F
   Never    Almost never Sometimes Most of the time Frequently Always

10. Consider using self-defense strategies such as karate against your dating partner if the need arises?

   A        B           C  D  E  F
   Never    Almost never Sometimes Most of the time Frequently Always

11. Meet in private place instead of a public place?

   A        B           C  D  E  F
   Never    Almost never Sometimes Most of the time Frequently Always

12. Try to be aware of common household objects that could be used as weapons if your dating partner became sexually aggressive?

   A        B           C  D  E  F
   Never    Almost never Sometimes Most of the time Frequently Always

13. Make yourself aware of exits from the area where you and your dating partner are?

   A        B           C  D  E  F
   Never    Almost never Sometimes Most of the time Frequently Always

14. Try to be aware of where other people are who may be able to help you in case of an emergency?

   A        B           C  D  E  F
   Never    Almost never Sometimes Most of the time Frequently Always

15. Carry enough money with you to get a taxi or have someone you can call, in case of an emergency?

   A        B           C  D  E  F
   Never    Almost never Sometimes Most of the time Frequently Always
Appendix C-6
Sexual Communication Survey

DIRECTIONS: The following questions refer to sexual communication. Think about how you typically behave on the first few dates that you have with a man. Please indicate by circling the choice which best fits you. If you do not date, please respond "Not applicable" for all of the following questions.

1. Do you speak openly to the guys that you go out with about the issue of birth control?
   
   A. Never           E. Most of the time
   B. Almost never    F. Almost all of the time
   C. Some of the time G. Always
   D. About half of the time H. Not Applicable (I do not date)

2. Do you speak openly to guys that you go out with about the issue of sexually transmitted diseases?
   
   A. Never           E. Most of the time
   B. Almost never    F. Almost all of the time
   C. Some of the time G. Always
   D. About half of the time H. Not Applicable (I do not date)

3. Do you ever say "yes" to something sexual when you really mean "no"?
   
   A. Never           E. Most of the time
   B. Almost never    F. Almost all of the time
   C. Some of the time G. Always
   D. About half of the time H. Not Applicable (I do not date)

4. Do you ever say "no" to something sexual when you really mean "yes"?
   
   A. Never           E. Most of the time
   B. Almost never    F. Almost all of the time
   C. Some of the time G. Always
   D. About half of the time H. Not Applicable (I do not date)
5. Do you ever end up allowing a guy that you go out with to hold your hand when you don't really want to, not because you feel forced or coerced, but because of some other concern (such as wanting him to like you or being too embarrassed to talk about it)?

A. Never  E. Most of the time
B. Almost never  F. Almost all of the time
C. Some of the time  G. Always
D. About half of the time  H. Not Applicable (I do not date)

6. Do you ever end up allowing a guy that you go out with to put his arms around you when you don't really want to, not because you feel forced or coerced, but because of some other concern (such as wanting him to like you or being too embarrassed to talk about it)?

A. Never  E. Most of the time
B. Almost never  F. Almost all of the time
C. Some of the time  G. Always
D. About half of the time  H. Not Applicable (I do not date)

7. Do you ever end up allowing a guy that you go out with to kiss you when you don't really want to, not because you feel forced or coerced, but because of some other concern (such as wanting him to like you or being too embarrassed to talk about it)?

A. Never  E. Most of the time
B. Almost never  F. Almost all of the time
C. Some of the time  G. Always
D. About half of the time  H. Not Applicable (I do not date)

8. Do you ever end up allowing a guy that you go out with to touch your breasts when you don't really want to, not because you feel forced or coerced, but because of some other concern (such as wanting him to like you or being too embarrassed to talk about it)?

A. Never  E. Most of the time
B. Almost never  F. Almost all of the time
C. Some of the time  G. Always
D. About half of the time  H. Not Applicable (I do not date)
9. Do you ever end up allowing a guy that you go out with to touch your genitals when you don't really want to, not because you feel forced or coerced, but because of some other concern (such as wanting him to like you or being too embarrassed to talk about it)?

A. Never        E. Most of the time
B. Almost never  F. Almost all of the time
C. Some of the time  G. Always
D. About half of the time  H. Not Applicable (I do not date)

10. Do you ever end up allowing a guy that you go out with to perform oral sex with you (you as the recipient) when you don't really want to, not because you feel forced or coerced, but because of some other concern (such as wanting him to like you or being too embarrassed to talk about it)?

A. Never        E. Most of the time
B. Almost never  F. Almost all of the time
C. Some of the time  G. Always
D. About half of the time  H. Not Applicable (I do not date)

11. Do you ever end up allowing a guy that you go out with to perform oral sex with you (you as the administrator) when you don't really want to, not because you feel forced or coerced, but because of some other concern (such as wanting him to like you or being too embarrassed to talk about it)?

A. Never        E. Most of the time
B. Almost never  F. Almost all of the time
C. Some of the time  G. Always
D. About half of the time  H. Not Applicable (I do not date)

12. Do you ever end up having vaginal intercourse with a guy that you go out with when you don't really want to, not because you feel forced or coerced, but because of some other concern (such as wanting him to like you or being too embarrassed to talk about it)?

A. Never        E. Most of the time
B. Almost never  F. Almost all of the time
C. Some of the time  G. Always
D. About half of the time  H. Not Applicable (I do not date)
13. Do you ever want to hold hands with a guy that you go out with, but not actually do it, because of some concern (such as fear that he will think badly of you or that your reputation might be damaged)?

A. Never  E. Most of the time
B. Almost never  F. Almost all of the time
C. Some of the time  G. Always
D. About half of the time  H. Not Applicable (I do not date)

14. Do you ever want to put your arms around a guy that you go out with, but not actually do it, because of some concern (such as fear that he will think badly of you or that your reputation might be damaged)?

A. Never  E. Most of the time
B. Almost never  F. Almost all of the time
C. Some of the time  G. Always
D. About half of the time  H. Not Applicable (I do not date)

15. Do you ever want to kiss a guy that you go out with, but not actually do it, because of some concern (such as fear that he will think badly of you or that your reputation might be damaged)?

A. Never  E. Most of the time
B. Almost never  F. Almost all of the time
C. Some of the time  G. Always
D. About half of the time  H. Not Applicable (I do not date)

16. Do you ever want a guy that you go out with to touch your breasts, but not actually do it, because of some concern (such as fear that he will think badly of you or that your reputation might be damaged)?

A. Never  E. Most of the time
B. Almost never  F. Almost all of the time
C. Some of the time  G. Always
D. About half of the time  H. Not Applicable (I do not date)

17. Do you ever want a guy that you go out with to touch your genitals, but not actually do it, because of some concern (such as fear that he will think badly of you or that your reputation might be damaged)?

A. Never  E. Most of the time
B. Almost never  F. Almost all of the time
C. Some of the time  G. Always
D. About half of the time  H. Not Applicable (I do not date)
18. Do you ever want to touch a guy’s genitals, but not actually do it, because of some concern (such as fear that he will think badly of you or that your reputation might be damaged)?

A. Never  E. Most of the time
B. Almost never  F. Almost all of the time
C. Some of the time  G. Always
D. About half of the time  H. Not Applicable (I do not date)

19. Do you ever want a guy that you go out with to perform oral sex with you (you as the recipient), but not actually do it, because of some concern (such as fear that he will think badly of you or that your reputation might be damaged)?

A. Never  E. Most of the time
B. Almost never  F. Almost all of the time
C. Some of the time  G. Always
D. About half of the time  H. Not Applicable (I do not date)

20. Do you ever want a guy that you go out with to perform oral sex with you (you as the administrator), but not actually do it, because of some concern (such as fear that he will think badly of you or that your reputation might be damaged)?

A. Never  E. Most of the time
B. Almost never  F. Almost all of the time
C. Some of the time  G. Always
D. About half of the time  H. Not Applicable (I do not date)

21. Do you ever want to have vaginal intercourse with a guy that you go out with, but not actually do it, because of some concern (such as fear that he will think badly of you or that your reputation might be damaged)?

A. Never  E. Most of the time
B. Almost never  F. Almost all of the time
C. Some of the time  G. Always
D. About half of the time  H. Not Applicable (I do not date)
Appendix C-7
Sexual Assertiveness Scale

<table>
<thead>
<tr>
<th></th>
<th>never</th>
<th>sometimes</th>
<th>usually</th>
<th>always</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0% of the time</td>
<td>25% of the time</td>
<td>50% of the time</td>
<td>75% of the time</td>
</tr>
</tbody>
</table>

1. I begin sex with my partner if I want to.
2. I let my partner know if I want my partner to touch my genitals.
3. I wait for my partner to touch my genitals instead of letting my partner know that's what I want. (R)
4. I wait for my partner to touch my breasts instead of letting my partner know that's what I want. (R)
5. I let my partner know if I want to have my genitals kissed.
6. Women should wait for men to start things like breast touching. (R)
7. I give in and kiss if my partner pressures me, even if I already said no. (R)
8. I put my mouth on my partner's genitals if my partner wants me to, even if I don't want to. (R)
9. I refuse to let my partner touch my breasts if I don't want that, even if my partner insists.
10. I have sex if my partner wants me to, even if I don't want to. (R)
11. If I said no, I won't let my partner touch my genitals even if my partner pressures me.
12. I refuse to have sex if I don't want to, even if my partner insists.
13. I have sex without a condom or latex barrier if my partner doesn't like them, even if I want to use one. (R)
14. I have sex without using a condom or latex barrier if my partner insists, even if I don't want to. (R)
15. I make sure my partner and I use a condom or latex barrier when we have sex.
16. I have sex without using a condom or latex barrier if my partner wants. (R)
17. I insist on using a condom or latex barrier if I want to, even if my partner doesn't like them.
18. I refuse to have sex if my partner refuses to use a condom or latex barrier.
### Appendix C-8

**Self-Efficacy Survey**

Please answer these questions concerning how confident you feel about your ability in question.

<table>
<thead>
<tr>
<th></th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
<th>F</th>
<th>G</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Not at all</td>
<td>Confident</td>
<td>Average</td>
<td>Very Confident</td>
<td></td>
<td></td>
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</table>

1. If a man you were with was attempting to get you to have sex with him and you were not interested, how confident are you that you could successfully resist his advances?

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<th></th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Not at all</td>
<td>Confident</td>
<td>Average</td>
<td>Very Confident</td>
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2. If a man you were with was attempting to pay for your meal when you did not want him to, how confident are you that you could be assertive enough to tell him that you would pay for your own way.

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<tr>
<th></th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
<th>F</th>
<th>G</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Not at all</td>
<td>Confident</td>
<td>Average</td>
<td>Very Confident</td>
<td></td>
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3. If a man you were with was attempting to get your to consume alcohol despite your wishes not to do so, how confident are you that you could successfully resist his pressuring?

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<th>D</th>
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<tbody>
<tr>
<td></td>
<td>Not at all</td>
<td>Confident</td>
<td>Average</td>
<td>Very Confident</td>
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</table>

4. How confident are you that you could successfully avoid a situation in which you could be sexually assaulted?

<table>
<thead>
<tr>
<th></th>
<th>A</th>
<th>B</th>
<th>C</th>
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<td>Not at all</td>
<td>Confident</td>
<td>Average</td>
<td>Very Confident</td>
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</table>

5. If a situation develops in which you feel you could be in danger of sexual assault, how confident are you that you could successfully think up ways to get out of that situation and then execute your plan?

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<th>A</th>
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<th>C</th>
<th>D</th>
<th>E</th>
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<tbody>
<tr>
<td></td>
<td>Not at all</td>
<td>Confident</td>
<td>Average</td>
<td>Very Confident</td>
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</tbody>
</table>
6. How confident are you that you could successfully recognize the signs that you might be in danger of being sexually assaulted?

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<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
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<th>F</th>
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<tbody>
<tr>
<td>Not at all</td>
<td></td>
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<td>Very Confident</td>
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<tr>
<td>Confident</td>
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</table>

7. How confident are you that if you recognized the danger signs of sexual assault you could avoid/prevent it from happening?

<table>
<thead>
<tr>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
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<tbody>
<tr>
<td>Not at all</td>
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<td>Confident</td>
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</table>
Appendix C-9
Global Perceptions of Risk

DIRECTIONS: Please read the following statements carefully and choose the best response for each.

1. How likely do you think that, during the next two months, you will find yourself in a situation where someone will make an attempt to involve you or pressure you into sexual behavior (fondling, kissing, petting, but not intercourse) when you don’t want to?
   A. 0%   F. 51-60%
   B. 1-20%  G. 61-70%
   C. 21-30%  H. 71-80%
   D. 31-40%  I. 81-90%
   E. 41-50%  J. 91-100%

2. In comparison to your friends, how likely do you think that, during the next two months, you will find yourself in a situation where someone will make an attempt to involve you or pressure you into sexual behavior (fondling, kissing, petting, but not intercourse) when you don’t want to?
   A. I feel that my chance is the same as my friends
   B. I feel that my chance is less than my friends
   C. I feel that my chance is greater than my friends

3. How likely do you think that, during the next three months, you will find yourself in a situation where someone will make an attempt to use their authority (boss, teacher, camp counselor, supervisor) to involve you or pressure you into sexual behavior (fondling, kissing, petting, but not intercourse)?
   A. 0%   F. 51-60%
   B. 1-20%  G. 61-70%
   C. 21-30%  H. 71-80%
   D. 31-40%  I. 81-90%
   E. 41-50%  J. 91-100%

4. In comparison to your friends, how likely do you think that, during the next three months, you will find yourself in a situation where someone will make an attempt to use their authority (boss, teacher, camp counselor, supervisor) to involve you into sexual behavior (fondling, kissing, petting, but not intercourse)?
   A. I feel that my chance is the same as my friends
   B. I feel that my chance is less than my friends
   C. I feel that my chance is greater than my friends
5. How likely do you think that, during the next three months, you will find yourself in a situation where someone will make an attempt to threaten or use some degree of physical force (twisting her arm, holding you down, etc.) to involve you in sexual behavior (fondling, kissing, petting, but not intercourse)?
   A. 0%   F. 51-60%
   B. 1-20%  G. 61-70%
   C. 21-30%  H. 71-80%
   D. 31-40%  I. 81-90%
   E. 41-50%  J. 91-100%

6. In comparison to your friends, how likely do you think that, during the next three months, you will find yourself in a situation where someone will make an attempt to threaten or use some degree of physical force (twisting your arm, holding you down, etc.) to involve you in sexual behavior (fondling, kissing, petting, but not intercourse)?
   A. I feel that my chance is the same as my friends
   B. I feel that my chance is less than my friends
   C. I feel that my chance is greater than my friends

7. How likely do you think that, in the next three months, you will find yourself in a situation where someone will make an attempt to threaten or use some degree of physical force (twisting your arm, holding you down, etc.) to have sexual intercourse with you (get on top of you, attempt to insert his penis)?
   A. 0%   F. 51-60%
   B. 1-20%  G. 61-70%
   C. 21-30%  H. 71-80%
   D. 31-40%  I. 81-90%
   E. 41-50%  J. 91-100%

8. In comparison to your friends, how likely do you think that, in the next three months, you will find yourself in a situation where someone will make an attempt to threaten or use some degree of physical force (twisting your arm, holding you down, etc.) to have sexual intercourse with you (get on top of you, attempt to insert his penis)?
   A. I feel that my chance is the same as my friends
   B. I feel that my chance is less than my friends
   C. I feel that my chance is greater than my friends
9. How likely do you think that, in the next three months, you will find yourself in a situation where someone will make an attempt to have sexual intercourse with you (get on top of you, attempt to insert his penis) by giving you alcohol or drugs, to prevent you from resisting?
   A. 0%   F. 51-60%
   B. 1-20%  G. 61-70%
   C. 21-30%  H. 71-80%
   D. 31-40%  I. 81-90%
   E. 41-50%  J. 91-100%

10. In comparison to your friends, how likely do you think that, in the next three months, you will find yourself in a situation where someone will make an attempt to have sexual intercourse with you (get on top of you, attempt to insert his penis) by giving you alcohol or drugs, to prevent you from resisting?
   A. I feel that my chance is the same as my friends
   B. I feel that my chance is less than my friends
   C. I feel that my chance is greater than my friends

11. How likely do you think that, in the next three months, you will find yourself in a situation where someone will make an attempt to overwhelm you with continual arguments and pressure to have sexual intercourse with you (get on top of you, attempt to insert his penis)?
   A. 0%   F. 51-60%
   B. 1-20%  G. 61-70%
   C. 21-30%  H. 71-80%
   D. 31-40%  I. 81-90%
   E. 41-50%  J. 91-100%

12. In comparison to your friends, how likely do you think that, in the next three months, you will find yourself in a situation where someone will make an attempt overwhelm you with continual arguments and pressure to have sexual intercourse with you (get on top of you, attempt to insert his penis)?
   A. I feel that my change is the same as my friends
   B. I feel that my chance is less than my friends
   C. I feel that my chance is greater than my friends
13. How likely do you think that, in the next three months, you will find yourself in a situation where someone will make an attempt to use your position of authority (boss, teacher, counselor, supervisor) to have sexual intercourse with you (get on top of you, attempt to insert his penis)?
   A. 0%   F. 51-60%
   B. 1-20%  G. 61-70%
   C. 21-30%  H. 71-80%
   D. 31-40%  I. 81-90%
   E. 41-50%  J. 91-100%

14. In comparison to your friends, how likely do you think that, in the next three months, you will find yourself in a situation where someone will make an attempt to use your position of authority (boss, teacher, counselor, supervisor) to have sexual intercourse with you (get on top of you, attempt to insert his penis)?
   A. I feel that my chance is the same as my friends
   B. I feel that my chance is less than my friends
   C. I feel that my chance is greater than my friends

15. How likely do you think that, in the next three months, you will find yourself in a situation where someone will make an attempt to threaten or use some degree of physical force (twisting her arm, holding her down, etc.) to have sexual acts with you (anal or oral intercourse or penetration by objects rather than the penis)?
   A. 0%   F. 51-60%
   B. 1-20%  G. 61-70%
   C. 21-30%  H. 71-80%
   D. 31-40%  I. 81-90%
   E. 41-50%  J. 91-100%

16. In comparison to your friends, how likely do you think that, in the next three months, you will find yourself in a situation where someone will make an attempt to threaten or use some degree of physical force (twisting her arm, holding her down, etc.) to have sexual acts with you (anal or oral intercourse or penetration by objects rather than the penis)?
   A. I feel that my chance is the same as my friends
   B. I feel that my chance is less than my friends
   C. I feel that my chance is greater than my friends
Appendix C-10
Rape Attribution Scale

**DIRECTIONS:** Below are statements describing thoughts women often have about why an assault occurred. Please indicate how often you have had each of the following thoughts in the past month. Please use the following scale:

<table>
<thead>
<tr>
<th>Never</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Often</th>
<th>Very Often</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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</tbody>
</table>

**How often have you thought:** I would be assaulted because...

1. Society doesn’t do enough to prevent violence against women  
2. I used poor judgment.  
3. I am just the victim type.  
4. It was just bad luck.  
5. The person thought he could get away with it.  
6. Men are taught not to respect women.  
7. I should have resisted more.  
8. I am a careless person.  
9. I was in the wrong place at the wrong time.  
10. The person wanted to feel power over someone.  
11. Men are socialized to be violent.  
12. I should have been more cautious.  
13. Things like this happen to people like me.  
14. Things like this happen at random.  
15. The person was sick.  
16. In our society, women are sex objects.  
17. I just put myself into a vulnerable situation.  
18. I am unlucky.  
19. I was a victim of chance.  
20. The person was angry at women.  
21. The media encourages violence against women.  
22. I didn’t do enough to protect myself.  
23. I am too trusting.  
24. Bad things like this are just a part of life.  
25. The person wanted to hurt someone.

**Scoring:**

<table>
<thead>
<tr>
<th>Societal</th>
<th>items: 1, 6, 11, 16, 21</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral self-blame</td>
<td>items: 2, 7, 12, 17, 22</td>
</tr>
<tr>
<td>Characterological self blame</td>
<td>items: 3, 8, 13, 18, 23</td>
</tr>
<tr>
<td>Chance</td>
<td>items: 4, 9, 14, 19, 24</td>
</tr>
<tr>
<td>Rapist</td>
<td>items: 5, 10, 15, 20, 25</td>
</tr>
</tbody>
</table>
Appendix C-11
Reporting and Recognizing Behaviors Scale

DIRECTIONS: The following questions ask about your likelihood to perform certain behaviors. Please circle the corresponding letter to each question.

A           B           C        D    E          F       G
Not at all      A little        Somewhat     Likely        Very      Extremely   Completely
Likely           Likely            Likely                     Likely           Likely              Likely

1. How likely are you to recognize unwanted sexual behaviors?

2. How likely are you to report an unwanted sexual act(s) to a friend?

3. How likely are you to report an unwanted sexual act(s) to your residential advisor?

4. How likely are you to report an unwanted sexual act(s) to Counseling and Psychological Services? (Either anonymously, via a third party, or yourself)

5. How likely are you to report an unwanted sexual act(s) on a survey like this?

6. How likely are you to report an unwanted sexual act(s) to the police or other agency (e.g., university)?
Appendix C-12
Transtheoretical Model Scale

1. During the past month, have you been thinking about using assertive behaviors in response to threatening dating situations? (e.g., saying “No” or “I am not comfortable with that”, speaking directly, maintaining a protective body language/posture.)
   A. No   B. Yes

2. During the past month, have you been actively trying to implement assertive responses to threatening dating situations? (e.g., saying “No” or “I am not comfortable with that”, speaking directly, maintaining a protective body language/posture.)
   A. No   B. Yes

3. Are you seriously considering trying to implement assertive responses to threatening dating situations sometime in the next six months? (e.g., saying “No” or “I am not comfortable with that”, speaking directly, maintaining a protective body language/posture.)
   A. No   B. Yes

4. Have you consistently implemented assertive behavior in response to threatening dating situations for the past 6 months? (e.g., saying “No” or “I am not comfortable with that”, speaking directly, maintaining protective body language/posture.)
   A. No   B. Yes

5. During the past month, have you been thinking about reducing your risk factors for experiencing unwanted sexual behavior? (e.g. provide your own transportation, walk home with friends).
   A. No   B. Yes

6. During the past month, have you been actively trying to reduce your risk for experiencing unwanted sexual behavior? (e.g. provide your own transportation, walk home with friends).
   A. No   B. Yes

7. Are you seriously considering trying to use strategies to reduce your risk for experiencing unwanted sexual behaviors sometime in the next six months? (e.g. provide your own transportation, walk home with friends).
   A. No   B. Yes

8. Have you maintained strategies to reduce your risk for experiencing unwanted sexual behaviors consistently for the past six months? (e.g. provide your own transportation, walk home with friends).
   A. No   B. Yes
9. In the **past month**, have you been **thinking about** using open sexual communication in dating situations? (e.g., speak openly about STD’s, birth control, sexual boundaries and desires.)
   A. No   B. Yes

10. In the **past month**, have you been **actively trying to implement** open sexual communication in dating situations? (e.g., speak openly about STD’s, birth control, sexual boundaries and desires.)
   A. No   B. Yes

11. Are you **seriously considering trying to implement** open sexual communication in dating situations **sometime in the next six months**? (e.g., speak openly about STD’s, birth control, sexual boundaries and desires.)
   A. No   B. Yes

12. Have you maintained open sexual communication in dating situations **for the past 6 months**? (e.g., speak openly about STD’s, birth control, sexual boundaries and desires.)
   A. No   B. Yes

13. In the **past month**, have you been **thinking about** engaging in responsible drinking behaviors when in dating or social situations with men? (e.g., pay attention to your dating partner’s alcohol intake, limit or monitor alcohol use, buy your own drinks.)
   A. No   B. Yes

14. In the **past month**, have you been **actively trying to** engage in responsible drinking behaviors when in dating or social situations with men? (e.g., pay attention to your dating partner’s alcohol intake, limit or monitor alcohol use, buy your own drinks.)
   A. No   B. Yes

15. Are you **seriously considering trying to** engage in responsible drinking behaviors when in dating or social situations with men **in the next six months**? (e.g., pay attention to your dating partner’s alcohol intake, limit or monitor alcohol use, buy your own drinks.)
   A. No   B. Yes

16. Have you **maintained** responsible drinking behaviors when in dating or social situations with men **for the past six months**? (e.g., pay attention to your dating partner’s alcohol intake, limit or monitor alcohol use, buy your own drinks.)
   A. No   B. Yes
Appendix C-13
Cognitive Appraisals of Self-Protective Behavior Scale

DIRECTIONS: Please choose the best response for each of the following questions and circle your answer.

DIRECTIONS: On a scale of 1 (Never) to 7 (Extremely Likely) how likely is it that you would experience some NEGATIVE OUTCOME (e.g., be embarrassed, create a scene, not have a good time) if you engaged in one of these activities?

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Not Likely</td>
<td>Moderately Likely</td>
<td>Extremely Likely</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

It is likely you will experience a NEGATIVE outcome when you:

1. Plan for what self-protective measure you would take if you were alone with your partner and he/she becomes sexually aggressive?

2. Have trusted friend(s) be with you and your dating partner?

3. Abstain or limit your alcohol intake to three drinks or less?

4. Let a friend or family member know where you are and whom you are with?

5. Speak directly and assertively?

6. Try to be alone with your dating partner?

7. Talk to people who know your dating partner to find out what he/she is like?

8. Pay attention to your dating partner’s drug/alcohol intake?

9. Provide your own transportation so you do not have to depend on your dating partner for transportation?

10. Consider using self-defense strategies such as karate against your dating partner if the need arises?

11. Meet in a private place instead of a public place?

12. Try to be aware of common household objects that could be used as weapons if your dating partner became sexually aggressive?
13. Make yourself aware of exits from the area where you and your dating partner are?

14. Try to be aware of where other people are who may be able to help you in case of an emergency?

15. Carry enough money with you to get a taxi or have someone you can call, in case of an emergency?

16. Trying/using drugs other than alcohol
   a. Marijuana
   b. Cocaine
   c. Hallucinogens
   d. Amphetamines (speed)
   e. Try/ Use Inhalants

17. Driving after drinking
   a. 1-2 alcoholic drinks
   b. 3-4 alcoholic drinks
   c. 5 or more alcoholic drinks

18. Drinking more than 5 alcoholic drinks on one occasion

19. Mixing drugs and alcohol

20. Playing drinking games

21. Riding in a car with someone who has consumed alcohol

22. Purchasing/mixing my own drinks

23. Leaving a social event with someone I have just met or do not know well
SECTION B: Please choose the best response for each of the following questions and circle your answer.

DIRECTIONS: On a scale of 1 (Never) to 7 (Extremely Likely) how likely is it that you would experience some POSITIVE OUTCOME (e.g. feel good about yourself, have a good time) if you engaged in one of these activities?

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Likely</td>
<td></td>
<td></td>
<td>Moderately Likely</td>
<td></td>
<td></td>
<td>Extremely Likely</td>
</tr>
</tbody>
</table>

It is likely to experience a POSITIVE OUTCOME when you:

24. Plan for what self-protective measure you would take if you were alone with your partner and he/she becomes sexually aggressive?

25. Have trusted friends(s) be with you and your dating partner?

26. Abstain or limit your alcohol intake to three drinks or less?

27. Let a friend or family member know where you are and whom you are with?

28. Speak directly and assertively?

29. Try to be alone with your dating partner?

30. Talk to people who know your dating partner to find out what he/she is like?

31. Pay attention to your dating partner’s drug/alcohol intake?

32. Provide your own transportation so you do not have to depend on your dating partner for transportation?

33. Consider using self-defense strategies such as karate against your dating partner if the need arises?

34. Meet in a private place instead of a public place?

35. Try to be aware of common household objects that could be used as weapons if your dating partner became sexually aggressive?
36. Make yourself aware of exits from the area where you and your dating partner are?

37. Try to be aware of where other people are who may be able to help you in case of an emergency?

38. Carry enough money with you to get a taxi or have someone you can call, in case of an emergency?

39. Trying/using drugs other than alcohol
   a. Marijuana
   b. Cocaine
   c. Hallucinogens
   d. Amphetamines (speed)
   e. Try/Use Inhalants

40. Driving after drinking
   a. 1-2 alcoholic drinks
   b. 3-4 alcoholic drinks
   c. 5 or more alcoholic drinks

41. Drinking more than 5 alcoholic drinks on one occasion

42. Mixing drugs and alcohol

43. Playing drinking games

44. Riding in a car with someone who has consumed alcohol

45. Purchasing/mixing my own drinks

46. Leaving a social event with someone I have just met or do not know well
Appendix C-14
Behavioral Intent Measure

**DIRECTIONS:** We would like to know how often you **INTEND** to participate in the following activities in the next two months. Please circle the number of times you **EXPECT** you will participate in each behavior in the next 2 months.

1. Plan for what self-protective measure you would take if you were alone with your partner and he/she becomes sexually aggressive?
   - 0  1  2-4  5-9  10-20  21-30  31+

2. Have trusted friends(s) be with you and your dating partner?
   - 0  1  2-4  5-9  10-20  21-30  31+

3. Abstain or limit your alcohol intake to three drinks or less?
   - 0  1  2-4  5-9  10-20  21-30  31+

4. Let a friend or family member know where you are and whom you are with?
   - 0  1  2-4  5-9  10-20  21-30  31+

5. Speak directly and assertively?
   - 0  1  2-4  5-9  10-20  21-30  31+

6. Try to be alone with your dating partner?
   - 0  1  2-4  5-9  10-20  21-30  31+

7. Talk to people who know your dating partner to find out what he/she is like?
   - 0  1  2-4  5-9  10-20  21-30  31+

8. Pay attention to your dating partner’s drug/alcohol intake?
   - 0  1  2-4  5-9  10-20  21-30  31+

9. Provide your own transportation so you do not have to depend on your dating partner for transportation?
   - 0  1  2-4  5-9  10-20  21-30  31+

10. Consider using self-defense strategies such as karate against your dating partner if the need arises?
    - 0  1  2-4  5-9  10-20  21-30  31+

11. Meet in a private place instead of a public place?
    - 0  1  2-4  5-9  10-20  21-30  31
12. Try to be aware of common household objects that could be used as weapons if your dating partner became sexually aggressive?

0 1 2-4 5-9 10-20 21-30 31+

13. Make yourself aware of exits from the area where you and your dating partner are?

0 1 2-4 5-9 10-20 21-30 31+

14. Try to be aware of where other people are who may be able to help you in case of an emergency?

0 1 2-4 5-9 10-20 21-30 31+

15. Carry enough money with you to get a taxi or have someone you can call, in case of an emergency?

0 1 2-4 5-9 10-20 21-30 31+

16. Trying/using drugs other than alcohol
   a. Marijuana

0 1 2-4 5-9 10-20 21-30 31+

b. Cocaine

0 1 2-4 5-9 10-20 21-30 31+

c. Hallucinogens

0 1 2-4 5-9 10-20 21-30 31+

d. Amphetamines (speed)

0 1 2-4 5-9 10-20 21-30 31+

e. Inhalants

0 1 2-4 5-9 10-20 21-30 31+

17. Driving after drinking
   a. 1-2 alcoholic drinks

0 1 2-4 5-9 10-20 21-30 31+

b. 3-4 alcoholic drinks

0 1 2-4 5-9 10-20 21-30 31+

c. 5 or more alcoholic drinks

0 1 2-4 5-9 10-20 21-30 31+

18. Drinking more than 5 alcoholic drinks on one occasion

0 1 2-4 5-9 10-20 21-30 31+
19. Mixing drugs and alcohol
   0  1  2-4  5-9  10-20  21-30  31+

20. Playing drinking games
   0  1  2-4  5-9  10-20  21-30  31+

21. Riding in a car with someone who has consumed alcohol
   0  1  2-4  5-9  10-20  21-30  31+

22. Purchasing/mixing my own drinks
   0  1  2-4  5-9  10-20  21-30  31+

23. Leaving a social event with someone I have just met or do not know well
   0  1  2-4  5-9  10-20  21-30  31+
### Appendix C-15
### Behavioral Frequency Measure

**DIRECTIONS:** We would like to know how often you participated in the following activities during the past 6 months. Please circle the number of times that you engaged in each behavior over the past 6 months.

1. Plan for what self-protective measure you would take if you were alone with your partner and he/she becomes sexually aggressive?
   - 0
   - 1
   - 2-4
   - 5-9
   - 10-20
   - 21-30
   - 31+

2. Have trusted friends(s) be with you and your dating partner?
   - 0
   - 1
   - 2-4
   - 5-9
   - 10-20
   - 21-30
   - 31+

3. Abstain or limit your alcohol intake to three drinks or less?
   - 0
   - 1
   - 2-4
   - 5-9
   - 10-20
   - 21-30
   - 31+

4. Let a friend or family member know where you are and whom you are with?
   - 0
   - 1
   - 2-4
   - 5-9
   - 10-20
   - 21-30
   - 31+

5. Speak directly and assertively?
   - 0
   - 1
   - 2-4
   - 5-9
   - 10-20
   - 21-30
   - 31+

6. Try to be alone with your dating partner?
   - 0
   - 1
   - 2-4
   - 5-9
   - 10-20
   - 21-30
   - 31+

7. Talk to people who know your dating partner to find out what he/she is like?
   - 0
   - 1
   - 2-4
   - 5-9
   - 10-20
   - 21-30
   - 31+

8. Pay attention to your dating partner’s drug/alcohol intake?
   - 0
   - 1
   - 2-4
   - 5-9
   - 10-20
   - 21-30
   - 31+

9. Provide your own transportation so you do not have to depend on your dating partner for transportation?
   - 0
   - 1
   - 2-4
   - 5-9
   - 10-20
   - 21-30
   - 31+

10. Consider using self-defense strategies such as karate against your dating partner if the need arises?
    - 0
    - 1
    - 2-4
    - 5-9
    - 10-20
    - 21-30
    - 31+

11. Meet in a private place instead of a public place?
    - 0
    - 1
    - 2-4
    - 5-9
    - 10-20
    - 21-30
    - 31+
12. Try to be aware of common household objects that could be used as weapons if your dating partner became sexually aggressive?
- 0  1  2-4  5-9  10-20  21-30  31+

13. Make yourself aware of exits from the area where you and your dating partner are?
- 0  1  2-4  5-9  10-20  21-30  31+

14. Try to be aware of where other people are who may be able to help you in case of an emergency?
- 0  1  2-4  5-9  10-20  21-30  31+

15. Carry enough money with you to get a taxi or have someone you can call, in case of an emergency?
- 0  1  2-4  5-9  10-20  21-30  31+

16. Trying/using drugs other than alcohol
   a. Marijuana
      - 0  1  2-4  5-9  10-20  21-30  31+
   b. Cocaine
      - 0  1  2-4  5-9  10-20  21-30  31+
   c. Hallucinogens
      - 0  1  2-4  5-9  10-20  21-30  31+
   d. Amphetamines (speed)
      - 0  1  2-4  5-9  10-20  21-30  31+
   e. Inhalants
      - 0  1  2-4  5-9  10-20  21-30  31+

17. Driving after drinking
   a. 1-2 alcoholic drinks
      - 0  1  2-4  5-9  10-20  21-30  31+
   b. 3-4 alcoholic drinks
      - 0  1  2-4  5-9  10-20  21-30  31+
   c. 5 or more alcoholic drinks
      - 0  1  2-4  5-9  10-20  21-30  31+

18. Drinking more than 5 alcoholic drinks on one occasion
- 0  1  2-4  5-9  10-20  21-30  31+
19. Mixing drugs and alcohol
   0  1  2-4  5-9  10-20  21-30  31+

20. Playing drinking games
   0  1  2-4  5-9  10-20  21-30  31+

21. Riding in a car with someone who has consumed alcohol
   0  1  2-4  5-9  10-20  21-30  31+

22. Purchasing/mixing my own drinks
   0  1  2-4  5-9  10-20  21-30  31+

23. Leaving a social event with someone I have just met or do not know well
   0  1  2-4  5-9  10-20  21-30  31+
Appendix C-16
Knowledge Measure: Sexual Assault Risk Reduction Program

DIRECTIONS: Please circle/write your answers directly on the following pages.

1. By believing you are not at risk for sexual assault you are less vulnerable because you probably were a low risk to begin with.
   a. True
   b. False

2. By believing you are at risk for sexual assault you are less vulnerable because you are more likely to take steps to try to protect yourself.
   a. True
   b. False

3. You are more at risk to experience a rape by someone you don’t know (stranger rape) than by someone you know or just met (on a date or at a party).
   a. True
   b. False

4. If someone gives you alcohol to impair your judgment and then has sex with you, is this rape?
   a. Yes
   b. No

5. Is it sexual assault if you are unconscious and someone has sex with you?
   a. Yes
   b. No

6. In Ohio is it considered sexual assault if you tell a man “no” you don’t want to have sex, but then you don’t make attempts to resist, such as yelling, hitting, pushing, struggling?
   a. Yes
   b. No

7. On average, what proportion of women on OU’s campuses were victims of rape or attempted rape during one quarter?
   a) 1/80
   b) 1/35
   c) 1/14
   d) 1/6

8. Are gay men and lesbians at risk of sexual assault from partners of the same sex?
   a. Yes
   b. No
9. Some situations that put women at risk of experiencing a sexual assault include:
   a. Drinking
   b. dressing in skanky/slutty clothes
   c. being isolated
   d. both a and b
   e. both a and c

10. Some male behaviors/characteristics that put women at risk of being sexually assaulted include:
    a. Drinking
    b. sexist attitudes
    c. offering to buy women drinks
    d. both a and c
    e. all of the above

11. Date rape drugs are prevalent on most college campuses, although there have been no confirmed reports of its use on OU’s campus.
    a. True
    b. False

12. You can figure out if a date rape drug has been placed in your drink by:
    a. noticing the residue on the bottom of your glass
    b. tasting something bitter in your drink
    c. an immediate rush to your head
    d. a and c
    e. none of the above

13. Some effects date rape drugs have include (circle all that apply):
    a. Blackout
    b. drunken appearance
    c. headaches
    d. dizziness

14. What percentage of college women who are raped know their attacker?
    a. 90%
    b. 84%
    c. 60%
    d. 30%
    e. 10%

15. In a national survey of college women, what percentage were victims of rape or attempted rape?
    a. 25%
    b. 10%
    c. 5%
16. A national survey of college women found that at least ___% of victims of acquaintance rapes had been drinking alcohol or taking drugs just before the assault.
   a. 55%
   b. 35%
   c. 15%

17. Some reasons First-year/Freshman women are at greater risk of experiencing sexual assault include:
   a. don’t know the limits of their drinking capacity
   b. a desire to be liked and to fit in
   c. they are more flirtatious with men
   d. feel pressure from others to drink
   e. b and c

18. Which of these is something you should not do in a moment of attempted sexual assault?
   a. yell, “Help! I’m upstairs!”
   b. try to actively resist
   c. kick the guy in the groin
   d. buy time with talking to him
   e. b and c

19. Two things a woman can do to avoid being slipped a date rape drug are:
   (a) ____________________ and (b) ____________________

20. When a woman on this campus is raped she could get support or help from:

21. If a woman who had been raped chose to see a therapist and the therapist was insensitive or made her uncomfortable, what should/could the woman do next?

22. Please list 4 things you could do to resist a rape in the moment of confrontation:
   f. ____________________
   g. ____________________
   h. ____________________
   i. ____________________

23. Why is drinking alcohol a risk factor for women?
   Please list 2 reasons: ____________________ and ____________________

24. Why is drinking alcohol a risk factor for men?
   Please list two reasons: ____________________ and ____________________
Appendix C-17
Vaccine Preventable Disease Program Knowledge Instrument

DIRECTIONS: Read each question and all alternatives carefully. Choose the best answer in each case. There is only one correct answer. You may write on this questionnaire. Indicate your choice by writing your answer in the blank to the left of the item number.

___ 1. The body’s natural defense against infection is
   A) vaccination.
   B) immunity.
   C) bacterium.
   D) phagocytosis.

___ 2. What is the major risk that immunization programs are designed to avoid?
   A) that an unimmunized person will catch an infectious disease and die
   B) that an unimmunized person will catch an infectious disease and suffer permanent injury
   C) that an unimmunized person will become part of an outbreak among all unimmunized children
   D) that an unimmunized person will become infected with a form of disease that resists treatment

___ 3. Diseases such as measles, mumps, and rubella (German measles) are targeted for immunization efforts mainly because they are
   A) the most common infections.
   B) serious and contagious, but rarely deadly.
   C) always deadly.
   D) incurable.

___ 4. Hepatitis is a viral inflammation of the
   A) pancreas.
   B) intestines.
   C) kidneys.
   D) liver.

___ 5. You have just brought your roommate to the hospital. She came down with what appeared to be flu two days ago, but you suspected meningitis when she complained of
   A) a severe headache and stiff neck.
   B) fatigue and lack of appetite.
   C) body aches and chills.
   D) nausea.

___ 6. Influenza (flu) enters the body through
A) the respiratory system.
B) the digestive tract.
C) breaks in the skin.
D) body fluids.

___ 7. A tetanus-diphtheria (Td) booster injection (shot) is necessary:
   A) every year.
   B) every five (5) years.
   C) every ten (10) years.
   D) only when you need it.

___ 8. Which of the following is true about the two main types of measles?
   A) Common measles features a high fever and a marked risk of birth
defects in unborn children.
   B) Rubella (German measles) is milder but poses more of a threat to
unborn children.
   C) Both are characterized by rather mild fever and a whole-body rash.
   D) There is no effective vaccine for either.

___ 9. Hepatitis B is spread when the virus is introduced directly into
   A) the ear.
   B) body fluids.
   C) the digestive tract.
   D) the respiratory system.

___ 10. An inflammation of the membranes that cover the brain and spinal cord,
which can be life threatening if caused by a bacterial infection is
   A) polio.
   B) encephalitis.
   C) meningitis.
   D) hepatitis B.

___ 11. Once you have influenza (flu), the most common approach to treating
influenza is to
   A) receive antiviral shots.
   B) treat the symptoms.
   C) take antibiotics.
   D) avoid infection.

___ 12. Kevin recently missed over a week of school with an infection that caused
both sides of his face to swell up. He probably had
A) common measles.
B) Rubella (German measles).
C) Lyme disease.
D) mumps.

___ 13. Washing hands before preparing, serving, or eating food is a common sense guideline to reduce the risk of
A) tetanus.
B) hepatitis A.
C) hepatitis B.
D) yeast infection.

___ 14. Vaccine preventable diseases have been eliminated from the United States
A) True
B) False

___ 15. Vaccines provide immunity by causing the body to produce antibodies against diseases.
A) True
B) False

___ 16. Hepatitis is a viral infection of the liver.
A) True
B) False

___ 17. The influenza (flu) vaccine is necessary every year.
A) True
B) False

___ 18. Lifetime immunity for pertussis (whooping cough) occurs after a single vaccination.
A) True
B) False

___ 19. Rubella (German measles) is especially dangerous for women in the early months of pregnancy because it can infect the fetus, causing severe birth defects.
A) True
B) False

___ 20. Generally you have flu and not a cold if you have a headache and high fever.
Use the following to answer questions 28-33:

a. diphtheria
b. measles
c. mumps
d. tetanus
e. rubella (German measles)
f. influenza (flu)

21. ___________ viral infection of the salivary glands

22. ___________ highly contagious infection leading to body rash and high fever

23. ___________ fatal, soil-borne bacterial infection that causes central nervous system damage

24. ___________ upper respiratory viral infection that can cause damage to a pregnant victim's developing fetus

25. ___________ potentially fatal illness that leads to inflammation of throat lining, swollen lymph nodes, and heart and kidney failure
Appendix C-18
Vaccine Preventable Disease Program: Perception and Attitudes Instrument

DIRECTIONS: Please answer the following questions by circling the corresponding letter.

<table>
<thead>
<tr>
<th>Perceived Susceptibility</th>
</tr>
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</table>

1. Have you had a dental exam and cleaning in the last year?
   A. Yes
   B. No
   C. Don’t Know

2. Have you performed a breast self exam in the last month?
   A. Yes
   B. No
   C. Don’t Know

3. Have you had a routine gynecological exam in the past year?
   A. Yes
   B. No
   C. Don’t Know

4. Have you had your cholesterol checked in the last five (5) years?
   A. Yes
   B. No
   C. Don’t Know

5. Have you had your blood pressure checked in the last two (2) years?
   A. Yes
   B. No
   C. Don’t Know

6. Do you use sunscreen daily?
   A. Yes
   B. No
   C. Don’t Know

7. Do you keep a current record of your vaccination status (“shot record”)?
   A. Yes
   B. No
   C. Don’t Know
### Perceived Severity

**How serious would you rate the following diseases?**

<p>| | | | | |</p>
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<tbody>
<tr>
<td>8.</td>
<td>Measles</td>
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<tr>
<td>A</td>
<td>Not at all serious</td>
<td>B</td>
<td>A little serious</td>
<td>C</td>
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<td></td>
<td></td>
<td>D</td>
<td>Serious serious</td>
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<td>9.</td>
<td>Mumps</td>
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<td>A</td>
<td>Not at all serious</td>
<td>B</td>
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<td>D</td>
<td>Serious serious</td>
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<td>10.</td>
<td>Rubella (German Measles)</td>
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<td>A</td>
<td>Not at all serious</td>
<td>B</td>
<td>A little serious</td>
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<td>11.</td>
<td>Tetanus</td>
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<td>A</td>
<td>Not at all serious</td>
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<td>12.</td>
<td>Diphtheria</td>
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<td>B</td>
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<td>D</td>
<td>Serious serious</td>
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<td>13.</td>
<td>Pertussis (Whooping Cough)</td>
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<td>A</td>
<td>Not at all serious</td>
<td>B</td>
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<td>14.</td>
<td>Polio</td>
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<tr>
<td>A</td>
<td>Not at all serious</td>
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<td>D</td>
<td>Serious serious</td>
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<td>15.</td>
<td>Varicella (Chicken Pox)</td>
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<tr>
<td>A</td>
<td>Not at all serious</td>
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<td>Serious serious</td>
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<td>16.</td>
<td>Hepatitis A</td>
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<tr>
<td>A</td>
<td>Not at all serious</td>
<td>B</td>
<td>A little serious</td>
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<td></td>
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<td>D</td>
<td>Serious serious</td>
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</table>
17. Hepatitis B
   - **A**: Not at all serious
   - **B**: A little serious
   - **C**: Somewhat serious
   - **D**: Serious
   - **E**: Extremely serious

18. Pneumococcal Disease (Pneumonia)
   - **A**: Not at all serious
   - **B**: A little serious
   - **C**: Somewhat serious
   - **D**: Serious
   - **E**: Extremely serious

19. Influenza (Flu)
   - **A**: Not at all serious
   - **B**: A little serious
   - **C**: Somewhat serious
   - **D**: Serious
   - **E**: Extremely serious

20. Meningococcal Meningitis (Spinal Meningitis)
   - **A**: Not at all serious
   - **B**: A little serious
   - **C**: Somewhat serious
   - **D**: Serious
   - **E**: Extremely serious

**How would you rate your risk of contracting the following diseases if you are NOT vaccinated (immunized)?**

21. Measles
   - **A**: Not at all likely
   - **B**: A little likely
   - **C**: Somewhat likely
   - **D**: Likely
   - **E**: Extremely likely

22. Mumps
   - **A**: Not at all likely
   - **B**: A little likely
   - **C**: Somewhat likely
   - **D**: Likely
   - **E**: Extremely likely

23. Rubella (German Measles)
   - **A**: Not at all likely
   - **B**: A little likely
   - **C**: Somewhat likely
   - **D**: Likely
   - **E**: Extremely likely

24. Tetanus
   - **A**: Not at all likely
   - **B**: A little likely
   - **C**: Somewhat likely
   - **D**: Likely
   - **E**: Extremely likely
<table>
<thead>
<tr>
<th>Disease</th>
<th>Likelihood</th>
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<td>Diphtheria</td>
<td>Not at all</td>
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<td>Hepatitis A</td>
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<td>Hepatitis B</td>
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<tr>
<td>Pneumococcal Disease (Pneumonia)</td>
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<td>Influenza (Flu)</td>
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<td>Meningococcal Meningitis (Spinal Meningitis)</td>
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Perceived Benefits

34. Vaccines strengthen the immune system.
   A  B  C  D  E  F
   Strongly Agree  Neutral  Disagree Strongly  Disagree Don’t know
   Agree

35. The vaccines available are very carefully and consistently tested for safety.
   A  B  C  D  E  F
   Strongly Agree  Neutral  Disagree Strongly  Disagree Don’t know
   Agree

36. As a result of research, vaccines are getting better and safer all the time.
   A  B  C  D  E  F
   Strongly Agree  Neutral  Disagree Strongly  Disagree Don’t know
   Agree

37. Vaccines are amongst the most effective and least costly forms of medical treatment ever created.
   A  B  C  D  E  F
   Strongly Agree  Neutral  Disagree Strongly  Disagree Don’t know
   Agree

38. The reason why vaccines are given regularly to people is that they result in lifelong protection from several serious diseases.
   A  B  C  D  E  F
   Strongly Agree  Neutral  Disagree Strongly  Disagree Don’t know
   Agree

39. The government should invest more money in the development of vaccines for serious diseases like AIDS and Cancer.
   A  B  C  D  E  F
   Strongly Agree  Neutral  Disagree Strongly  Disagree Don’t know
   Agree

40. Vaccines have, over the years, produced many more health benefits than health troubles.
   A  B  C  D  E  F
   Strongly Agree  Neutral  Disagree Strongly  Disagree Don’t know
   Agree
41. College students should be required to show proof of vaccination before entering college.
   A Strongly Agree  B Agree  C Neutral  D Disagree  E Strongly Disagree  F Don’t know
   Strongly Disagree

42. College students living in on-campus housing should be required to show proof of vaccination to live in the residence halls.
   A Strongly Agree  B Agree  C Neutral  D Disagree  E Strongly Disagree  F Don’t know
   Strongly Disagree

43. Vaccination requirements protect me from getting diseases from people who are not immunized.
   A Strongly Agree  B Agree  C Neutral  D Disagree  E Strongly Disagree  F Don’t know
   Strongly Disagree

**Perceived Barriers**

44. I am concerned that my immune system could be weakened by too many vaccinations.
   A Strongly Agree  B Agree  C Neutral  D Disagree  E Strongly Disagree  F Don’t know
   Strongly Disagree

45. I am more likely to trust vaccinations that have been around for awhile.
   A Strongly Agree  B Agree  C Neutral  D Disagree  E Strongly Disagree  F Don’t know
   Strongly Disagree

46. The safeguards used in making vaccines are slack and ineffective.
   A Strongly Agree  B Agree  C Neutral  D Disagree  E Strongly Disagree  F Don’t know
   Strongly Disagree

47. A vaccine can give you a serious case of the very same disease you are trying to avoid.
   A Strongly Agree  B Agree  C Neutral  D Disagree  E Strongly Disagree  F Don’t know
   Strongly Disagree
48. The idea of taking a newly developed vaccine, even if it has been very carefully tested, makes me very nervous.

A  B  C  D  E  F
Strongly Agree  Agree  Neutral  Disagree  Strongly Disagree  Don’t know

49. An increasing number of people are becoming anti-vaccine oriented as more information about vaccines and how they are developed is available on the Internet.

A  B  C  D  E  F
Strongly Agree  Agree  Neutral  Disagree  Strongly Disagree  Don’t know

50. I have religious beliefs that prevent me from taking vaccines.

A  B  C  D  E  F
Strongly Agree  Agree  Neutral  Disagree  Strongly Disagree  Don’t know

51. I have not been vaccinated for a disease because the vaccination was too expensive.

A  B  C  D  E  F
Strongly Agree  Agree  Neutral  Disagree  Strongly Disagree  Don’t know

52. I have not been vaccinated for a disease because there was not enough vaccine (“shots”) available for every person who needed one.

A  B  C  D  E  F
Strongly Agree  Agree  Neutral  Disagree  Strongly Disagree  Don’t know

53. I have not been vaccinated for a disease because I do not know where to get the vaccination.

A  B  C  D  E  F
Strongly Agree  Agree  Neutral  Disagree  Strongly Disagree  Don’t know

54. I have not been vaccinated for a disease because I am afraid of needles.

A  B  C  D  E  F
Strongly Agree  Agree  Neutral  Disagree  Strongly Disagree  Don’t know
### Cues to Action

55. I have access to all the information I need to make good decisions about vaccination.

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<thead>
<tr>
<th>A</th>
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<th>F</th>
<th>Comment</th>
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<tr>
<td>Strongly Agree</td>
<td>Agree</td>
<td>Neutral</td>
<td>Disagree</td>
<td>Strongly Disagree</td>
<td>Don’t know Enough to Comment</td>
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56. I clearly understand the immunization (vaccination) policy of the college/university that I am attending.

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<tr>
<td>Strongly Agree</td>
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<td>Disagree</td>
<td>Strongly Disagree</td>
<td>Don’t know Enough to Comment</td>
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57. I have been provided a list of recommended vaccinations by the college/university that I am attending.

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<tr>
<td>Strongly Agree</td>
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<td>Disagree</td>
<td>Strongly Disagree</td>
<td>Don’t know Enough to Comment</td>
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58. I intend to take an influenza (flu) vaccine this year, or I have already done so.

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<tr>
<td>Strongly Agree</td>
<td>Agree</td>
<td>Neutral</td>
<td>Disagree</td>
<td>Strongly Disagree</td>
<td>Don’t know Enough to Comment</td>
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59. I intend to take a Hepatitis B vaccination this year, or I have already done so.

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<tr>
<td>Strongly Agree</td>
<td>Agree</td>
<td>Neutral</td>
<td>Disagree</td>
<td>Strongly Disagree</td>
<td>Don’t know Enough to Comment</td>
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60. I intend to take a Meningitis vaccination this year, or I have already done so.

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<tr>
<td>Strongly Agree</td>
<td>Agree</td>
<td>Neutral</td>
<td>Disagree</td>
<td>Strongly Disagree</td>
<td>Don’t know Enough to Comment</td>
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### Self-Efficacy

61. I don’t really know what a vaccine is and how it works.

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<tr>
<td>Strongly Agree</td>
<td>Agree</td>
<td>Neutral</td>
<td>Disagree</td>
<td>Strongly Disagree</td>
<td>Don’t know Enough to Comment</td>
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</tbody>
</table>
62. A vaccine is a medical treatment in which dangerous viruses and bacteria are killed or modified and then put into your body.

A | B | C | D | E | F
---|---|---|---|---|---
Strongly Agree | Agree | Neutral | Disagree | Strongly Disagree | Don’t know Enough to Comment

63. I don’t really know why I received vaccinations as a child.

A | B | C | D | E | F
---|---|---|---|---|---
Strongly Agree | Agree | Neutral | Disagree | Strongly Disagree | Don’t know Enough to Comment

64. I am able to make an informed choice with regards to vaccination.

A | B | C | D | E | F
---|---|---|---|---|---
Strongly Agree | Agree | Neutral | Disagree | Strongly Disagree | Don’t know Enough to Comment

---

Survey items extracted from:

Appendix C-19
Elaboration Likelihood Model Questionnaire

**DIRECTIONS:** Please answer the following questions by circling the corresponding letter.

1. How important was the topic of this program to you personally?
   - A Not at all
   - B Somewhat
   - C Average
   - D Important
   - E Very Important

2. How motivated were you to listen to the presentation?
   - A Strongly Motivated
   - B Somewhat Motivated
   - C Neutral
   - D Slightly not motivated
   - E Not Motivated at all

3. How difficult to understand was the information presented?
   - A Very easy to understand
   - B Easy to understand
   - C Just Right
   - D Difficult to understand
   - E Very Difficult to understand

4. During the presentation I was distracted from thinking about the topic.
   - A Strongly Agree
   - B Agree
   - C Neutral
   - D Disagree
   - E Strongly Disagree

5. There was enough time in the presentation to think about the topic.
   - A Strongly Agree
   - B Agree
   - C Neutral
   - D Disagree
   - E Strongly Disagree

6. The presenter made good points about the topic.
   - A Strongly Agree
   - B Agree
   - C Neutral
   - D Disagree
   - E Strongly Disagree

7. To what extent did you try to process (think about) the information provided?
   - A Not at all to a small degree
   - B To a small degree
   - C To an average degree
   - D To an above average degree
   - E Very much

8. To what extent did you find the presentation well organized?
   - A Not at all
   - B Somewhat
   - C Average
   - D Organized
   - E Very Organized

   - Organized
   - Organized
9. To what extent did you find the presentation easy to follow?

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10. To what extent did you find it difficult to concentrate on the presentation?

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11. In your estimation, how logical was the information presented?

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12. In your estimation, how accurate was the information presented?

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13. How would you rate the quality of the presenter’s information?

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<td>Poor</td>
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14. To what extent would you recommend this program to other women?

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<td>Not at all</td>
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Open ended Response: Please answer the following questions as clearly and completely as possible.

15. What did you learn from participating in this program?

16. What recommendations would you suggest to improve the program?
Appendix C-20
Self-Defense Follow-up Evaluation

DIRECTIONS: Recall that you participated in a self-defense program about three months ago. We’d like you ask you a few questions about it.

1. Did you share the information with any of your women friends?
   A. No
   B. Yes

2. Did you practice or rehearse the self-defense techniques?
   A. No
   B. Yes

Did you use any of the following techniques that you learned during the prevention program or the self-defense class (during the past two months)?

3. Assertive body language?
   A. No
   B. Yes

4. Increased attention to your intuition?
   A. No
   B. Yes

5. Yelling and running away?
   A. No
   B. Yes

6. Physical self-defense?
   A. No
   B. Yes

7. Have you participated in any other sexual assault prevention program during the past two months?
   A. No
   B. Yes
Appendix D-1
Revised Program Protocol

The Ohio University Sexual Assault Risk Reduction Program:
Revised Protocol 2004-2005

Christine A. Gidycz
Ohio University

Steven J. Lynn
SUNY-Binghamton

Cindy L. Rich
Ohio University

Catherine Loh
Ohio University

Nichole L. Marioni
Ohio University

Lindsay M. Orchowski
Ohio University
I. Random Assignment of Participants

Before participants enter the room, give them an index card and tell them to go directly to the room. Example: please go directly to Porter 107.

Pres. - Allow participants to determine their room and to leave if necessary.

Asst. - Collect cards from those who enter each room

II. Introductory Information

Asst. - As participants enter the room hand out the packets with the informed consent, confidentiality agreement, contact sheet, and subject number calculation on top.

This is group “purple”, you can only participate in this study one time, no matter what group you were in.

For follow-up sessions: If you are in doubt that you are in the right group, I have a list of names and you can come up and I will check to see if your name is on it. Does anyone need to come up and check, please do it now.

This is a multi-part study. You are in the sexual assault risk-reduction program group, therefore, you will be asked to fill out surveys tonight and to also participate in sexual assault prevention program. This will take about 3 hours. Next, you will be asked to come back and participate a self-defense course in about two weeks at well works that will take another 2 hours and you will get 2 additional experimental credit points. You will be asked to participate in a 2-month follow-up at the end of the term, and will receive 2 experimental credit points for filling out questionnaires and participating in a brief review of the program material. At the 2-month follow-up you will receive 7 credit points for participating in all 3 parts of the study.
If for some reason, you are unable to attend the 2-month follow-up, you should contact the facilitator, Lindsay Orchowski, to receive credit points for participation in earlier parts of the study. You will be given information on how to contact the experimenter to take with you after today’s session.

Finally, you will be asked to come back for a 4-month follow-up in the (winter/spring). You will not receive experimental credit points for participation. Participation in the 4-month follow-up is voluntary, and will help the research team to understand how we can improve this program in the future.

Does anyone have any questions?

Please read over and sign the informed consent form. You have been given a second copy of this form to take with you.

The next form is a confidentiality agreement, stressing that you understand the nature of participation, and agree to maintain the confidentiality of the group discussion. It is important that you do not share information discussed during the session with others.

Please read the agreement carefully.

Now you should be looking at a contact form. Because you will be asked to come back for follow-ups and because students may move or change their phone number, we are asking you to give us the address and phone number of someone we can call for your new number if necessary. It is best if you list your parents or another relative that will be sure to know your number.
Pres. - Collect informed consent, confidentiality agreement and contact forms

You should now be looking at the subject calculation form. This form will be calculated each time you come, so please fill it out carefully. This is done so that we can assure your complete confidentiality and so that you feel that you can respond honestly to the surveys.

Pres- demonstrate how to calculate the subject calculation form on overhead projector.

Now, take out the surveys from the manila envelope. Please record your subject number in the identification number area of the questionnaires. I know this is a little confusing, does anyone need any help with this, or does anyone have any questions?

Please do not write your name or any identifying information on the questionnaires.

You now should be looking at a packet of surveys. Please remember to fill out the front and back page of each survey, taking time to clearly circle each answer. When you've finished filling out the surveys, please put all the materials back into the envelope. Then please sit quietly until everyone is finished. Are there any questions? The study will take no longer than three hours tonight. It is now (state time), you will be done no later than (state time they will be finished).

Pres. - When you notice that everyone is done, ask "Does anyone need more time?"

Please keep your packets and envelopes on the desk in front of you.

**Let's take a 5 minute break, feel free to leave the room to go to the bathroom or get a drink. Make sure when you come back you sit in the exact same seat.

Hello my name is ___________ and this is _______________.

Keep in mind this is a multi-part study, and you will receive 7 credits for your participation at the end of the second session, 2 months from now. At the end of this
session, you will be asked to come up front and sign up for a day and time for the self-defense component of the program, as well as the 2-month follow-up of the study.

III. Program Introduction

Today you will be participating in a program designed to reduce the risk that you will experience a sexual assault. What we hope to communicate to you today is that you are all at risk to experience a sexual assault, and we hope that this program will provide you with some useful information about how to reduce your risk.

This program addresses acquaintance rape perpetrated by males against females. We know that men can also be sexually assaulted, however, the majority of assaults are perpetrated by males, and so we are focusing on male aggression against women today. We also know that some of you may not be heterosexual, however, we hope that this information will still be helpful to you or some of your friends. Finally, we know that there are likely to be survivors of sexual assault in the audience today. We have designed this program with you in mind, too. We hope this program furthers your recovery and decreases the chances that you will experience another assault.

Before beginning our slides, we want to make it clear that we believe that the perpetrators are always responsible for sexually aggressive acts. In fact, we have developed a prevention program for college men that has been administered in previous quarters at Ohio University. However, until it can be demonstrated that programs with men are effective, women need to be aware of ways to decrease their risk. By believing that you are not at risk for rape you are in fact more vulnerable because you will be less likely to
take steps to try to protect yourself. We want to provide you with some of those steps today.

It is important to keep in mind that we believe that sexual assault reflects issues of power, control, and male dominance over women that are reinforced by the society in which we live.

_Pres – ask the following questions and elicit a discussion (try to limit to about 5 minutes)._ “Do you see violence towards women in your daily life?” “How do you think society fosters violence towards women?”

**IV. Background Definitions and Statistics**

_Pres. - Dim lights._

Let's start the program by defining rape.

_Asst. - Show SLIDE 1._

_Pres. - Read SLIDE 1._

_Asst. - Show SLIDE 2._

_Pres. - Read SLIDE 2._

Many people are unaware of the fact that when someone deliberately gives you alcohol to impair your judgment and then has sex with you, this is rape. When you are unconscious and someone has sex with you, this is also sexual assault. These types of assaults are commonly occurring on college campuses like ours, so you need to be aware of them.

As most of you are probably aware:

_Asst. - Show SLIDE 3._

_Pres. - Read SLIDE 3._
Today we will be focusing on rape between acquaintances because this is far more common than stranger rape.

We would also like to emphasize that:

People tend to think that if a woman doesn't actively resist, that this is not rape. However, that is not the case.

With those definitions in mind, we would like to emphasize that college is a high risk period for sexual assault. In 1987, a landmark study on sexual assault on college campuses was conducted. The researchers found the following:

More recent studies have failed to find any decline in rates of sexual assault on college campuses.

We would also like to emphasize that first-year women may be at a particularly high risk to experience an assault. For many first-year women, like a number of you, this may be your first time away from home. It may be important for you to feel like you fit in, you may feel pressure from others to drink, and for some of you, this may be the first time that you have really drank, and thus you may not be aware of your limits. This next slide (Asst. - Show SLIDE 7) highlights this point and emphasizes that sexual assaults occur very frequently on our own campus.
Given that there are about 15 of you in this room, these figures suggest that approximately 2-3 of you are likely to be victimized over just this quarter. We hope that this program might help to bring those numbers down to zero.

*Asst. - Turn off slides.*

To illustrate to you the frequency and diversity of sexual assault experiences among college women, we would like to show you a video of actual victims talking about their experiences. After you watch these women speak, we would like to hear your thoughts about their experiences and how they might compare to what either you or your friends have experienced or to your perceptions about sexual assault. The women in this tape highlight not only what has happened to them, but what they feel would be helpful to you in order to reduce your risk of sexual assault. As you view the video, please consider risk factors that may increase the likelihood a woman will experience a sexual assault. The video should highlight many examples of these, however you are welcome and encouraged to also consider risk factors from any experiences that you or your acquaintance may have had. In particular, think about risk factors in terms of the characteristics and actions of the perpetrators, the beliefs and behaviors of the women and the specific situations presented. If you have already experienced a sexual assault, this tape was made to help reduce the chances that you might be revictimized and to communicate to you that you are not alone. All their stories are real, the only thing that has been changed are their names.

**V. "I Thought it Would Never Happen to Me"**

*Asst. - Roll the tape entitled, "I Thought it Would Never Happen to Me", produced and directed by Christine A. Gidycz & Colleagues.*
VI. Post Film Discussion

Asst. - Stop tape.

Pres. – Ask for reactions and allow about 15 minutes for discussion. In the discussion ask the following, “Are these women like you or your friends”? and “Can you relate to situations and women like them?”

VII. Risk Factors

OK. Let's talk about risk factors. We know there are specific risk factors that increase a woman's likelihood to experience unwanted sexual contact. Some of these risk factors may be characteristics of the man, such as his attitudes, treatment of others, and behavior. A woman's personal experiences, beliefs, or actions may also increase her risk in certain situations. Finally, there are some things in normal social or dating situations that can be dangerous. Let's take a few minutes and break up into smaller groups to discuss these issues.

During this time, I want you to discuss with your group the characteristics of men, situations, and behavior that may increase a woman's risk. Please generate a list of these risk factors and we will discuss them with the whole group. Would someone please write things down and present the ideas that their group came up with?

(Break into groups of about three participants each. Asst. - Distribute pencils and handouts.)

(Allow a few minutes for discussion, then ask for their ideas. “Let’s start with the characteristics of the man”? With each appropriate response, reinforce the response by saying such things as "that's right", "that's a good example", "good point", "that's good", "yes", "good observation", "that's very perceptive". The procedure will be such that when someone offers a characteristic, reinforce the responses. When examples of the
characteristic have been exhausted, provide other examples if they have not been given. Note: if participants identify examples that are not on the slides, reinforce if the response is appropriate. If people miss one of the factors that are on the slides, say, "The only other factor that I can identify," or "The other factors that I can identify include,"

Asst. - Lights, turn on slide projector.

Asst. - When the discussion is finished, show SLIDE 8.

Asst. - Show Slide 8.

As you can see, you were able to identify all/most of the characteristics of the man that we presented.

Pres. - Read SLIDE 8 from the top to the bottom. Always discuss them in the order that they appear on the slide. If participants identified characteristics that were not on the slide, say, "you came up with some additional characteristics as well - that's great."

Before we go on, we should note that women often tend to underestimate their risks for experiencing unwanted sexual advances by someone she knows. Therefore, women may be less prepared to protect against sexual advances if they occur. However, women are more likely to experience sexual victimization by an acquaintance than by a stranger. It is important to trust your intuition, even during situations that may seem familiar to you.

(Allow a few minutes for discussion, then ask for their ideas. “Let’s now move on to question two on the worksheet and discuss the personal or situational characteristics that may place a woman at risk”? With each appropriate response, reinforce the response by saying such things as "that's right", "that's a good example", "good point", "that's good", "yes", "good observation", "that's very perceptive". The procedure will be such that when someone offers a characteristic, reinforce the responses. When examples of the characteristic have been exhausted, provide other examples if they have not been given. Note: if participants identify examples that are not on the slides, reinforce if the response is appropriate. If people miss one of the factors that are on the slides, say, "The only other factor that I can identify," or "The other factors that I can identify include,"
As you can see, you were able to identify all/most of the personal and situational characteristics that may place a woman at risk.

*Pres.* - Read SLIDE 9 from the top to the bottom. *Always discuss them in the order that they appear on the slide. If participants identified characteristics that were not on the slide, say, "you came up with some additional characteristics as well - that's great."*

**B. Discussion of Risk Factors**

Now what I would like to do is to elaborate a little on the last point on this slide that relates to not taking drinks from others when you don't know where they came from. You need to be aware of date rape drugs. There have been reported rapes involving the use of these drugs right here at Ohio University.

*Asst.* - Show SLIDE 10.

*Pres.* - Read SLIDE 10.

*Asst.* - Show SLIDE 11.

*Pres.* - Read SLIDE 11.

Jackie on the tape was most likely given a drug by a guy that she met at a college party, and the consequences for her were very severe. Since these drugs are often put into drinks, it’s a good idea to know where your drinks come from.

**C. Discussion of the role of alcohol**

Before moving on, let’s talk a little more about the role of alcohol.

*Asst.* - Show SLIDE 12.

*Pres.* - Read SLIDE 12.

Why might alcohol be a risk factor for sexual assault?
Pres. - Elicit discussion about why alcohol might be a risk factor. If participants do not mention anything about the offender say, "What about from the male perspective? Men are often drinking as well when these assaults take place?"

Asst. - Following discussion, show SLIDE 13.
You identified most/all of the reasons that we identified.

Pres. - Read SLIDE 13 from top to bottom.
Asst. - Show SLIDE 14.
Pres. - Read SLIDE 14 from top to bottom.

We’re not telling you to not go to parties or to not drink or have fun, but we do want you to be aware of this information

D. Post-assault Reactions
Another issue that we would like to address about the tape relates to the process of recovery for rape survivors. One of the points the tape makes is that there is no "correct" way of surviving a sexual assault. There are lots of variations in how people respond. At the same time, people often go through what appear to be stages of recovery, and this is perfectly normal. What is important to remember is that you can recover from a sexual assault and that help is available. The next slide depicts the stages of recovery that are commonly, although not universally, experienced by survivors.

Asst. - Show SLIDE 15.
Pres. - Read SLIDE 15.
When women are in the first stage, they tend to try to ignore what happened and use a lot of denial. Some women will drink at this stage in order to help them deal with the pain. If you have been sexually assaulted and are drinking a lot after the assault, or have a lot of guilt and little self-respect, it is particularly important that you seek help. Not only because of your pain, but also as we talked about previously because drinking enhances your risk for sexual assault.

In the second and third stages, a survivor often feels flooded by emotion and can experience intrusive thoughts like nightmares and flashbacks. Rape survivors often feel a lot of guilt at this time and may blame themselves. Some of the survivors on the tape felt like this. Finally, in the last stage, survivors often feel significantly less blame and are more able to talk about the experience and move on. When they reach this stage, many women often feel that they emerge as stronger from the experience and are able to help others that have had similar experiences.

At the end of the program, we will give you a handout with information about resources in this community that will assist you in your recovery if you need it. If you hook up with a counselor or therapist who you feel is not helpful to you, don't give up. Find someone else that you can talk to.

**VII. Sexual Assault Risk Factors**

We would now like to try to put what you learned into practice. Let’s discuss ways to handle risky situations. What do you say, for example, when you come face to face with a man who is doing things that make you feel uncomfortable? We will address this issue
during the next brief tape. We will stop this tape at various points and discuss ways to handle these situations. We would like you to think about specific things that you would say and do in these situations. This tape was developed at Ohio University by running focus groups with college women just like you where we asked them to tell us about difficult social situations that they have been in. They also gave us some ideas for how women might handle these situations.

We want to help you generate as many options as possible if you find yourself in an uncomfortable situation. We want you to leave this program with some specific strategies that you think will work for you to dealing with these situations.

*Asst. - Show film depicting the risky situations "Keep Your Options Open: Alternative Solutions for Stressful Social Situations" produced and directed by Christine A. Gidycz & Colleagues.*

The first situation involves a young woman at a party and a guy that seemingly has a bad reputation who asks her to leave with him.

*Asst. - Roll tape: Scene 1 - Stop tape after option 1, where she goes with him.*

*Pres. After viewing her leaving, ask the following question(s), "What do you think about her going with him?", "Have you ever liked a guy that your friends don’t", "What could you say to get out of going to his room?"*  *Reinforce appropriate responses. If risky responses are given, elicit feedback from the group by asking something like, "What does
everyone think of that?". After exhausting alternatives, say, "You came up with some great ideas, now we're going to see some of them being played out on the tape". If the group's ideas are fairly discrepant from the taped responses say the following, "Notice that other women like yourselves came up with some different ideas as well". If the group's responses are fairly consistent with the taped responses say the following, "Notice that other women like yourselves came up with many of the same ideas as you". Asst. – Roll tape

Pres. – in black space before option 2 So, one option is to go

Pres. – in black space before option 3 So, make a plan to hook up with your friends later

Pres. – in black space before option 4 So, try to take your friends along

Pres. – in black space before option 5 You could come up with an excuse

Risky dating scenarios are rarely clear-cut. The cues may be very ambiguous that a dating situation is moving from friendly to dangerous. Because the cues in a potentially threatening dating situations are often quite ambiguous, women may often decide not to react assertively, and disregard potential warning signs. There may also be perceived drawbacks to reacting assertively.

For example, some worry that they will feel embarrassed if they respond assertively to a potential perpetrator if the threat is ungrounded. Women may be especially reluctant to acting assertively when the situation involves someone they know. Can anyone think of other factors that might inhibit you from responding assertively in this situation?
**Pres. Hand out Sheet 1.**

In front of you is a list of the four strategies used in the previous section of video. There is a space next to each option for you to list the potential benefits, as well as drawbacks of implementing each strategy. Take a minute to list the potential benefits and risks to implementing each strategy.

**Pres. Wait for women to fill out Sheet 1.**

Would anyone like to share some of the reasons why these strategies might be beneficial? *Reinforce appropriate responses* What about some of the drawbacks to using one of the strategies? *Reinforce appropriate responses.*

You all brought up some really good points. It is important that we think about how we might respond in these situations, and what factors might prevent us from following our instincts. By understanding our own thought processes and behaviors, we are more likely to identify potentially risky situations, and react with confidence.

The second situation involves a young woman getting asked out by a guy who seems to have some sexist attitudes about women.

*Asst. - Roll tape: Scene 2 - Stop tape after option 1 where she goes with him.*

*Pres. After viewing her leaving, ask the following question(s), "What do you think about her going with him?", "Have you ever felt uncomfortable about a guy's attitudes towards
women?" "Let's brainstorm about some other ways to deal with men with these kinds of attitudes". Reinforce appropriate responses. If risky responses are given, elicit feedback from the group by asking something like, "What does everyone think of that?". After exhausting alternatives, say, "You came up with some great ideas, now we're going to see some of them being played out on the tape". If the group's ideas are fairly discrepant from the taped responses say the following. "Notice that other women like yourselves came up with some different ideas as well". If the group's responses are fairly consistent with the taped responses say the following. "Notice that other women like yourselves came up with many of the same ideas as you".

Asst. – Roll tape

Pres. – in black space before option 2 So, one option is to go

Pres. – in black space before option 3 So, you could agree to go, but meet him there. Also, you could let him know that you aren't happy with his attitude

Pres. – in black space before option 4 You obviously can just refuse to go.


What do you have to lose in this situation? Take a minute and think how you might be feeling in this situation, and how you might react.

What are some of the benefits to using each of the strategies? Reinforce appropriate responses What might be a reason that would inhibit you from reacting assertively in this situation? Reinforce appropriate responses.
You all brought up some really good points. Understanding the benefits to reacting assertively helps us to take the warning signs of a potentially threatening situation seriously.

The third situation involves a young woman on the phone with a guy that she barely knows pressuring her to go to an isolated location with him. She clearly feels uncomfortable going with him, however, he apparently won't take "no" for an answer.

Asst. - Roll tape: Scene 3 - Stop tape after she agrees to go with him.

Pres. After viewing her agreeing, ask the following question(s), "What do you think about her going with him?", "Have you experienced similar kinds of pressure and guys who insist on having their own way?", "Let's brainstorm about some other ways to handle this situation?" Reinforce appropriate responses. If risky responses are given, elicit feedback from the group by asking something like, "What does everyone think of that?". After exhausting alternatives, say, "You came up with some great ideas, now we're going to see some of them being played out on the tape". If the group's ideas are fairly discrepant from the taped responses say the following, "Notice that other women like yourselves came up with some different ideas as well". If the group's responses are fairly consistent with the taped responses say the following, "Notice that other women like yourselves came up with many of the same ideas as you".

Asst. – Roll tape

Pres. – in black space before option 2 One alternative is to go.

Pres. – in black space before option 3 Another option is to insist on meeting him there
Another thing is to move the meeting to a less isolated and more familiar place.

Pres. Hand out Sheet 3.

Take a minute and think how you might be feeling in this situation, and how you might react.

What are some of the benefits to using each of the strategies? Reinforce appropriate responses. What might be a reason that would inhibit you from reacting assertively in this situation? Reinforce appropriate responses. These are all great points. Often when have a plan for how you might react in a potentially threatening situation, you can be confident in your response.

The fourth situation involves a young woman at a bar being pressured by a guy to drink more alcohol when she clearly doesn't want to.

Asst. - Roll tape: Scene 4 - Stop tape after she sits back down and apparently drinks.

Pres. After viewing her giving in to his pressure, ask the following question(s), "What do you think about her staying and drinking?", "Have you experienced similar kinds of pressure to drink more alcohol than you want?", "What are some things that you could do to handle this situation?" Reinforce appropriate responses. If risky responses are given, elicit feedback from the group by asking something like, "What does everyone think of that?". After exhausting alternatives, say, "You came up with some great ideas, now we're going to see some of them being played out on the tape". If the group's ideas are fairly discrepant from the taped responses say the following, "Notice that other women
like yourselves came up with some different ideas as well". *If the group's responses are fairly consistent with the taped responses say the following*, "Notice that other women like yourselves came up with many of the same ideas as you".

**Asst. – Roll tape**

*Pres. – in black space before option 2* She can stay and drink more

*Pres. – in black space before option 3* She can refuse and leave, attempting to keep it light

*Pres. – in black space before option 4* She can let him have it

*Pres. – in black space before option 5* You could come up with an excuse

*Pres. Hand out Sheet 4*

There are a variety of ways to handle this situation. Take a minute and think how you might react, and what some of the benefits and consequences to using each strategy might be.

What are some of the benefits to using each of the strategies? *Reinforce appropriate responses* What might be a reason that would sway you not to react assertively in this situation? *Reinforce appropriate responses* You all brought up some really good points. Understanding how you intend to act can help prevent from second guessing yourself when faced with a potentially risky situation.

The fifth situation involves a young woman at a party and a guy asks her up to his room.
Asst. - Roll tape: Scene 5 - Stop tape at the decision point.

Pres. After viewing the decision point, "What do you think she should do?" "Have you experienced similar kinds of pressure to go up to a guy’s room", "Would you feel comfortable going with him". "Let's watch what happens when she expresses her discomfort at different points in time"

Asst. - Roll tape

Asst. – Roll tape

Pres. – in black space before option 2 She can decide immediately not to go

Pres. – in black space before option 3 She goes, but quickly gets out of there

Pres. – in black space before option 4 She waits a little longer, but assertively decides to leave

Pres. – in black space before option 5 She kisses him and then still decides to leave, he’s more aggressive in this situation

Pres. - After viewing the end of the tape, say, This woman obviously changed her mind at various points, "Up to what point is it OK to change your mind?” Pres. Wants participants to address the issue that it is OK to change their minds at any time, however, the longer they wait to express their discomfort, the greater their risk. Wouldn’t it be nice if we could change our minds at any point and guys would respect our wishes.

VIII. What to do when confronted with an acquaintance assault

Asst. - Distribute handout.
There has been some controversy over whether it is better for a woman to actively resist or passively submit to a rape. Some researchers argue that if a woman fights back, she will anger the rapist and he will in turn become violent. This outcome may be true in cases of stranger rape. However, the majority of research indicates that this is not the case with regard to acquaintance rape. Studies on acquaintance rape show that active resistance does not increase the probability of injury. Generally, strategies such as fighting back, running away, and yelling for help are more effective than pleading with the rapist, trying to talk him out of it, crying, or "turning cold". In general, the more things that you do and the more quickly you act, the more likely you are to get away. However, each situation must be evaluated on an individual basis and it is not uncommon for women to freeze when faced with such a frightening situation. We give you some specific strategies in this handout to try if faced with a potentially assaultive situation and the second part of our program will involve you learning some self-defense strategies from a national expert on this topic. Look at your handout and I will review the strategies.

Pres. - Read only the main headings on the handout.
What To Do When Confronted With An Acquaintance Rape

1) **Stay calm:** Concentrate on being assertive.

2) **Appraise your situation, then act quickly:** If you can run, can you get to an area where there are others who can assist you? If you yell, will someone hear you? How violent is the man who is threatening you? Is he more likely to verbally bully you than to use physical force or a weapon? Once you decide on a course of action, act quickly.

3) **Try to get away:** Run toward buildings, lights, the street, anywhere you are likely to find other people. If you're in a car, try to get out. If you can't get out, use the horn.

4) **Yell for help:** Ex., "Help, police!" "Help, I'm being attacked on the parking lot!" or "Fire!"

5) **When necessary, attack forcefully:** Your goal is to incapacitate him long enough for you to get away. Don't worry about hurting him. Think through exactly what you're going to do, and get ready for the fact that you're going to cause him pain.

6) **If you can't get away, buy time with talk:** Some women tell the man they find him attractive and ask him about himself. When he thinks that he no longer needs to use force, he may let his guard down long enough for you to make a break for the door. Or, tell him you want sex but need to go to the bathroom first. The bathroom door may have a lock on it. If it does, use it. If the door doesn't have a lock, you may be able to get out the bathroom window, or start screaming out the window.

7) **Giving in is not consent:** It is a survival strategy. You do not need to sustain injury or death to "prove" that you were raped.

9) **Get help if you are assaulted:** Here are some places to start:
   a) Sexual Assault Nurse Examiners: 593-1660
   b) Careline: 593-3344
   c) Ohio University Police Department: 593-1911
   d) Ohio University Office of Judiciaries: 593-2626

10) **If you are assaulted, keep your options open:**
   a) Call the police. Remember that you can report the assault without pressing charges.
   b) Call a sexual assault survivor advocate.
   c) Seek medical attention immediately to assess or treat possible injuries, sexually transmitted diseases, and pregnancy.
IX. Closing of the Session

We’ve covered a lot of material today. Some of the information may have been new to you. However, it is likely that some of you may have been thinking about the various risk factors and ways to react assertively when faced with a potentially threatening situation. Some of you may already be trying to implement self-protective behaviors in your daily routine.

Using these self-protective strategies isn’t easy or simple. Like any part of our life-style, engaging in self-protective behaviors and utilizing an assertive communication style are behaviors that might not come naturally at first. So, it is normal if you feel hesitant to engage in some of the strategies we talked about today.

We encourage you to think about how best to introduce the program material into your lifestyle. Adopting these self-protective strategies will be an ongoing process. When individuals plan ahead and intend to engage in certain behaviors, they are more likely to react quickly and confidently in risky situations.

While we are waiting for effective prevention programs to be developed for men, it is important for women to be aware of how we can implement self-protective behaviors in our own daily lives.

Are there any additional questions?

Pres. - Address questions.

Asst. - Be sure to record questions and presenter's answers to them.
I'm going to distribute another set of surveys which contains a program evaluation. Please answer surveys by circling your response directly onto the questionnaire. When you are done, please return all materials to the envelope. Remember to come up front before you leave to turn in your materials and to sign up for the second part of the study which will involve a two-hour long self-defense program offered by Cheryl Cesta, a nationally known expert on self-defense techniques for women. We believe that this part of the program will further help to reduce your risk for experiencing sexual assaults and other unwanted sexual experiences. We will attempt to give you a reminder call about this program a few days before. Because this is an ongoing study, we would appreciate that you not discuss the study or the procedures with other students. Thank you for participating in the program.

*Asst.* - Distribute survey and evaluations.

What is rape?

According to Ohio law, (similar to many states), rape is defined as sexual intercourse without consent. This includes vaginal, anal, and oral intercourse, with penetration, no matter how slight, when there is force or threats of force.

(Ohio Revised Code 2907)

Do you know that it is still sexual assault if...?

- objects or fingers are used for penetration

- alcohol or drugs are given secretly, forcefully, or deceptively to impair your judgement, control and resistance

- you are unconscious
You can be raped by...

- a boyfriend
- an ex-boyfriend
- an acquaintance or friend
- a date
- someone you meet at a bar, party or friend’s house
- a husband
- a family member
- a stranger

The majority of all rapes reported to the police occur between people of the same race.

Rape can occur in same-sex relationships:
in one study, 12% of gay men and 31% of lesbians reported being victims of forced sex by their partners

(Waterman et al., 1989)
A victim need not prove physical resistance to the offender in order for it to be rape. If a woman says “NO” and the man forces her to have sex, it is rape.

How frequent is rape among college students?

- 1 in 4 women in a national survey of college students were victims of rape or attempted rape
- 84% of those raped knew their attacker
- 57% of the rapes happened on dates
How susceptible are first-year students?

In a study conducted with primarily first-year students, over one academic quarter at OHIO UNIVERSITY it was found that:

• 1 in 35 women either experienced a rape

• 1 in 8 women experienced other types of forced sexual contact

• 1 in 10 men reported perpetrating an act of forced sexual contact, sexual coercion, rape or attempted rape (Gidycz et al., 2004)

Danger Signals From Men

• ignores your opinion, controls situation, gets jealous when there is no reason

• talks negatively about women, doesn’t view you as “equal”

• drinks heavily, uses drugs, or tries to get you intoxicated

• physically violent or unable to handle sexual or emotional frustration without anger

• emotionally abusive to you or others or enjoys being cruel to animals or children
Situational Risk Factors

- drinking excessively
- being in isolated places, no friends present
- going with or trusting men you don’t know
- wanting to “fit in”, having a negative self-image, or wanting to be liked
- non-assertive behavior
- not trusting your instincts
- accepting drinks from others

Date Rape Drugs

They are odorless and colorless sedatives that are usually put in drinks and take effect in 15 minutes to 1 hour. Their effects include blackouts, complete memory loss, a drunken appearance, headaches, dizziness, and heavy sedation.
BEWARE OF DATE RAPE
DRUGS
THEY ARE KNOWN AS:

- Roofies
- Rope
- Roach
- the Forget Pill
- Gamma
- Rohypnol
- GHB
- Liquid Ecstasy
- Liquid E
- Liquid X

SLIDE ELEVEN

In a national survey of college students, it was found that:

About 75% of the men and at least 55% of the women involved in an acquaintance rape had been drinking alcohol or taking drugs just before the assault.

SLIDE TWELVE
Alcohol Enhances Risk
When men drink or use drugs, they may:
• think women want sex more than they really do
• think that a drunk woman is “fair game”
• experience impaired judgement and impulse control
• feel less responsible for their actions when drunk
• become emotionally volatile

SLIDE THIRTEEN

Alcohol Enhances Risk
When women drink or use drugs, they may:
• experience impaired awareness
• experience impaired judgment
• be less able to physically resist

SLIDE FOURTEEN
Stages of Recovery

- denial / numbing
- intrusive thoughts, nightmares, emotional flooding
- alteration of denial/numbing and intrusive thoughts/flooding
- integration
Appendix D-2
Vaccine Preventable Disease Program Protocol

Vaccine Preventable Diseases Peer Education Program

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I. Key Information

To Check the Experiment System Sign-Up or Award Experimental Credit Points:
Web Address:  http://psychpool-ohio.sona-systems.com/
Login:  raffle
Password:  health

To Login to Porter Classroom Computers:
**Be sure you select “PorterXXX (this computer)”, where XXX is the room number from the pull-down menu when you login
Login:  ou-psych (all lowercase letters)
Password:  porterXXX, where XXX is the room number (all lowercase letters) [Example: for Porter 100, the password is “porter100”]

Technology:
You will need to set up the Classroom Performance System (CPS).

Connect the Receiver Unit and Test the Pads:
1. Connect the receiver unit to a serial port (9-pin COM port) on the back of your computer.
2. Start CPS by selecting the CPS icon from the “Programs” on Windows Explore.
3. Click the Settings menu item, then select the Delivery Options command.
4. Click the Detect CPS Receiver button.
5. CPS automatically finds an available serial port.
6. If you have any issues or questions, refer to the CPS User’s Guide available on the desktop.

Delivering the Lesson Using the Receiver Unit and Response Pads:
1. From the Lessons tab, select the lesson entitled VPD.
2. Click the Tools button and select the Preview Command.
3. Click the Start button to activate the response pads.
4. Click End to see the correct answer and the > (right arrow) button to progress to the next question.
II. Random Assignment of Participants

Before participants enter the room, give them an index card and tell them to go directly to the appropriate room. Example: “Please go directly to Porter 107.”

Facilitator A: Allow participants to determine the appropriate room.
Facilitator B: Collect cards from those who enter each room and have each participant sign in.

III. Introductory Information

As participants enter the room, hand out the packets containing informed consent forms and surveys with the informed consent forms on top.

Hello, my name is (first and last name). I am a (class rank) here at Ohio University.

Hello, my name is (first and last name). I am a (class rank) here at Ohio University.

We will be facilitating the program this evening. This is an experiment to evaluate health interventions for women. You have been randomly assigned to Intervention “green”. You can only participate in this study one time, no matter what group you were in. During this session, you will be asked to complete three tasks. First, you will be asked to fill out questionnaires concerning sexual experiences, dating behaviors, and vaccine preventable diseases. Next, you will be asked to participate – to your comfort level – in a vaccine preventable disease education and awareness program designed by college women especially for college women. Finally, you will be asked to complete an evaluation form regarding the health education program.

Please be aware that this is a three part experiment. Today is the first part. After today, you will be asked to return for Part Two – a two-month follow-up. At the two-month follow-up, you will be asked whether you have been able to utilize the program information during the two months between Part One and Part Two. At the two-month follow-up, you will be given five (5)
experiment points toward the research requirement in your psychology class. It is important that you understand that all experiment points will be awarded AFTER participation in Part Two – the two-month follow-up.

Should you be unable to participate in the two-month follow-up, please contact the experimenter to receive experiment points for participation in earlier parts of the study.

Part Three of the experiment is a four-month follow-up. You will be asked to return for a four-month follow-up, however, experiment points will NOT be awarded for participation. Participation in the four-month follow-up is voluntary, and will help the research team understand how we can improve this program in the future.

Does anyone have any questions?

You have been given a manila envelope. The first sheet is a consent form. Please read over and sign the informed consent form. Show the participants the informed consent form. You have been given a second copy of this form to take with you.

The next form is a confidentiality agreement, stressing that you understand the nature of participation, and agree to maintain the confidentiality of the group discussion. Show the participants the confidentiality agreement. It is important that you do not share information discussed during the session with others. Please read the agreement carefully and sign it.

Now you should be looking at a contact form. Show the participants the contact form. Because you will be asked to come back for follow-ups and because students may move or change their phone number, we are asking you to give us the address and phone number of someone we can call for your new number if necessary. It is best if you list your parents or another relative that will be sure to know your telephone number.

Collect informed consent forms, confidentiality agreement, and contact forms.
You should now be looking at the subject number calculation form. *Show the participants the subject number calculation form.* This form will completed each time you come, so please fill it out carefully. This is done so that we can assure your complete confidentiality and so that you feel you can respond honestly to the surveys.

*Demonstrate how to calculate the subject number on the chalkboard – step by step.*

First, write the last four digits of your social security number.

On the second line, write the numbers corresponding to the month and day of your birthday. If the month or day is only one digit, please put a “0” in the first space. For example, if you were born on January 1, you should record it as “01/01”.

Add the digits together and place on the third line.

Next, think about your mother’s full name. Do not use nicknames. For example, if your mother’s full name is “Christine”, but she goes by Chris, you should record the number of letters as “09” because there are 9 letters in the name Christine.

Add this number to the line above. This is your subject calculation number.

Now, take out the surveys from the manila envelope. Please record your subject number in the identification number area of the questionnaires. *Show the participants where they are to record their subject calculation numbers.*

I know this is a little confusing. Does anyone need any help with this or have any questions?

You should now be looking at the surveys. Please remember to fill out the front and back page of each survey, taking time to clearly circle each answer. *Show the participants that the surveys are double-sided.* You are allowed to write directly on the surveys. Please respond to the survey questions right on the survey. When you’ve finished filling out the surveys, please put all of the materials back into the envelope. Then please sit quietly until everyone is finished.
Are there any questions?

The study will take no longer than 3 hours tonight. It is now (state time), you will be finished no later than (state time the study will conclude).

*When you notice that everyone is finished, ask:* Does anyone need more time?

Please keep your packets and envelopes on the desk in front of you.

**Let’s take a 5 minute break, feel free to leave the room and go to the bathroom or get a drink. Make sure that when you return, you sit in the exact same seat.*
IV. Program Introduction

Again, my name is (first name only).

And my name is (first name only).

Today you will be participating in a program designed to educate college students about vaccine preventable diseases. Because the term “vaccine preventable diseases” can be a lot to repeat over and over, they are commonly referred to as “VPDs”.

*Write “VPDs” on the chalkboard.*

Whenever you hear a reference to “VPDs,” we are referring to vaccine preventable diseases.

Some of you may be familiar with the term “immunization.”

*Write “immunization” on the chalkboard.*

It is important for you to understand that “immunization” is a synonym – a word that has the same meaning – for “vaccination.”

*Add “= vaccination” to the word immunization on the chalkboard. The chalkboard should now read “immunization = vaccination.”*

What we hope to communicate to you today is that we are all at risk for vaccine preventable diseases. However, the key word is “preventable.” We hope this program will provide you with the information that you need to help reduce your risk for vaccine preventable diseases and make informed decisions with regards to your health. As with any health care issue, should you have specific questions or concerns related to your personal risk, we recommend that you share your concerns with your health care provider.

Before we begin the program, we have a few reminders. You have received and signed a consent form, which indicates your consent to participate in this educational program and the focus group that follows. The vaccine preventable disease educational program is being recorded on videotape to
ensure the integrity and consistency of the educational program. As stated in the consent form you signed, the videotape will be focused on us, the facilitators, the whole time. It is not our intent to videotape you, the participants, at any time.

Begin VPD Educational Program.

SLIDE 2

By a show of hands, how many of you have heard of these diseases?

Did you know that there are vaccines that prevent each of these diseases?

The purpose of this program is to increase your awareness of the vaccines that are available to you and why they are necessary for your health and the health of others around you.

How many of you think that you are susceptible to contracting these diseases?

Why do you think you are susceptible?

Why not?

POSSIBLE ANSWERS: Don’t think they are susceptible because these diseases are almost eradicated. Don’t think they are susceptible because they have never heard of some of the diseases.

There are pictures of the effects of these diseases contained in this presentation. These pictures are not being used as a “scare tactic” or to make you uncomfortable, we are using these pictures for the sole purpose of education. Our generation has been fortunate in that we have rarely seen what these diseases do. Many of our grandparents have witnessed these diseases first-hand and so were eager to obtain vaccinations against them. Since many of you have never seen the complications, the pictures help to illustrate the seriousness of these diseases.
Why Vaccinate?
While it is true that some diseases such as polio and diphtheria are becoming very rare in the U.S. largely because we have been vaccinating against them, the question: why vaccinate, still remains an issue.

Although diseases are beginning to be a rarity we cannot let ourselves be blind sided by this positive occurrence in the healthcare community. According to the CDC – which stands for “Center for Disease Control and Prevention” - we can compare this phenomenon to a leaky boat.

When a boat has a leak, it is necessary to bail out the water. In the beginning, you bail as fast as you can. After you have been bailing for awhile, the water level declines and the boat begins to dry. What happens if you don’t fix the leak?

Exactly. If the leak isn’t fixed, the water starts seeping in – and soon you would be bailing out the boat again. Repairing the leak is the only way you will stop the leak for good.

We can think of the human population as the boat, disease as the leak, and vaccination as the bailing. Once you stop administrating the vaccination it gives the disease time to slowly make its way back into the human population. Therefore, unless we can totally eliminate the disease or ‘stop the leak’ it is important that we continue to administer the vaccinations.

Vaccinations offer us a protection that most people now-a-days take for granted. By taking away that protection, more and more people will have the chance of becoming infected and then spread diseases to others.

We vaccinate to protect ourselves, but we need to protect our children, grandchildren, and even their grandchildren, too. For example, small pox shots are no longer given to children because the disease no longer exists, in a way we ‘stopped the leak’. By continuing to vaccinate we help ensure future parents that they can trust that diseases like polio and meningitis won’t infect, cripple, or kill children. Immunizing remains the best way to put an end to the serious effects of certain diseases.
Before we tell you about the different vaccinations for each disease, it is important to know how vaccines work in your body to protect you from infections. A vaccine can be given in a liquid form by mouth, in an aerosol and powder form by inhalation, or most commonly, by a shot. Vaccines usually contain a weakened or dead disease germ, and sometimes it is just part of the disease germ. In some cases, the germ itself is not what makes you sick, but they may release toxins that do. For these diseases, a vaccine containing inactivated toxins would be administered. When the vaccine enters your body, your immune system sees it as a foreign invader. It attacks by making antibodies to fight the weakened or dead germs from the vaccine. Once the antibodies have attacked one time, they have learned how to fight the disease, and create a memory of the disease, so if the real disease germs enter the body, you won’t get sick.

The protection that a vaccine gives you is called **immunity**, and the protection from the disease you are vaccinated for will usually last a lifetime.

Some vaccines require a **booster shot** which is an additional dose to make sure that your body has developed anti-bodies to the disease.

Does anyone have any questions about this process, or how vaccines work?

Does anyone know the difference between a bacterial and viral infection?
Now that you know the basics, we are going to look at certain vaccine preventable diseases individually. There are two types of infections: bacterial and viral. Antibiotics are used to treat bacterial infections and some bacterial infections can be prevented by vaccination. On the other hand, antibiotics are useless against viral infections. Some viral infections can be prevented by vaccination. Your body’s immune system can get rid of some bacterial and viral infections on its own.
Unfortunately, due to popular media and other various sources, it is common to hear misleading information about whether you should or should not receive a vaccination. We are now going to show you a brief clip from a popular media source that shows one of the misconceptions, and demonstrates how someone watching the show may be led to think vaccinations are dangerous.

*(Show Clip of the Simpsons)*

As you can see, even a popular show like the Simpsons can alter your view about the safety of being immunized. We want to clear the air about a few of the other misconceptions about vaccines so that you can make informed decisions when choosing whether or not to get a vaccination. So now we are going to show you four clips from a video called *Separating Fact from Fear*. The clips may start at an odd place, but we wanted to get these certain points across to you without showing the entire film.

*Show Clips: 1) Are Vaccinations Necessary? Part 3
2) Are Vaccines Safe?
3) Is it better to be naturally or artificially immunized?
4) New vaccines, Should you wait?*

We hope that these clips have helped to clarify some of the misleading ideas about vaccines that you may have heard of, or may encounter in the future. Are there any questions before we move on?
Now, let’s talk about the risks associated with vaccinations. It can be scary to receive a shot and not be sure of what the outcome may be. Like any drug, vaccines are capable of causing serious problems, even death. However, vaccines are held to the highest safety standards. Most people who receive vaccinations experience no reaction at all or only mild side effects, such as fever or soreness at the injection site. It is rare for any person to suffer from a more serious side effect like an allergic reaction.

There are signs that one can look for that may indicate a moderate or severe reaction:

- After being vaccinated moderate reactions may include a high fever or any behavioral changes.
- More serious reactions include difficulty breathing, hoarseness or wheezing, hives, paleness, weakness, a fast heartbeat, dizziness, and/or swelling of the throat.

All of these reactions can be treated as long as the patient contacts medical help immediately.

One particular vaccine that should be noted as a potential threat to some is the influenza or “flu” vaccine. In order to produce large quantities of the vaccine (especially during pandemics) it is common to grow the viruses in chicken eggs. Therefore if you are allergic to eggs you should not get the influenza vaccine. Another vaccine that should be noted is the MMR vaccine and its questionable link to autism. You may have heard through the media or other sources about a link between the MMR vaccine and the development of autism. Many scientific studies have found no relationship between the two and have disproved studies that have previously suggested a link.

Remember, you should always take time to discuss the benefits and risks of vaccination and any other medical procedure with your health care provider.

Are there any questions?
Hepatitis A is a liver disease caused by the Hepatitis A virus (HAV) which can affect anyone. There are 17,000 cases annually in the US. HAV is found in the stool (feces) of a person with Hepatitis A. It is usually spread from person to person by putting something in the mouth that has been contaminated with the stool of a person with Hepatitis A.

Do any of you remember the recent outbreak of Hepatitis A?

This outbreak was connected with green onions that were served at a Chi Chi’s restaurant. It killed three people and sickened nearly 600 people. The contamination could have been caused by anything from a sewage leak in a farm field to feces in a shipper's truck. Workers who failed to wash their hands at any stage of the onions' transit from field to the restaurant are another possible culprit.

As you can see, Hepatitis A’s **incubation period** is about two to six weeks.

Just so you know, when we refer to the **incubation period** for each of these diseases, we mean the time it takes from initial contraction of the bacteria or virus until the infected person starts to display symptoms of the disease.

The best protection against HAV is the Hepatitis A vaccine. The vaccine is given in 2 doses. The second dose or booster should be given 6-18 months after the first injection. Also always remember to wash your hands with soap and water after using the bathroom, changing a diaper, and before preparing and eating food.
Adults will have signs and symptoms of Hepatitis A more often than children will. Symptoms of Hepatitis A are jaundice which is a yellowing of the skin, fatigue, abdominal pain, loss of appetite, nausea, diarrhea, and fever. Once you have gotten Hepatitis A you cannot get it again, however those who do get HAV, about 15% will have prolonged or relapsing symptoms over a 6-9 month period. Remember that there is a vaccination for Hepatitis A and that it is required if you work in the following fields: foodservice, daycare, and hospital settings.

**ACTIVITY**
Before we move on to the next vaccine preventable disease, we would like to ask you to think about the following scenario. Imagine that you are planning on getting a piercing or tattoo. What health concerns you would have related to the procedure?

Did you ever think of Hepatitis B?

Yes it is true that this can be transmitted by getting piercing or tattoos if certain precautions are not taken.

Now we will discuss Hepatitis B.
Hepatitis B is a disease caused by the Hepatitis B virus (HBV) which attacks the liver. It is estimated that each year 80,000 people, mostly young adults get infected each year. The highest rate of the disease occurs in 20-49 year-olds.

It is transmitted through body substances such as blood and blood products, saliva, amniotic fluid, semen and vaginal secretions.

HBV is spread through having sex with an infected individual without using a condom, by sharing drugs, or needles, or from an infected mother to her baby during birth. Hepatitis B is more infectious than HIV or hepatitis C, because there are very high concentrations of hepatitis B viruses in the blood and body fluids of infected people, and hepatitis B viruses can live for several days in dried blood on table surfaces, needles, and syringes. Because hepatitis B is found in infected blood at high concentrations, it can be transmitted by personal care items such as razors and equipment used by manicurists, estheticians, barbers and cosmetologists. This can happen when even a small amount of infected blood, so tiny it cannot be seen, stays on equipment and comes into contact with an open cut or sore, rash or eyes, mouth or nostrils (mucous membranes) of another person. Other equipment that comes into contact with blood includes tattooing and body piercing needles, cuticle scissors, nail files and emery boards, hair clippers, hair removal tools such as tweezers and electrolysis equipment and even hair-cutting scissors and combs.

People at risk for HBV are persons with multiple sex partners or diagnosis of a sexually transmitted disease, men who have sex with men, sex contacts of infected persons, injection drug users, household contacts of chronically infected persons, infants born to infected mothers, and health care and public safety workers.
Now let’s go over the symptoms of the hepatitis B virus. It’s important to know that 30% of those who have Hepatitis B have no signs or symptoms, and signs and symptoms are less common in children than adults. Symptoms that may occur are jaundice, fatigue, abdominal pain, loss of appetite, nausea, vomiting, and joint pain.

The best protection against HBV is the Hepatitis B vaccine which has been around since 1982. However, you should not get this vaccine if you have ever had a reaction to baker’s yeast or a previous dose of a hepatitis B vaccine, also you should not get the vaccine if you are ill the day of the vaccination. Wait till you are feeling better to go get the vaccine. The vaccination is spanned over 6 months. After the first injection the subsequent doses should be given after 1 month and then the last of the series of shots at 6 months.

HBV can cause lifelong infection, cirrhosis (scarring) of the liver, liver cancer, liver failure, and death. It is estimated that each year 80,000 people, mostly young adults get infected every year.

**ACTIVITY**

What you think you should look for when choosing a place to get a piercing or tattoo?

What would you look for and what would you ask the technician?

**Give time for discussion**

The Association of Professional Piercers suggests that the technician should be wearing a fresh pair of sterile gloves, the technician opens a new sterile needle in front of the client and disposes of the needle in a medical sharps container when finished, and to never have a piercing gun used on any part of the body besides the ear lobes. Make sure you are comfortable with your technician to be able to ask any question that you may have.

Don’t forget your Hepatitis B immunization – Hepatitis B is a vaccine PREVENTABLE disease!
After you have a piercing or a tattoo, if you have any signs of infection – be sure to contact your health care provider. To help you with signs and symptoms of infection, you can view Hudson Health Center’s website:

Link to this website:
http://www.ohiou.edu/hudson/shs_page.html
Click on “Health Topics”
Click on “Tattoo and Piercing Care”
Meningitis is a very serious disease, 10-15% of cases are fatal; and of patients who do recover 10-15% have permanent hearing loss, mental retardation, and loss of limbs. This disease can kill within hours! Meningitis is the inflammation of the lining around the brain and spinal cord. Generally meningitis is transmitted through direct contact with respiratory secretions. People can be asymptomatic carriers; which means they will not get sick but they may pass the disease to others. People who are most at risk for meningitis are people living in close quarters such as dorm rooms, especially college freshman. Meningitis peaks late winter to early spring. Annually, there are 3-8 cases of this disease per every 100,000 students.

Another area of concern when it comes to college students and meningitis is bars. This is when meningitis can be caught or spread more easily. The bacteria and viruses that cause meningitis can be passed through kissing, eating or drinking from others utensils, and from close contact in crowded rooms. Smoking and drinking makes it harder for immune systems to effectively ward off the conditions.

The incubation period for meningitis has been found to be between two and ten days.

Remember the focus of this program is vaccine preventable diseases. The keyword is PREVENTABLE. We will discuss ways to reduce your risk.
Bacterial meningitis is serious and can be caused by a range of different bacteria however most are caused by meningococcal bacteria. Bacterial meningitis can lead to brain damage, hearing loss, or learning disability. Symptoms of bacterial meningitis are severe headache, stiff neck, dislike of bright lights, fever, vomiting, drowsy and less responsive, and rash.

There is a Meningitis vaccine available that is good for 3-5 years. So if you are vaccinated freshman year it will last through your college career. The vaccine can prevent against 4 types of the meningococcal disease.

We are now going to play a video taken from the show 20/20 about college students who contract meningitis. **(Play video)**

**DEBRIEF**

- How many of you have thought about meningitis before watching the video?
- What are some risk factors for contracting meningitis?
- How do you feel after watching a video about meningitis that relates to your age group and in your present environment on a college campus?
- What are some ways that you can reduce your risk?
- Let’s talk about the meningitis vaccine. How many of you remember reading this sheet with your pre-college information? Note that the CDC still does NOT recommend the meningitis for the general population, but supports the American College Health Association’s (ACHA’s) decision to educate students and parents about meningitis and the available vaccine.
- How much did the video say that the meningitis vaccine cost? (ANSWER: $60). Today, the vaccination costs around $80. Do you think that cost is too high for the vaccine? Why or why not? How many of you know someone who has spent $80 or more on a clothing item (pair of jeans), pair of shoes, or accessory (purse)? Does that put the cost of the vaccine into perspective for you?

It’s important to remember that there is a vaccine for this disease and that it is preventable.
If you have questions about meningitis or the meningitis vaccine, Hudson Health Center’s Website provides some valuable information:

*Link to this website:*

http://www.ohiou.edu/hudson/shs_page.html

Click on “Health Topics”

Click on “Meningitis”
Out of curiosity, how many people in this room have had the flu once in the past two years?

How do you know you have the flu? What are some signs and symptoms?

As you can see flu affects many people each year. We will now discuss more information about the flu.
Influenza (commonly called “the flu”) is a contagious respiratory illness caused by the influenza virus that strives in cold and low humidity (outbreaks mostly during cold winter months). Infection with influenza viruses can result in illness ranging from mild to severe and life-threatening complications. An estimated 10% to 20% of U.S. residents get the flu every year.

The flu is spread mainly by person to person through respiratory droplets coming from sneezes and coughs. Just as an FYI a droplet or sneeze is generally spread 3 feet (flip back to previous slide). Less common but still a mode of transmission is through inanimate objects with respiratory droplets and then touching the nose or mouth before properly washing one’s hands. Studies show that adults can spread the virus to others one day before even developing symptoms up to 7 days after getting sick. Young children can spread the disease for even longer than 7 days after getting sick.
Symptoms of flu include fever (usually high), headache, extreme tiredness, dry cough, sore throat, runny or stuffy nose, and muscle aches. Gastro-intestinal symptoms include nausea, vomiting, and diarrhea are much more common among children than adults.

Each year the flu vaccine is different because it is developed to protect you from the most prevalent strains for that season. Because of this it is possible to get sick by contracting a different strain, but getting the vaccine is still the best method of prevention. Does everyone understand what we mean by this?

Other good habits for prevention include avoiding close contact with people who are sick, stay home when you are sick, cover your mouth and nose with a tissue when coughing and sneezing, wash your hands frequently, and avoid touching your eyes, nose, and mouth.
There are certain people who are at increased risk for serious complications from the flu, these people include people 65 years and older and people of any age with chronic medical conditions. Pregnant women and children between 6 months and 23 months of age are also at increased risk from flu complications. Serious complications caused by flu include bacterial pneumonia, dehydration, and worsening of chronic medical conditions such as congestive heart failure, asthma, or diabetes. Children may get sinus problems and ear infections.
There is a special vaccine called D-T-P. It is a single vaccine that protects you against three diseases. The D-T-P vaccine protects us against three diseases: diphtheria, tetanus, and pertussis.

Pertussis, one of the diseases the D-T-P vaccine protects against, is commonly known as Whooping Cough. Pertussis is an infection of the respiratory system that is spread by coughing and sneezing. First symptoms appear as a common cold and then about two weeks later, the cough becomes wet and brings up thick stringy mucous. Coughing can occur in long spells that ends in a gasping sound. The good news is that lifetime immunity is attained for Pertussis after receiving the first vaccine. We often receive this vaccination as children.

We will be discussing tetanus and diphtheria at length because we need a BOOSTER shot every 10 years to protect against these diseases.

**Discussion question**
How many of you have heard of the “booster” shot?

When would you get a tetanus booster?
(Answer: step on a rusty nail, deep puncture or cut)
The tetanus bacterium is very common, it can be found in soil, dust, and manure. The most common infections result from a deep puncture wound or cut. There are approximately 40 cases of tetanus annually. An infection can also result from a pin prick. Tetanus cannot be spread from person to person. Although, there is no lasting immunity to Tetanus, a booster every 10 years prevents infection.

The next slide shows graphic images of severe muscle spasms due to neonatal tetanus and adult tetanus. The following contains a picture of a persons gluteus (buttocks), if you are uncomfortable viewing these images please feel free to turn away.
The first picture shows neonatal tetanus. Remember that a newborn cannot hold its own head up, but here you can see the rigidity of the spine and the muscle spasms in the arms and legs. The second picture is an adolescent suffering from severe muscle spasms.

Can anyone think of how an infant would get tetanus? (Answer: Neonatal tetanus is spread to the newborn through use of unsterile cutting equipment on the umbilical stump.)
The symptoms of tetanus include: headache, neck and jaw stiffness, difficulty swallowing, muscle spasms, sweating, and fever. These symptoms can lead to severe muscle spasms resulting in temporary paralysis, locking of the jaw, and death by suffocation. Suffocation results from the paralysis of the diaphragm, which is the muscle below the rib cage that controls breathing.
This picture shows the membrane caused by the Diphtheria bacteria in the back of the throat.
Diphtheria is a bacterial infection of the upper respiratory tract and occasionally of the skin. This disease is airborne and is spread by coughing and sneezing. Diphtheria is a rare disease here in the United States. Its prevalence rate is approximately 1 in 272 million people annually.
Diphtheria usually begins with a sore throat, slight fever, and swollen neck. The bacteria multiply in the throat, nose, or on the skin. These bacteria cause a membrane to form in the nose or throat which then leads to suffocation. If the infection is on the skin, a lesion or open sore will form. The bacteria can also release a toxin that spreads through the bloodstream which can lead to muscle paralysis, heart and kidney failure, and death.
The MMR vaccine stands for Measles, Mumps, and Rubella. I’m going to tell you a little bit about each of the three diseases that it gives you immunity against. This picture shows the prominent rash of measles.
Measles is caused by a virus that infects the throat and lungs and there are 100 cases of measles are reported a year. It is spread by coughing and sneezing and the CDC stated that it is so highly contagious that anyone who is not immunized will probably get it, eventually. The incubation period for this disease is 10-12 days, again this is the time period from contracting the disease to displaying the symptoms.
At the onset of symptoms, one might experience a high fever, cough, runny nose, red watery eyes, and a rash that starts at the hair line and spreads down the face and neck, and eventually reaching the hands and feet. These symptoms last for about a week. Some complications of this disease include diarrhea, ear infections, pneumonia, seizure, inflammation of the brain that can cause deafness and retardation, and finally death. Complications of Measles occur in about 20% of reported cases, and or more likely to occur in children under five years of age, and adults that are twenty and over.
This picture shows a young boy with mumps. Notice the swollen lymph nodes under the jaw.
Mumps is a disease of the lymph nodes that is caused by a virus. 307 people are infected with mumps every year. Why do you think that the number of people infected with Mumps each year is so small? (Answer: VACCINATION!)

It is also spread by coughing and sneezing. Symptoms of this disease include a fever, headache, muscle ache, and swelling of the lymph node that are close to the jaw. Can anyone think of another illness they would think they would have if they had these symptoms?
Mumps can include meningitis, painful inflammation of the testicles or ovaries, inflammation of the pancreas, deafness, and rarely death.
As you can see this child is displaying the prominent rash that is caused by the Rubella virus.
Lastly, Rubella also known as German measles is a respiratory disease caused by a virus. There are 267 annual cases of Rubella. Why do you think that there are only 267 annual cases of Rubella? (Answer: Vaccination)

Like Measles and Mumps, Rubella is also spread by coughing and sneezing. The symptoms of Rubella are a rash and fever that lasts 2 to 3 days.
Knowing about Rubella is especially important for women. This is because, in pregnant women, the complications of Rubella are mainly birth defects. If a pregnant woman contracts Rubella, there is a 20% chance that her unborn child may suffer from defects such as deafness, cataracts (which can lead to blindness), heart defects, mental retardation, and liver and spleen damage.

If you are sexually active and can’t imagine having a child right now – think for a minute about how having a child with these severe defects and/or disabilities would change your life. For this reason, the MMR vaccine is an important prevention action.

Remember in the beginning of this program how we discussed that a small amount of people who get a vaccine can fail to acquire desired immunity? There are ways to test if a person has enough immunity against some diseases. When planning to become pregnant, you should check with your always consult your health care provider before “trying” to become pregnant. Oftentimes, the doctor will send you to the lab to get a titer. A titer is a test that scans your blood to make sure you have enough immunity against the Rubella virus.
What we hope we communicated to you today is that we are all at risk for vaccine preventable diseases. Again, the key word is “preventable.” We hope this program provided you with the information that you need to help reduce your risk for vaccine preventable diseases and make informed decisions with regards to your health. As with any health care issue, should you have specific questions or concerns related to your personal risk, we recommend that you share your concerns with your health care provider.

Distribute debriefing packet. BE SURE TO HOLD UP THE PAGES AS YOU TALK ABOUT THEM SO THAT PARTICIPANTS CAN FOLLOW ALONG.

This packet is yours to keep following the educational program. The first page of the packet consists of some general information about the educational program you participated in this evening. Please notice that there are several resources on this sheet that may be very helpful to you. As an Ohio University student, Hudson Health Center is a very valuable resource – should you think you are sick or if you want to discuss your vaccination status with a health care provider. If you have specific questions about the vaccine preventable diseases we discussed tonight or vaccine preventable diseases in general, you can contact Hudson Health Center or the National Immunization hotline, a hotline number sponsored by the Centers for Disease Control and Prevention – sometimes referred to as the “CDC.” As students, we are very familiar with technology and the World Wide Web. For that reason, several reliable websites – including the Hudson Health Center Website that we looked at today – with factual information are listed for you to use as resource.

The second page of the packet is the CDC’s current recommendations for adult vaccinations. Recall from our educational program that it is a common myth that vaccinations are just for children. Many young adults, like us, do need vaccinations to prevent diseases such as hepatitis B, hepatitis A, flu, tetanus and/or meningococcal disease (bacterial meningitis). This handout can give you an idea about the vaccinations that are particularly relevant to young adults and adults.
The next few pages of the packet contain a vaccination record. We encourage you to take a few minutes of your busy schedules to complete this record. To complete this information, you may need to ask your parent and/or guardian for the dates you received each vaccination. Another good source of information to help you as you complete this record is your family physician or health care provider. It is important to become aware of your current vaccination status and continue to update your record when and if you choose to update your vaccinations. This vaccination record is helpful to have whenever you change health care providers, travel to a foreign country, or need to be seen in an emergency room.

Finally, we have included CDC fact sheets about each of the vaccine preventable diseases we discussed in the program tonight. Please feel free to read these sheets at your leisure to reconcile any unanswered questions you might have.

We hope that this information will help to guide you in making informed choices.

• What are some different choices you will make now or in the future regarding vaccinations?
• Does anyone have any questions at this time?

At the conclusion of this program, we hope you can make more informed decisions when choosing whether or not to be vaccinated.
Vaccine Preventable Diseases

- Hepatitis A & B
- Meningococcal (meningitis)
- Influenza
- Tetanus
- Diphtheria
- Measles, Mumps, Rubella (MMR)
Why Vaccinate?

- Vaccines have reduced or eliminated many infectious diseases
- “Stop the Leak”
- Protecting the Future

How Vaccines Work

- Methods of administration
  - Oral, inhalation, or injection
- Contents of vaccines
- What happens in your body
- Immunity: the body’s ability to resist infection from a specific disease
- Booster shots
Bacterial vs. Viral Infections

- Bacterial
  - Vaccines
  - Antibiotics
- Viral
  - Vaccines

Misconceptions About Vaccination
Risks of Vaccination

- Outcomes
  - Moderate reactions
  - Severe reactions
- What you can do if you experience a reaction
- Vaccine to take note of
  - Influenza Vaccine
  - Measles, Mumps, Rubella

Hepatitis A

- **Definition:** liver disease caused by Hepatitis A virus
- **Mode of Transmission**
  - Stool/feces of infected person
- **Incubation period**
  - 2 to 6 weeks
Hepatitis A

- **Definition:** liver disease caused by Hepatitis A virus
- **Mode of Transmission**
  - Stool/feces of infected person
- **Incubation period**
  - 2 to 6 weeks

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**Signs & Symptoms**
- Jaundice
- Fatigue
- Abdominal pain
- Loss of appetite
- Nausea
- Diarrhea
- Fever
Hepatitis B

- **Definition**: disease caused by the Hepatitis B virus which attacks the liver
- **Mode of Transmission**
  - Body substances: blood and blood products, saliva, amniotic fluid, semen and vaginal secretions
- **Incubation period**
  - 1 to 5 months

Signs & Symptoms
- Jaundice
- Fatigue
- Abdominal pain
- Loss of appetite
- Nausea
- Joint pain

Complications
- Lifelong infection, cirrhosis (scarring) of the liver, liver cancer, liver failure, death
Meningococcal (Meningitis)

- **Definition:** inflammation of the lining around the brain and spinal cord
- **Mode of Transmission**
  - Direct contact with respiratory secretions
- **Incubation period**
  - 2 to 10 days

**Signs & Symptoms**
- Severe headache
- Stiff neck
- Dislike of bright lights
- Fever
- Vomiting
- Drowsy
- Less responsive
- Rash

**Complications**
- Permanent hearing loss, mental retardation, loss of limbs, brain damage
Influenza

- **Definition**: contagious respiratory illness commonly referred to as the flu caused by influenza virus
- **Mode of Transmission**
  - Person to person through respiratory droplets mainly from sneezes and coughs
- **Incubation period**
  - 1 to 3 days
Influenza

- Signs & Symptoms
  - Fever (usually high)
  - Headache
  - Extreme tiredness
  - Dry cough
  - Sore throat
  - Runny or stuffy nose
  - Muscle aches

- Gastrointestinal symptoms
  - Nausea
  - Vomiting
  - Diarrhea

Complications
- Bacterial pneumonia, dehydration, worsening of chronic medical conditions—congestive heart failure, asthma, diabetes
Three Diseases One Vaccine

- Diphtheria, Tetanus, and Pertussis are given as one vaccine
- The initial vaccine includes all three
- Booster vaccine is needed for Diphtheria and Tetanus

Three Diseases One Vaccine: Tetanus

- **Definition:** bacterial disease that affects the nervous system
- **Mode of transmission**
  - Open cut or wound with tetanus contaminated object
- **Incubation period**
  - 3 days to 3 weeks
Three Diseases One Vaccine: Tetanus

- Signs & Symptoms
  - Headache
  - Neck and jaw stiffness
  - Difficulty swallowing
  - Spasms
  - Sweating
  - Fever

- Complications
  - Severe muscle spasms, locking of the jaw, death by suffocation

SLIDE TWENTY TWO
Three Diseases One Vaccine: Diphtheria

- **Definition:** bacterial infection of the upper respiratory tract and occasionally the skin
- **Mode of transmission**
  - Coughing and sneezing
- **Incubation period**
  - 2 to 5 days
Three Diseases One Vaccine: Diphtheria

- Signs & Symptoms
  - Fever
  - Headache
  - Rapid pulse
  - Sore throat
- Complications
  - Suffocation, paralysis, heart and kidney failure, death

MMR: Measles
MMR: Measles

- Measles, Mumps, and Rubella are given as one injection
- **Definition:** viral infection of the throat and lungs
- **Mode of transmission**
  - Coughing and sneezing
- **Incubation Period**
  - 10 to 12 days

Signs & Symptoms (last about 1 week)
- High fever
- Cough
- Runny nose/watery eyes
- Rash

Complications
- Diarrhea, ear infection, pneumonia, seizures, inflammation of brain, death
MMR: Mumps

- **Definition:** Viral infection of the lymph nodes
- **Mode of transmission**
  - Coughing and sneezing
- **Incubation period**
  - 14-24 days
- **Signs & Symptoms**
  - Fever
  - Headache
  - Muscle ache
  - Swollen lymph nodes
**MMR: Mumps**

- Complications
  - Meningitis, inflammation of testicles/ovaries and/or pancreas, deafness, death

**MMR: Rubella**
MMR: Rubella

- **Definition:** Viral infection of the respiratory system
- **Mode of transmission**
  - Coughing and sneezing
- **Incubation period**
  - 16-18 days
- **Signs & Symptoms (lasts 2-3 days)**
  - Fever and rash

SLIDE THIRTYTHREE

MMR: Rubella

- **Complications**
  - Birth defects
    - Prevention - titer

SLIDE THIRTYFOUR
The Ohio University Sexual Assault Risk Reduction Program:
Revised Protocol 2004-2005

BOOSTER SESSION

Christine A. Gidycz
Ohio University

Steven J. Lynn
SUNY-Binghamton

Cindy L. Rich
Ohio University

Catherine Loh
Ohio University

Nichole L. Marioni
Ohio University

Lindsay M. Orchowski
Ohio University

I. Assignment of Participants
As participants enter the room, check the sign-in sheet and identify if they participated in:

Purple group: Sexual assault Risk Reduction Program
Green group: Vaccine Preventable Disease Education and Awareness Program

Tell participants in the purple group to go to room Porter 107. Participants in the green group should go to room 100/101.

Pres. - Allow participants to determine their room and to leave if necessary.
Asst. - Have each participant sign in.

II. Introductory Information

Asst. - As participants enter the room hand out the packets with two informed consent forms, one confidentiality agreement, contact sheet, and subject number calculation on top.

Hello, my name is (first and last name). I am a (class rank) at Ohio University.

Hello, my name is (first and last name). I am a (class rank) at Ohio University.

We will be facilitating the program this evening.

This is group “purple”; and this is PART TWO of the study. Previously, you should have participated in a seminar to reduce the risk that you will
experience a sexual assault. You may have also attended a self-defense seminar. Please note, that other women in this study previously participated in other types of health interventions. So if you are in doubt that you are in the right group, I have a list of names and you can come up and I will check to see if your name is on it. Does anyone need to come up and check? If so, please do it now.

Let’s get started. As you know, this is a multi-part study. Tonight, you will be participating in the booster session of a sexual assault risk-reduction program. You will receive 2 experimental credit points for filling out questionnaires and participating in a brief review of the program material. Although you will receive 2 experimental points for participating in tonight’s session of the study, those of you who participated in a self-defense seminar will have 2 additional credit points added to your experimental credit points. Overall, you will have received 7 credit points for participating in all 3 parts of the study.

Please contact the facilitator, Lindsay Orchowski, if there is difficulty in receiving experimental credit points for this study. You will be given information on how to contact the experimenter to take with you after today’s session.

Finally, you will be asked to come back for 4-month follow-up in the (winter/spring). You will not receive experimental credit points for participation. Participation in the 4-month follow-up is voluntary, and will
help the research team to understand how we can improve this program in the future. We will call you during the END of (winter/spring) term to schedule your 4-month follow-up visit. Your continued participation in this study provides the research team with valuable information and feedback on the effectiveness of health interventions for women. We appreciate your continued participation in this study.

Does anyone have any questions?

Please read over and sign the informed consent form. You have been given a second copy of this form to take with you.

The next form is a confidentiality agreement, stressing that you understand the nature of participation, and agree to maintain the confidentiality of the group discussion. It is important that you do not share information disclosed during the session with others. Please read the agreement carefully.

Now you should be looking at a contact form. Because you will be asked to come back for the 4-month follow-up, and because students may move or change their phone number, we are asking you to give us the phone number of someone we can call for your new number if necessary. It is best if you list your parents or another relative that will be sure to know your number.

When you are finished, raise your hand and we will collect the forms. You should have one white consent form, one green confidentiality agreement
and one blue contact form. Remember to keep one consent form for yourself.

Pres. - Collect informed consent, confidentiality agreement and contact forms

You should now be looking at the subject calculation form. This form will be calculated each time you come, so please fill it out carefully. This is done so that we can assure your complete confidentiality and so that you feel that you can respond honestly to the surveys.

Pres- demonstrate how to calculate the subject calculation form on overhead projector.

First, write the last four digits of your social security number. On the second line, write the numbers corresponding to the month and day of your birthday. If the month or day is only 1 digit, please put a “0” in the first space. For example, if you were born on January 1, you should record it as “01/01”. Add the digits together and place on the third line.

Next, think about your mother’s full name. Do not use nicknames. For example, if your mother’s first name is Christine, but she goes Chris, you should record it as “09”. There are nine letter letters in the name Christine. Add this number to the line above. This is your subject calculation number.

Now, take out the surveys from the manila envelope. Please record your subject number in the identification number area of the questionnaires. I know this is a little confusing, does anyone need any help with this, or does anyone have any questions?
Please do not write your name or any identifying information on the questionnaires.

You now should be looking at a packet of surveys. Please remember to fill out the front and back page of each survey, taking time to clearly circle each answer. When you've finished filling out the surveys, please put all the materials back into the envelope. Then please sit quietly until everyone is finished. Feel free to read or do work while you are waiting for others to finish. Are there any questions? The study will take no longer than three hours tonight. It is now (state time), you will be done no later than (state time they will be finished).

Pres. - When you notice that everyone is done, ask "Does anyone need more time?"

Please keep your packets and envelopes on the desk in front of you.

**Let's take a 5 minute break, feel free to leave the room to go to the bathroom or get a drink. Make sure when you come back you sit in the exact same seat.

Hello my name is ___________ and this is _______________.

Keep in mind this is an ongoing study, and you will receive a total 7 credits for your participation in all three sessions of the study. You will be contacted to participate in a 4-month follow-up during the winter term. At this follow-up you will be asked to complete questionnaires to provide feedback on the program. Participation in this 4-month follow-up is
voluntary, and helps to provide the research team with valuable information on health interventions for women.

Tonight we will be discussing some of the topics that came up during the sexual assault risk reduction program, as well as the self-defense class. If you were unable to attend a self-defense class, this is a valuable time for you to pick up on some of the information.

Let’s start with talking about risk-factors.

DISCUSSION QUESTIONS (2 MONTH FOLLOW-UP)

1) After a prevention program many women are more likely to see and recognize risk factors that have been shown to be associated with sexual assault. These can be factors about the guy, the situation, or the victim. What are some of the risk factors of sexual assault? Can anyone discuss a risky situation they’ve seen or encountered in the past 2-months? Please list some risk factors that you or your friends may have experienced during the past 2 months. You may also list risk factors that you remember from the prevention program.

Pres. – If discussion is slow, bring up the following topics:
Asst. – Join in discussion by inserting comments and points from the list below as appropriate

Danger Signals from Men:
1. Ignores your opinion, controls the situation, gets jealous when there is no reason
2. Talks negatively about women, doesn’t view you as “equal”
3. Drinks heavily or uses drugs, tires to get you intoxicated
4. Physically violent or unable to handle sexual or emotional frustration without anger
5. Emotionally abusive to you or others or enjoys being cruel to animals or children

**Situational Risk Factors:**
1. Drinking excessively
2. Being in isolated places
3. Going with or trusting men you don’t know
4. Wanting to fit in, having a negative self-image, wanting to be liked
5. Non-assertive behavior
6. Not trusting instincts
7. Accepting drinks from others

**Role of alcohol:**
*When men drink or use drugs they may:*
1. Think women want sex more than they do
2. Think that a drunk woman is fair game
3. Impaired impulse control
4. Impaired judgment
5. Feel less responsible for their actions
6. Emotionally and physically volatile

*When women drink or use drugs they may:*
1. Experience impaired impulse control
2. Impaired judgment
3. Be less able to physically resist

2) You learned many self-defense strategies or techniques during the prevention program. What are some of the self-defense strategies that you learned during the seminar? Can anyone discuss how they have utilized these skills in the past 2-months? Please list any strategies that you or your friends may have used during the past 2 months (such as limiting alcohol use, being more assertive, trusting your intuition, etc). You may also list risk factors that you remember from the prevention program.

*Pres. – If discussion is slow, bring up the following topics:*

*Asst. – Join in discussion by inserting comments and points from the list below as appropriate*

*Asst. – Comment on the ease/difficulty of performing behaviors. Reinforce responses that reflect use of strategies (e.g., “It makes me glad to hear you responded with such confidence” etc.)*

1. Assertive body language?
2. Avoiding “telegraphing” or showing your suspicions or fears?
3. Assertive verbal response?
4. Increased attention to your intuition?
5. Yelling and running away?
6. Physical self-defense?

3) What things were most helpful or useful for you about the prevention program and why?

**IX. Closing of the Session**

Thank you for participating in the booster session today. We’ve reviewed a lot of material today. It is likely that some of you may have been thinking about the various risk factors and ways to react assertively when faced with a potentially threatening situation since our first session. Since then, you may already be trying to implement self-protective behaviors in your daily routine.

We emphasize that using self-protective behaviors and communicating assertively isn’t easy or simple. Like any part of our life-style, self-protective behaviors and utilizing an assertive communication style are behaviors that might not come naturally at first. So, it is normal if you are still feeling hesitant to engage in some of the strategies we talked about today.

We encourage you to think about how best to continue to introduce the program material into your lifestyle. Adopting these self-protective strategies will be an ongoing process. We believe that when women have a plan for engaging in protective and assertive behaviors, that we can react quickly, and with confidence when in uncomfortable or even threatening situations.
While we are waiting for effective prevention programs to be developed for men, it is important for women to be aware of how we can implement self-protective behaviors in our own daily lives.

Are there any additional questions?

*Pres. - Address questions.*

*Asst. - Be sure to record questions and presenter's answers to them.*

Remember that we will be contacting you for a 4-month follow-up session, during the winter term. If you are not on campus during winter/spring term, we will mail you survey materials at your request. Because this is an ongoing study, we would appreciate that you not discuss the study or the procedures with other students. Thank you for participating in the program. Your ongoing participation provides researchers with vital information on health programs for women.

I’m going to distribute another set of surveys which contains a program evaluation. Please answer surveys by circling your response directly onto the questionnaire. When you are done, please return all materials to the envelope.

*Asst. - Distribute survey and evaluations.*

*Asst. / Pres. - Collect envelopes and evaluations. Give debriefing.*
Appendix D-4
Vaccine Preventable Disease Booster Session Protocol

Evaluation of Health Interventions for Women
VPD – Session II Protocol

Holly Raffle, MA, CHES, ATC

Department of Psychology
College of Arts and Sciences
Ohio University
I. Key Information

To Check the Experiment System Sign-Up or Award Experimental Credit Points:
Web Address: http://psychpool-ohio.sona-systems.com/
Login: raffle
Password: health

To Login to Porter Classroom Computers:
**Be sure you select “PorterXXX (this computer)”, where XXX is the room number from the pull-down menu when you login
Login: ou-psych (all lowercase letters)
Password: porterXXX, where XXX is the room number (all lower case letters) [Example: for Porter 100, the password is “porter100”]

Technology:
• You will need the USB (“flash”, “jump”, etc.) drive that we used during Session I.
• You will need to set up the Classroom Performance System (CPS).

USING CPS:
Connect the Receiver Unit and Test the Pads:
1. Connect the receiver unit to a serial port (9-pin COM port) on the back of your computer.
2. Start CPS by selecting the CPS icon from the “Programs” on Windows Explore.
3. Click the Settings menu item, then select the Delivery Options command.
4. Click the Detect CPS Receiver button.
5. CPS automatically finds an available serial port.
6. If you have any issues or questions, refer to the CPS User’s Guide available on the desktop.

Delivering the Lesson Using the Receiver Unit and Response Pads:
1. From the Lessons tab, select the lesson entitled VPD.
2. Click the Tools button and select the Preview Command.
3. Click the Start button to activate the response pads.
4. Click **End** to see the correct answer and the > (right arrow) button to progress to the next question.

II. Proper Room Assignment of Participants

As participants arrive, direct them to the appropriate room. Example: “Please go directly to Porter 107.”

III. Introductory Information

*As participants enter the room, hand out the packets containing informed consent forms and surveys with the informed consent forms on top.*

Hello, my name is (first and last name). I am a (class rank) here at Ohio University.

Hello, my name is (first and last name). I am a (class rank) here at Ohio University.

We will be facilitating the program this evening. This is an experiment to evaluate health interventions for women. At session one, you were randomly assigned to Intervention “green”. If you were not assigned to Intervention “green” please let us know at this time.

During this session, you will be asked to complete three tasks. First, you will be asked to fill out questionnaires concerning sexual experiences, dating behaviors, and vaccine preventable diseases. Next, you will be asked to participate – to your comfort level – in a “booster” session related to the vaccine preventable disease education and awareness program that you completed two months ago. Finally, you will be asked to complete an evaluation form regarding the “booster” session.

Recall that this is a three part experiment. Today is Part Two. After today’s session, you will be awarded five (5) experiment points toward the research requirement in your psychology class.

Part Three of the experiment is a four-month follow-up. You will be asked to return for a four-month follow-up, however, experiment points will NOT be awarded for participation. Participation in the four-month follow-up is
voluntary, and will help the research team understand how we can improve this program in the future.

Does anyone have any questions?

You have been given a manila envelope. The first sheet is a consent form. Please read over and sign the informed consent form. *Show the participants the informed consent form.* You have been given a second copy of this form to take with you.

The next form is a confidentiality agreement, stressing that you understand the nature of participation, and agree to maintain the confidentiality of the group discussion. *Show the participants the confidentiality agreement.* It is important that you do not share information discussed during the session with others. Please read the agreement carefully and sign it.

Now you should be looking at a contact form. *Show the participants the contact form.* Because you will be asked to come back for follow-ups and because students may move or change their phone number, we are asking you to give us the address and phone number of someone we can call for your new number if necessary. It is best if you list your parents or another relative that will be sure to know your telephone number.

*Collect informed consent forms, confidentiality agreement, and contact forms.*

You should now be looking at the subject number calculation form. *Show the participants the subject number calculation form.* This form will completed each time you come, so please fill it out carefully. This is done so that we can assure your complete confidentiality and so that you feel you can respond honestly to the surveys.

*Demonstrate how to calculate the subject number on the chalkboard – step by step.*

First, write the last four digits of your social security number.
On the second line, write the numbers corresponding to the month and day of your birthday. If the month or day is only one digit, please put a “0” in the first space. For example, if you were born on January 1, you should record it as “01/01”.

Add the digits together and place on the third line.

Next, think about your mother’s full name. Do not use nicknames. For example, if your mother’s full name is “Christine”, but she goes by Chris, you should record the number of letters as “09” because there are 9 letters in the name Christine.

Add this number to the line above. This is your subject calculation number.

Now, take out the surveys from the manila envelope. Please record your subject number in the identification number area of the questionnaires. Show the participants where they are to record their subject calculation numbers.

I know this is a little confusing. Does anyone need any help with this or have any questions?

You should now be looking at the surveys. Please remember to fill out the front and back page of each survey, taking time to clearly circle each answer. Show the participants that the surveys are double-sided. You are allowed to write directly on the surveys. Please respond to the survey questions right on the survey. When you’ve finished filling out the surveys, please put all of the materials back into the envelope. Then please sit quietly until everyone is finished.

Are there any questions?

The study will take no longer than 2 hours tonight. It is now (state time), you will be finished no later than (state time the study will conclude).

When you notice that everyone is finished, ask: Does anyone need more time?

Please keep your packets and envelopes on the desk in front of you.
**Let’s take a 5 minute break, feel free to leave the room and go to the bathroom or get a drink. Make sure that when you return, you sit in the exact same seat.**
IV. Program Introduction

Again, my name is (first name only).

And my name is (first name only).

Today you will be participating in a “booster” session that will review the information that you learned about vaccine preventable diseases during Session I. As a reminder, because the term “vaccine preventable diseases” can be a lot to repeat over and over, we will often refer to them as “VPDs”.

What we hope to remind you about today is that we are all at risk for vaccine preventable diseases. However, the key word is “preventable.” We hope this program will provide you with the information that you need to help reduce your risk for vaccine preventable diseases and make informed decisions with regards to your health. As with any health care issue, should you have specific questions or concerns related to your personal risk, we recommend that you share your concerns with your health care provider.

Before we begin the program, we have a few reminders. You have received and signed a consent form, which indicates your consent to participate in this educational program and the focus group that follows. The vaccine preventable disease educational program is being recorded on videotape to ensure the integrity and consistency of the educational program. As stated in the consent form you signed, the videotape will be focused on us, the facilitators, the whole time. It is not our intent to videotape you, the participants, at any time.

Begin VPD Booster Session.
Vaccine Preventable Diseases Peer Education Program
Booster Session

This educational program is designed to be an active learning experience for you. To facilitate your learning, we are using the Classroom Performance System. We will be handing every program participant a CPS response pad. The response pads are numbered. Only you know the number on your response pad.

*Distribute CPS response pads.*

Does everyone have a response pad?

During this session, you will be participating in quiz show. The topic of the quiz show is vaccine preventable diseases. The questions will be posted on the computer screen.

*Show CPS computer screen.*

After the questions are posted, you will use your response pads to answer the questions. As you respond using your keypad, be sure to aim your response pad at the receiver.

*Show students the CPS receiver (spaceship).*

Recall that your response pads are numbered. Remember, only you know your response pad numbers. When you respond to the question using your keypad, your response pad number will turn BLUE. This is how the computer informs you it has received your response. Because only you know your response pad number, the quiz is completely confidential. The quiz will be scored as a group and at no time will individual response pads be scored as correct or incorrect. Only you will know if you answered the question correctly. Because the quiz is reasonably confidential, we ask that you answer all questions – even if you are just guessing.

You will be allotted 1 minute to read and answer each question. Should you change your mind during the minute, you can key in a different answer using your response pad.
Again, because the quiz is reasonably confidential, we ask that you answer all questions – even if you are just guessing. Let’s get started!

**Question One:**
In general, vaccinations are…
A. 100% safe  
B. 100% effective  
C. Both A and B  
D. None of the above.

*After students answer and you look at the class results…*

_Give a comment regarding class performance._
The correct answer is “D. None of the above.” Vaccines are neither 100% safe nor 100% effective, but they do offer the “highest degree of protection with the lowest rate of untoward or unpleasant effects.” Further, the benefits of getting vaccinated are thought by most health professionals to outweigh the risks.

**Question Two:**
You should NOT get a vaccine if…
A. You are taking antibiotics  
B. You have a simple cold  
C. You had a severe allergic reaction after a previous dose of the vaccine  
D. All of the above.

*After students answer and you look at the class results…*

_Give a comment regarding class performance._
The correct answer is “C. You had a severe allergic reaction after a previous dose of the vaccine.” In general, vaccines do not need to be delayed for mild illnesses, with or without fever, such as a cold or if you are taking antibiotics. Having had a serious allergic reaction to a vaccine is usually a contraindication or a reason not to get another one.
Question Three:
DTP stands for…
A.  **Diphtheria, Tetanus, and Pertussis**
B.  Diphtheria, Tetanus, and Pneumonia
C.  Diphtheria, Tetanus, and Prevnar

*After students answer and you look at the class results…*

*Give a comment regarding class performance.*  
The correct answer is “A. Diphtheria, Tetanus, and Pertussis.” In case you were wondering, Prevnar - the “P” in response “C” - is a new vaccine that protects against infections with the streptococcus pneumoniae bacteria which commonly causes meningitis, blood infections, pneumonia, and ear infections. The Prevnar vaccine is commonly given to children under two years of age.

Question Four:
MMR stands for…
A.  **Measles, Mumps, Rubella**
B.  Measles, Meningitis, Rubella
C.  Measles, Meningitis, Rotavirus
D.  Meningitis, Mumps, Rotavirus

*After students answer and you look at the class results…*

*Give a comment regarding class performance.*  
The correct answer is “A. Measles, Mumps, Rubella.” For your information, the “R” in responses “C” and “D” – Rotavirus – is a virus that causes green diarrhea in infants and young children.

Question Five:
George Washington died from…
A.  hepatitis B
B.  **diphtheria**
C.  small pox

*After students answer and you look at the class results…*
Give a comment regarding class performance.
The correct answer I “B. diphtheria.” Diphtheria is a serious disease caused by a bacteria. This germ produces a poisonous substance or toxin which frequently causes heart and nerve problems. The death rate is 5 percent to 10 percent, with higher death rates (up to 20 percent) in the very young and the elderly.

Although diphtheria is rare in the U.S., it is still a threat. Diphtheria is common in other parts of the world and with the increase in international travel, diphtheria and other infectious diseases are only a plane ride away. If we stopped immunization, the U.S. might experience a situation similar to the Newly Independent States of the former Soviet Union. With the breakdown of the public health services in this area, diphtheria epidemics began in 1990, fueled primarily by persons who were not properly vaccinated. From 1990-1999, more than 150,000 cases and 5,000 deaths were reported.

Question Six:
Which of the following diseases is not contagious?
A. hepatitis B  
B. meningitis  
C. rubella  
D. tetanus

After students answer and you look at the class results...

Give a comment regarding class performance.
The correct answer is “D. tetanus.” Tetanus is infectious, but not contagious, so unlike other vaccine-preventable diseases, immunization by members of the community will not protect others from the disease. Because tetanus bacteria are widespread in the environment, tetanus can only be prevented by immunization. If vaccination against tetanus were stopped, persons of all ages in the U.S. would be susceptible to this serious disease.

Tetanus is a severe, often fatal disease. The bacteria that cause tetanus are widely distributed in soil and street dust, are found in the waste of many animals, and are very resistant to heat and germ-killing cleaners. From 1922-1926, there were an estimated 1,314 cases of tetanus per year in the U.S. In
the late 1940's, the tetanus vaccine was introduced, and tetanus became a disease that was officially counted and tracked by public health officials. In 2000, only 41 cases of tetanus were reported in the U.S.

People who get tetanus suffer from stiffness and spasms of the muscles. The larynx (throat) can close causing breathing and eating difficulties, muscles spasms can cause fractures (breaks) of the spine and long bones, and some people go into a coma, and die. Approximately 30 percent of reported cases end in death.

Question Seven:
In 1578, the first reported epidemic of pertussis occurred in:
A. Paris
B. Rome
C. London

After students answer and you look at the class results...

Give a comment regarding class performance.
The correct answer is “A. Paris.” Pertussis can be a severe illness, resulting in prolonged coughing spells that can last for many weeks. These spells can make it difficult for a child to eat, drink, and breathe. Because vomiting often occurs after a coughing spell, infants may lose weight and become dehydrated. In infants, it can also cause pneumonia and lead to brain damage, seizures, and mental retardation.

Before pertussis immunizations were available, nearly all children developed whooping cough. In the U.S., prior to pertussis immunization, between 150,000 and 260,000 cases of pertussis were reported each year, with up to 9,000 pertussis-related deaths.

Since the early 1980s, reported pertussis cases have been increasing, with peaks every 3-4 years; however, the number of reported cases remains much lower than levels seen in the pre-vaccine era. Compared with pertussis cases in other age groups, infants who are 6 months old or younger with pertussis experience the highest rate of hospitalization, pneumonia, seizures, Encephalopathy (a degenerative disease of the brain) and death. From 1990
to 1996, 57 persons died from pertussis; 49 of these were less than six months old.
Question Eight:
The term ________ probably comes from a Latin word meaning “miserable.”
A. mumps
B. meningitis
C. measles

After students answer and you look at the class results...

Give a comment regarding class performance.
The correct answer is “C. measles.” Measles is one of the most infectious diseases in the world and is frequently imported into the U.S. In 1997-2000, most cases were associated with international visitors or U.S. residents who were exposed to the measles virus while traveling abroad. More than 90 percent of people who are not immune will get measles if they are exposed to the virus.

Before measles immunization were available, nearly everyone in the U.S. got measles. An average of 450 measles-associated deaths were reported each year between 1953 and 1963.

In the U.S., up to 20 percent of persons with measles are hospitalized. Seventeen percent of measles cases have had one or more complications, such as ear infections, pneumonia, or diarrhea. Pneumonia is present in about six percent of cases and accounts for most of the measles deaths. Although less common, some persons with measles develop encephalitis (swelling of the lining of the brain), resulting in brain damage.

Question Nine:
A major cause of liver cancer is:
A. hepatitis B
B. meningitis
C. polio
D. diphtheria

After students answer and you look at the class results...

Give a comment regarding class performance.
The correct answer is “A. hepatitis B.” More than 2 billion persons worldwide have been infected with the hepatitis B virus at some time in their lives. Of these, 350 million are life-long carriers of the disease and can transmit the virus to others. One million of these people die each year from liver disease and liver cancer.

National studies have shown that about 12.5 million Americans have been infected with hepatitis B virus at some point in their lifetime. One and one quarter million Americans are estimated to have chronic (long-lasting) infection, of whom 20 percent to 30 percent acquired their infection in childhood. Chronic hepatitis B virus infection increases a person's risk for chronic liver disease, cirrhosis, and liver cancer. About 5,000 persons will die each year from hepatitis B-related liver disease resulting in over $700 million medical and work loss costs.

The number of new infections per year has declined from an average of 450,000 in the 1980s to about 80,000 in 1999. The greatest decline has occurred among children and adolescents due to routine hepatitis B vaccination.

Infants and children who become infected with hepatitis B virus are at highest risk of developing lifelong infection, which often leads to death from liver disease (cirrhosis) and liver cancer. Approximately 25 percent of children who become infected with life-long hepatitis B virus would be expected to die of related liver disease as adults.

<table>
<thead>
<tr>
<th>Question Ten:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Known as a disease afflicting armies, ____________ was one of the leading causes of hospitalization during World War I.</td>
</tr>
<tr>
<td>A. measles</td>
</tr>
<tr>
<td>B. mumps</td>
</tr>
<tr>
<td>C. rubella</td>
</tr>
<tr>
<td>D. diphtheria</td>
</tr>
</tbody>
</table>

After students answer and you look at the class results...

Give a comment regarding class performance.
The correct answer is “B. mumps.” Before the mumps vaccine was introduced, mumps was a major cause of deafness in children, occurring in approximately 1 in 20,000 reported cases. Mumps is usually a mild viral disease. However, rare conditions such as swelling of the brain, nerves and spinal cord can lead to serious side effects such as paralysis, seizures, and fluid in the brain.

Serious side effects of mumps are more common among adults than children. Swelling of the testes is the most common side effect in males past the age of puberty, occurring in up to 20 percent to 50 percent of men who contract mumps. An increase in miscarriages has been found among women who develop mumps during the first trimester of pregnancy.

An estimated 212,000 cases of mumps occurred in the U.S. in 1964. After vaccine licensure in 1967, reports of mumps decreased rapidly. In 1986 and 1987, there was a resurgence of mumps with 12,848 cases reported in 1987. Since 1989, the incidence of mumps has declined, with an estimated 327 cases in 2000.

Question Eleven:
When was the last major rubella epidemic (outbreak) in the United States?
A. 1964-1965
B. 1974-1975
C. 1984-1985

After students answer and you look at the class results...

Give a comment regarding class performance.
The correct answer is “A. 1964-1965.” While rubella is usually mild in children and adults, up to 90 percent of infants born to mothers infected with rubella during the first trimester of pregnancy will develop congenital rubella syndrome (CRS), resulting in heart defects, cataracts, mental retardation, and deafness.

In 1964-1965, before rubella immunization was used routinely in the U.S., there was an epidemic of rubella that resulted in an estimated 20,000 infants born with CRS, with 2,100 neonatal deaths and 11,250 miscarriages. Of the
20,000 infants born with CRS, 11,600 were deaf, 3,580 were blind, and 1,800 were mentally retarded.

Due to the widespread use of rubella vaccine, only six CRS cases were provisionally reported in the U.S. in 2000. Because many developing countries do not include rubella in the childhood immunization schedule, many of these cases occurred in foreign-born adults. Since 1996, greater than 50 percent of the reported rubella cases have been among adults. Since 1999, there have been 40 pregnant women infected with rubella. If we stopped rubella immunization, immunity to rubella would decline and rubella would once again return, resulting in pregnant women becoming infected with rubella and then giving birth to infants with CRS.

Question Twelve:
Before going to college, students, especially those that will be living in a residence hall should consider getting…
A. a Measles vaccine
B. Prevnar
C. a DTP vaccine
D. a meningococcal vaccine

After students answer and you look at the class results...

Give a comment regarding class performance.
The correct answer is “D. a meningococcal vaccine.” Recall that meningococcal vaccines prevent bacterial meningitis. First year college students, particularly those who live in residence halls have a slightly increased risk of getting meningococcal disease – meningitis – and should consider getting a meningococcal vaccine.

Some forms of bacterial meningitis are mildly contagious and can be spread through coughing or kissing. The majority of cases occur in children, but the incidence among teens and young adults 15 to 24 years old is increasing. Meningococcal meningitis, a form of meningitis caused by N. meningitidis, can spread among college students in dormitories. The CDC now recommends that college freshmen who live in dorms be vaccinated against this particular form of meningitis.
Question Thirteen:
Symptoms of bacterial meningitis can occur quickly.
A. True
B. False

After students answer and you look at the class results...

Give a comment regarding class performance.
The correct answer is “A. True.” The symptoms in adults and children can appear suddenly and include high fever, severe headache, stiff neck, discomfort in being near bright lights, nausea and vomiting. The symptoms in newborns may be subtle and include fever, lethargy, poor feeding, problems breathing, irritability and vomiting. As the disease progresses, the patient may have seizures.

We want to briefly clarify the basic difference between bacterial and viral meningitis. Bacterial meningitis is the disease that we discussed and watched a video about during the first part of this program two months ago. Bacterial meningitis is a very serious and deadly infection of the membranes around the brain and spinal cord. It is spread through close contact with respiratory secretions of an infected person. It can be treated with antibiotics and prevented by receiving a vaccination.

On the other hand, viral meningitis is rarely serious and can be caused by a number of different viruses. There is no treatment for viral meningitis and it typically clears up on its own within week. Regular hand washing and avoiding mosquito bites is the best prevention for viral meningitis.

Question Fourteen:
Most people who are diagnosed early with bacterial meningitis and treated promptly will recover fully.
A. True
B. False

After students answer and you look at the class results...

Give a comment regarding class performance.
The correct answer is “A. True.” In some cases, however, the bacterial infection can progress so quickly that the patient dies within 48 hours, even with treatment. The bacteria that cause meningitis are becoming resistant to many of the antibiotics that were once used to treat it. Newer, more expensive drugs must now be used.
Question Fifteen:
The best ways to avoid the flu include…
A. Getting a yearly flu shot
B. Washing your hands often
C. Avoiding unnecessary contact with people during flu season
D. All of the above

After students answer and you look at the class results...

Give a comment regarding class performance.
The correct answer is “D. All of the above.” All of the answers are common-sense precautions against getting the flu.

Flu Shot
As many of you know, there has been a lot of media attention surrounding flu shots this season. During manufacturing of the flu shot, contamination with bacteria caused the number of flu shot available to be decreased.

Therefore, this season flu vaccines are being reserved for people 65 years and older, people with any chronic medical condition, pregnant women, and children between 6 to 23 months of age.

Fortunately, there is now an alternative to the flu shot. The FDA has approved FluMist, an intranasal – inhaled through the nose – live virus influenza vaccine for healthy children and adolescents, ages 5-17 years, and healthy adults, ages 18-49. Currently, Hudson Health Center does not stock FluMist, so you will need to contact your health care provider and decide if FluMist is right for you.

Because many people will not able to get vaccinated against flu this year; we have a few reminders on how to stay healthy during flu season: avoid close contact with people who are sick, stay at home when you are sick, cover your mouth with a tissue or your sleeve – and NOT your hands – when coughing or sneezing, wash your hands frequently, and avoid touching your eyes, nose and mouth.
Question Sixteen:
How often do you have to get a flu shot?
A. Every other year
B. Once, at age 6 months
C. Once, at age 65
D. Every year

After students answer and you look at the class results...

Give a comment regarding class performance.
The correct answer is “D. Every year.” Because the flu virus changes most years, you have to get a flu vaccine each year.

Question Seventeen:
You should usually not get a flu vaccine if you are allergic to:
A. peanuts
B. milk
C. eggs
D. latex

After students answer and you look at the class results...

Give a comment regarding class performance.
The correct answer is “C. eggs.” Serious allergic reactions to egg proteins, including severe anaphylactic (respiratory) reactions, are usually considered to be a reason to not receive the influenza vaccine. The influenza vaccine is produced in embryonated eggs, and so can sometimes cause a reaction in children with egg protein allergies.

Question Eighteen:
Is there a vaccine that prevents hepatitis?
A. Yes, hepatitis A
B. Yes, hepatitis B
C. Yes, hepatitis C
D. A, B, and C
E. A and B
After students answer and you look at the class results...

Give a comment regarding class performance.
The correct answer is “E. A and B.” There is a vaccination available for both hepatitis A and hepatitis B. Remember the hepatitis A vaccine does not protect a person from hepatitis B and vice versa. Right now, there is no vaccination to prevent hepatitis C.

Question Nineteen:
Can a person get hepatitis from tattoos and body piercing (including ears)?
A. Yes
B. No

After students answer and you look at the class results...

Give a comment regarding class performance.
The correct answer is “A. Yes.” Hepatitis B and C can be transmitted by tattooing and body piercing if the artist uses a needle that has been used before. Dirty tattoo needles and piercing equipment can also spread other diseases such as HIV. There are safe tattoo and piercing artists. Be sure to protect yourself should you choose to get a tattoo or piercing by using good judgment when choosing an artist, being aware of general cleanliness practice, and getting your hepatitis B vaccination.

Question Twenty:
Can a person get hepatitis by eating contaminated food?
A. Yes
B. No

After students answer and you look at the class results...

Give a comment regarding class performance.
The correct answer is “A. Yes.” Hepatitis A is spread by putting something in your mouth – even though it may look clean – that has been contaminated with the feces (poop) of a person with hepatitis A. This includes food. So it is important to wash your hands before leaving the bathroom or after changing a diaper because you could touch something that could later go into your mouth.
This is the end of our VPD Booster Session. Does anyone have any questions about VPD’s or vaccination?

Thank you for participating in our quiz show. Please pass your response pads to the left so they can be collected.
Quiz items and responses extracted from the following sources:

Immunization Quiz:
http://pediatrics.about.com/cs/quizzes/l/bl_vaccine_quiz.htm

Flu Shot Quiz:
http://pediatrics.about.com/library/quiz/bl_flu_quiz.htm?

Meningitis Quiz:

Hepatitis Quiz:
http://www.iwannaknow.org/faqs/hepquiz.pdf

Interesting Facts about VPD’s:
http://www.cispimmunize.org/fam/fam_main.html
V. Participant Debriefing

What we hope we communicated to you today is that we are all at risk for vaccine preventable diseases. Again, the key word is “preventable.” We hope this program provided you with the information that you need to help reduce your risk for vaccine preventable diseases and make informed decisions with regards to your health. As with any health care issue, should you have specific questions or concerns related to your personal risk, we recommend that you share your concerns with your health care provider.

*Distribute debriefing sheet.*

This sheet is yours to keep following the educational program. Please notice that there are several resources on this sheet that may be very helpful to you. As an Ohio University student, Hudson Health Center is a very valuable resource – should you think you are sick or if you want to discuss your vaccination status with a health care provider. If you have specific questions about the vaccine preventable diseases we discussed tonight or vaccine preventable diseases in general, you can contact Hudson Health Center or the National Immunization hotline, a hotline number sponsored by the Centers of Disease Control and Prevention – sometimes referred to as the “CDC.” As students, we are very familiar with technology and the World Wide Web. For that reason, several reliable websites with factual information are listed for you to use as resource.

VI. Closing the Educational Program

Are there any additional questions?

*One facilitator should address the questions. The other facilitator should record the questions and the facilitator’s answers to them.*

We are now going to turn off the video recorder.

*Turn off the video recorder.*

We are now going to distribute the program evaluation form.
Distribute program evaluation form.
Please write your subject calculation number from the calculation sheet on the evaluation form. It is OK to pull the subject number form out of the packet to double-check the number if you don’t remember it. Please do not write your name on the evaluation form. You are allowed to write directly on the evaluation form. Please note that the evaluation form is double sided. Show the participants that the form is double sided. When you’ve finished filling out the evaluation form, please put all of the materials back into the envelope. Then please sit quietly until everyone is finished.

When you notice that everyone is finished, ask: Does anyone need more time?

Please keep your packets and envelopes on the desk in front of you. We will collect them after you leave.

VI. Conclusion

Thank you for participating in our educational program. Remember to take your debriefing sheet with you, as it is yours to keep. Your experiment points will be credited to you some time today. We encourage you to use the information from this program to make informed choices about your health.

Collect packets. Be sure that each participant leaves the room with her debriefing sheet.
Appendix E-1
Program Protocol Process Evaluation Form

Date: ______________
Facilitators: ________

I. Random Assignment
1. Did facilitator inform women of their group?

II. Introductory Information
1. Did the facilitators introduce themselves?
2. Did the facilitator explain the purpose of the experiment?
3. Did the facilitator explain that this is a three part experiment?
4. Did the facilitator demonstrate how to complete the subject number calculation form?
5. Did the facilitator collect the confidentiality, contact, and calculation forms?
6. Did the facilitators provide a 5 minute break?

III. Program
1. Did the facilitator outline the purposes of the program?
2. Did the facilitator make clear the program’s views on sexual assault?
3. Did the participants discuss how violence against women is reflected in society?

IV. Background Definitions and Statistics
1. Did the facilitator define rape and present slide 1 and 2?
2. Did the facilitator show and read slide 3 and 4 regarding information on rape?
3. Did the facilitator show and read slide 5?
4. Did the facilitator show and read slide 6 regarding the incidence rates of rape among college women?
5. Did the facilitator show and read slide 7 regarding statistics among first-year female students at Ohio University?

V. “I thought it would never happen to me”

1. Did the facilitator introduce the video of women talking about their sexual assault experiences?
2. Did facilitator show ask the participants to consider risk factors that could increase the likelihood of a woman experiencing a sexual assault?

VI. Post Film Discussion

1. Did the facilitator ask for reactions to the video?
12. Did the facilitator respond to the comments of the participants?

VII. Risk Factors

1. Did the facilitator ask if the participants to discuss the characteristics of a man that may increase a woman’s risk of sexual assault?
2. Did the facilitator reinforce positive responses?
3. Did the facilitator show slide 8?
4. Did the ask the participants to discuss the personal or situational characteristics that may place a woman at risk?
5. Did the facilitator reinforce positive responses?
6. Did the facilitator show slide 9?

VIII. Discussion of the role of alcohol

1. Did the facilitator show and read slide 12?
2. Did the facilitator elicit a discussion about why alcohol could be a risk factor for Sexual assault, especially from the male perspective?
3. Did the facilitator show and read slide 13?

4. Did the facilitator show slide 14 about why alcohol enhances risk for sexual assault?

**IX. Post-assault reactions**

1. Did the facilitator show slide 15 and discuss stages of recovery?

2. Did the facilitator discussion common reactions have in the 1st and 2nd stages?

**X. Sexual Assault Risk Factors**

1. Did the facilitator hand out the workbook?

2. Did the facilitator introduce the video on handling risky situations?

3. Did the facilitator ask the participants to think about potential benefits and drawbacks to implementing each strategy?

4. Did the facilitator show the first scenario, “Bad Reputation”, of the film “Keep your options open…”?

5. Did the facilitator initiate a discussion about the benefits and drawbacks of the strategies?

6. Did the facilitator show the second scenario, “Sexist Attitude”?

7. Did the facilitator initiate a discussion about the benefits and drawbacks of the strategies?

8. Did the facilitator show the third scenario, “Won’t take no for an answer”?

9. Did the facilitator initiate a discussion about the benefits and drawbacks of the strategies?

10. Did the facilitator show the fourth scenario, “Pressured to drink”?

11. Did the facilitator initiate a discussion about the benefits and drawbacks of the strategies?
12. Did the facilitator show the fifth scenario, “Asked to a male’s room”?

13. Did the facilitator initiate a discussion about the benefits and drawbacks of the strategies?

**XI. What to do when confronted with an acquaintance assault**

1. Did the facilitator distribute the handout?

2. Did the facilitator discuss actively versus passively submitted to a rape?

3. Did the facilitator review the strategies if a participant would be faced with a potential assaultive situation?

**XII. Conclusion**

1. Did the facilitator talk about the variety of reactions to program material?

2. Did the facilitator remind participants about self-defense course?

3. Were participants thanked for their participation?
Appendix E-2  
Vaccine Preventable Disease Process Evaluation Form

Date: ______________

Facilitators: _________

I. Introductory Information

1. Did the facilitators introduce themselves?

2. Did the facilitator specify that the participants are assigned to the “green” Intervention?

3. Did the facilitator explain the purpose of the experiment?

4. Did the facilitator explain that this is a three part experiment?

5. Did the facilitator demonstrate how to complete the subject number calculation form?

6. Did the facilitator collect the confidentiality, contact, and calculation forms?

7. Did the facilitators provide a 5 minute break?

II. Program

1. Did the facilitator write VPD and immunization = VPDs on the chalkboard?

2. Did the facilitator show the slide listing two VPD’s?

3. Did the facilitator discuss the pictures of the diseases that will be shown?

4. Did the facilitator show slide 3, why vaccinate?

5. Did the facilitator show slide 4, how vaccines work?

6. Did the facilitator define immunity and booster shot?

7. Did the facilitator ask the participants what is the difference between Bacterial and a viral infection?

8. Did the facilitator show slide 5 and do activity?
9. Did the facilitator show slide 6 and four clips from “Separating Fact/Fear”?

10. Did facilitator show slide 7 and discuss why we need to continue vaccinating?

11. Did the facilitator ask if there were any questions?

12. Did the facilitator show slide 8?

13. Did the facilitator ask if there were any questions?

14. Did the facilitator show slide 9 about Hepatitis A and discuss: Definition, mode of transmission, and incubation period?

15. Did the facilitator define “incubation period”?

16. Did the facilitator show slide 10 and discuss signs and symptoms?

17. Did the facilitator lead the activity?

18. Did the facilitator show slide 11 about Hepatitis B and discuss: Definition, mode of transmission, and incubation period?

19. Did the facilitator define “Hemodialysis”?

20. Did the facilitator show slide 12 and discuss: signs, symptoms and complications?

21. Did the facilitator show slide 13 about Meningococcal (meningitis) and discuss:
   Definition, mode of transmission, and incubation period?

22. Did the facilitator define “preventable”?

23. Did the facilitator show slide 14 and discuss: signs, symptoms?

24. Did the facilitator play the 20/20 video?

25. Did the facilitator debrief the participants after the video?

26. Did the facilitator show slide 15 about Influenza?

27. Did the facilitator show slide 16 and discuss: Definition, mode of transmission, and incubation period?
28. Did the facilitator show slide 17 and discuss: signs, symptoms?
29. Did the facilitator show slide 18 and discuss: complications?
30. Did the facilitator show slide 19 about DTP?
31. Did the facilitator ask discussion questions?
32. Did the facilitator show slide 20 about Tetanus and discuss: Definition, mode of transmission, and incubation period?
33. Did the facilitator show slide 21?
34. Did the facilitator show slide 22 and discuss: signs, symptoms, complications?
35. Did the facilitator show slide 23?
36. Did the facilitator show slide 24 about Diptheria and discuss: Definition, mode of transmission, and incubation period?
37. Did the facilitator show slide 25 and discuss: signs, symptoms, complications?
38. Did the facilitator show slide 26?
39. Did the facilitator show slide 27 about Measles and discuss: Definition, mode of transmission, and incubation period?
40. Did the facilitator show slide 28 and discuss: signs, symptoms, complications?
41. Did the facilitator show slide 29?
42. Did the facilitator show slide 30 about Mumps and discuss: Definition, mode of transmission, and incubation period?
43. Did the facilitator show slide 31 and discuss: complications?
44. Did the facilitator show slide 32?
45. Did the facilitator show slide 33 about Rubella and discuss: Definition, mode of transmission, and incubation period?
46. Did the facilitator show slide 34?

47. Did the facilitator define “titer”?

**III. Participant Debriefing**

48. Did the facilitator distribute debriefing packet?

**IV. Closing the program**

49. Did the facilitator ask if there were any questions?

50. Were participants thanked for their participation?
Appendix E-3
Booster Session Process Evaluation Form

Date: ______________
Facilitators: _________

I. Assignment of Participants

1. Did the facilitator identify if the participants were in the “purple” or “green” group?
2. Did the facilitator ask if anyone needed to check their group?

II. Introductory Information

1. Did the facilitators introduce themselves?
2. Did the facilitator state that this group is the “purple” group and that it is part two of the study?
3. Did the facilitator discuss the experimental points that will be received by the participants?
4. Did the facilitator tell the participants that they will be asked to come back for a 4-month follow-up which is voluntary?
5. Did the facilitator review the consent form, confidentiality agreement, and the contact form?
6. Did the facilitator demonstrate how to calculate the subject calculation form?
7. Did the facilitator give the participants a 5 minute break after the surveys were finished?
8. Did the facilitator introduce herself and review the credit points for the study?
9. Did the facilitator tell the participants what topics will be discussed, beginning with risk-factors?
III. Discussion Questions

1. Did the facilitator initiate a discussion with the participants about risk factors of sexual assault or a risky situation that they have encountered?
2. Did the facilitator and/or assistant bring up points regarding danger signals from men?
3. Did the facilitator and/or assistant bring up points regarding situational risk factors?
4. Did the facilitator and/or assistant bring up points regarding the role of alcohol and actions that could be taken by men?
5. Did the facilitator and/or assistant bring up points regarding the role of alcohol and how it could affect women?
6. Did the facilitator question some of the self-defense strategies that were learned during the seminar?
7. Did the facilitator ask the participants if they have utilized any of these skills in the past 2 months?
8. Did the facilitator and/or assistant bring up some of the potential strategies that could be used by the participants?
9. Did the facilitator ask the participants what things were most helpful for them about the prevention program?

IV. Closing of the Session

1. Did the facilitator thank the participants for participating in the booster session?
2. Did the facilitator state that self-protective behaviors can be difficult to utilize and it is normal if they are still feeling hesitant?
3. Did the facilitator ask the participants if they had any questions?
4. Did the facilitator remind the participants that they will be contacted for a 4-month follow-up session during the winter term?

5. Did the facilitator distribute the other set of surveys?

6. Did the facilitator distribute the debriefing forms?
Appendix E-4
Vaccine Preventable Disease Booster Session Process Evaluation Form

Date: ______________

Facilitators: _________

I. Introductory Information

1. Did the facilitators introduce themselves?

2. Did the facilitator specify that the participants are assigned to the “green” Intervention?

3. Did the facilitator explain the purpose of the experiment?

4. Did the facilitator discuss the three tasks that are to be completed?

5. Did the facilitator explain that this is a three part experiment and that the participants will receive 5 experimental points?

6. Did the facilitator discuss the confidentiality, contact, and calculation forms?

7. Did the facilitator collect the confidentiality, contact, and calculation forms?

8. Did the facilitator demonstrate how to calculate the subject number?

9. Did the facilitator give the participants a 5 minute break?

II. Program Introduction

10. Did the facilitator review what will be discussed during the “booster” session?

11. Did the facilitator write VPD and immunization = VPDs on the chalkboard?

12. Did the facilitator distribute the CPS response pads?

13. Did the facilitator discuss the quiz and how to use the CPS pads?

14. Did the facilitator show, and then discuss, question 1?

15. Did the facilitator show, and then discuss, question 2?
16. Did the facilitator show, and then discuss, question 3?
17. Did the facilitator show, and then discuss, question 4?
18. Did the facilitator show, and then discuss, question 5?
19. Did the facilitator show, and then discuss, question 6?
20. Did facilitator show, and then discuss, question 7?
21. Did the facilitator show, and then discuss, question 8?
22. Did the facilitator show, and then discuss, question 9?
23. Did the facilitator show, and then discuss, question 10?
24. Did the facilitator show, and then discuss, question 11?
25. Did the facilitator define “incubation period”?
26. Did the facilitator show, and then discuss, question 12?
27. Did the facilitator show, and then discuss question 13?
28. Did the facilitator show, and then discuss, question 14?
29. Did the facilitator show, and then discuss, question 15?
30. Did the facilitator show, and then discuss, question 16?
31. Did the facilitator show, and then discuss, question 17?
32. Did the facilitator show, and then discuss, question 18?
33. Did the facilitator show, and then discuss, question 19?
34. Did the facilitator show, and then discuss question 20?
35. Did the facilitator ask the participants if they had any questions?
36. Did the facilitator thank the participants?
37. Did the facilitator give the participants the websites from which the quiz items were extracted from?
III. Participant Debriefing

38. Did the facilitator stress the word “preventable”?

39. Did the facilitator distribute the debriefing sheets?

IV. Closing the Educational Program

40. Did the facilitator ask if there were any additional questions?

41. Did the facilitator distribute the program evaluation form?

V. Conclusion

42. Did the facilitator thank the participants?
Appendix F-1
Focus Group Protocol: Phase I

Note: If, at any time, someone asks a question you don’t know how to answer, tell her that you will find the answer, and someone will contact her (be sure to get her number or e-mail address).

If less than 4 women show up for the focus group, please explain that you are unable to conduct the experiment because we would not be able to ensure a comfortable discussion environment. Get the woman’s name and explain that she is welcome to sign up for the study again since she was not able to participate this time. Give her experimental credit points.

(5 minutes) Sign-in, Informed Consent and Survey completion
As people come into the room, have them sign their name and e-mail address on the sign-up sheets (check the sign-up sheet as people sign it to be sure everyone fills it out correctly). Remind participants that the sign-in is for the purpose of receiving psychology 101 credits for participation. Ask participants to spread out around the table, so that they have plenty of room and are comfortable. Once everyone is seated say:

FACILITATOR: “Hello, my name is (first and last name). I am a (class rank) here at Ohio University. I will be facilitating the focus group this evening. The information we learn from the focus group will help to improve Ohio University’s Sexual Assault Risk Reduction Program.

Participation will take 1-hour. During the discussion tonight, you will be asked to provide feedback on several components of program protocol. It is important to remember that a focus group methodology cannot guarantee confidentiality. All topics discussed in the focus group should not be discussed in the session. Understand however, that it is possible that other group members may later disclose information revealed by other group members. Disclosure of personal experiences is entirely optional.

To protect confidentiality, we ask that you do not use your name during this session. You may also discontinue the discussion at any time without
penalty, or may “pass” on discussion topics. Also, the facilitator will be available for 30 minutes following this group to talk about any concerns you might have. This session is being audiotaped so that responses can be coded for later evaluation. However, these responses will be in no way linked to your identity.

Hand out 2 consent forms and confidentiality agreement:

FACILITATOR: The first two forms are consent agreements. Please read over the consent form. If you agree to participate in the focus group, please sign the forms. The second consent form is yours to keep. (Show participants the informed consent forms). The next form is a confidentiality agreement, stressing that you understand the nature of participation, and agree to maintain the confidentiality of the group discussion. It is important that you do not share information discussed during the session with others. Please read the agreement carefully. (Once participants have signed the form, and remind the participants that the second copy is theirs to keep. Collect confidentiality agreements and consent forms).

(10 minutes) Hand out the packets and say:

FACILITATOR: Once again, thank you for coming. Before we begin, we will complete a few questionnaires. Remember, these questionnaires will not be linked to you in any way.

Hand out packets.
FACILITATOR: Please open your packet. Write directly on the questionnaires, and circle the most appropriate answer. When you are finished, please place your survey form back into the manila envelope, and return the envelope to this bin. After everyone is finished completing the survey, we will begin the focus group discussion.

Introduction:
FACILITATOR: Well, let’s get started. So we are all on the same page, let me tell you a bit about the Ohio University Sexual Assault Risk Reduction Program. The Ohio University Sexual Assault Risk Reduction Program is a result of ongoing research and program modification in the Lab for the Study and Prevention of Sexual Assault. It is designed to reduce college women’s risk for sexual victimization through the application of theoretical models of behavior and attitude change. We believe that although it may not be possible to control the attitudes and behaviors of perpetrators, we can try to induce positive change in women’s risky behaviors, attitudes, and perceptions of threat—factors that, we as women, may have more control over. Today we will be talking about some new theories that may help to improve the program. The first one is the idea of “readiness to change”. Has anyone heard of this theory before?

(10 minutes) Readiness to Change
FACILITATOR: The idea of “readiness to change” was developed by scientists in health psychology, and is often related to topics such as smoking cessation or weight loss.
The theory of “readiness to change” suggests that in order to perform a behavior, we must not only be planning to change, but also actively trying to change. Individuals are typically in various “stages” of “readiness to change”. For example, I may not even be thinking about my behaviors, or I may be actively trying to implement a new behavior in my lifestyle. A good example of readiness to change is in smoking cessation programs. It is common to think that not everyone is equally ready to quit smoking: some may not want to quite at all, while others struggle to quit for quite a long time.

The same approach can be applied to sexual assault prevention programs. In our program, we encourage women to lower their risk by engaging in self-protective behaviors—such as drinking responsibly or acting assertively in threatening situations. Just like quitting smoking, it is likely that women are at different levels of readiness to change in implementing protective behaviors.

We are considering including the theory of readiness to change in the risk-reduction program. The program will begin with a brief introduction of readiness to change, much like the one I just gave. This introduction will be aimed at helping participants to realize that program material may affect women differently. Women may be at different “stages” of enacting risk-reduction strategies. For example, women may be hesitant to enact self-protective strategies that are new to them. We hope to let women know that different reactions to
program material are normal, so that they can understand how they can best implement program material in their own lives.

Questions:

Q1: What are your initial reactions to talking about readiness to change in a prevention program?

Q2: What concerns do you have of applying this theory?

   If no one brings up “blame” as an issue, ask:

   The theory of readiness to change looks at behavior modification from the individual’s perspective.

   Do you think that this theory might imply blame or responsibility on women for protecting themselves from sexual victimization?

   Would it be helpful to address that readiness to chance is not meant to incur blame or responsibility to the victim in an introduction to the material?

   What else might be helpful to introduce this topic in a clear manner, so not to imply that we in any way hold the woman responsible?

Q3: What might be the benefits of applying this theory?

FACILITATOR: Research suggests that if individuals believe that they are going to engage in a behavior, they are more likely to do it.

Questions:

Q4: What are your reactions to including a discussion of “intentions” of engaging in behaviors after the introduction of readiness to change?

Q5: Would a discussion on our intentions for behaviors be helpful to you as a participant in the program?
(5 minutes) Distribute Measure

**FACILITATOR:** In front of you is a measure that might be used in program evaluation regarding the theory of readiness to change. Please take a few minutes to review the questions we are asking.

*Focus group facilitator will go through the instrument, item by item. For items that appear to cause confusion or items that the group is unable to answer, the facilitators will ask some or all of the following follow-up questions:*

**Questions:**

Q1: Are there any items asked on the questionnaire that you do not understand or do not think other participants will understand? *(Inquire why)*

Q2: Are there any items asked on the questionnaire that make you feel uneasy or uncomfortable or that you think will make other participants feel uneasy or uncomfortable? *(Inquire why)*

(10 minutes) Pros and Cons

**FACILITATOR:** The second theory that we will be talking about is the pros and cons of performing some of the risk-reducing behaviors. According to this model of pros and cons, one’s beliefs of our susceptibility to harm, as well as the positive and negative consequences of our actions influence not only what we anticipate, but also what we perceive as threatening and warranting active resistance. There are many pros and cons to responding to sexually threatening scenarios, especially when the situation involves an acquaintance. For example,
we may risk embarrassment by responding assertively to a known potential perpetrator if the potential threat is ungrounded. Decisions to act protectively induce a cost/benefit analysis wherein the benefits must be perceived to be greater than the costs in order for the risk-reducing action to be implemented. So, if women believe they are not at risk for assault, and perceive the cost of reacting assertively to a threat to be high, it is likely that they may not respond when faced with a dangerous situation. By talking about costs and benefits of assertive response, we hope to encourage women to think critically about the costs and benefits of their actions in order to reduce their perception that they are invulnerable to assault, and also to increase their confidence is responding assertively. By encouraging women to be more aware of their own cost-benefit analyses, we can help women to better understand their behaviors, and think proactively in the future.

Questions:

Q1: What are your initial reactions to talking about the pros and cons of reacting assertively to threat in a prevention program?

Q2: What concerns do you have of applying this theory?

Q3: What might be the benefits of applying this theory?

Q4: What is a good format to talk about pros and cons?

Q5: Would you feel comfortable talking about why you may not implement some risk-reducing behaviors?

(5 minutes) Distribute Measure
FACILITATOR: In front of you is a measure that might be used in program evaluation, regarding this theory of pros and cons. Please take a few minutes to review the questions we are asking.

*Focus group facilitators will go through the instrument, item by item. For items that appear to cause confusion or items that the group is unable to answer, the facilitators will ask some or all of the following follow-up questions:*

**Questions:**

Q1: Are there any items asked on the questionnaire that you do not understand or do not think other participants will understand? *(Inquire why)*

Q2: Are there any items asked on the questionnaire that make you feel uneasy or uncomfortable or that you think will make other participants feel uneasy or uncomfortable? *(Inquire why)*

(15 minutes) **Video:**

FACILITATOR: We are now going to view a video currently utilized in the Ohio University Sexual Assault risk reduction program, which depicts a series of risky dating situations. You will be asked to provide feedback on the strengths and weaknesses of the video, as well as how these scenarios can be made into a series of vignettes. In the program the video is introduced by asking participants to think about what they say when they come face to face with a man who is doing things that make them feel uncomfortable. The tape was developed by
running focus groups with women at Ohio University, and asking them to share
some of the difficult social situations they encountered.

During each scenario, the tape is stopped at various points, and participants are
asked to discuss ways to handle the situation, and to brainstorm options and
strategies they might use if they found themselves in an uncomfortable situation.
Let us start with the first scenario. It involves a young woman at a party and a guy
that seemingly has a bad reputation who asks her to leave with him. Watch the
video, and when it is finished, we will discuss the main risk factors in the video.
Also, note any features of the scenario that would be important for you to include
in a vignette. It is our intention that rather than watching the video, the
participants will read these vignettes and generate similar options or strategies to
use if they encountered this situation.

Questions:
What were the risk factors in this scenario?
What were the main features of the scenario?
What did you see as the main features of the scenario?

FACILITATOR: Let’s move on to the second scenario. This scenario involves a
young women getting asked out by a guy who seems to have some sexist attitudes
about women. Again, think of the main features of the scenario that would be
important for you to include in a vignette.

Questions:
What were the risk factors in this scenario?
What were the main features of the scenario?

What did you see as the main point of the scenario?

*Continue with 3-5th scenarios.*

**FACILITATOR:** The third scenario involves a young woman on the phone with a guy that she barely knows pressuring her to go to an isolated location with him. She clearly feels uncomfortable going with him, however, he apparently won’t take “no” for an answer.

**FACILITATOR:** The fourth situation involves a young woman at a bar being pressured by a guy to drink more alcohol when she clearly doesn’t want to.

**FACILITATOR:** The fifth situation involves a young woman at a party and a guy asks her up to his room.

*Questions:*

What were the risk factors in this scenario?

What were the main features of the scenario?

What did you see as the main point of the scenario?

*Questions:*

Overall what are the weaknesses of this video?

The strengths?

Is there other more important information that should be covered in vignettes such as these?

Do you think that vignettes will be an effective way to convey this information?

*(Explain)*

*Conclusion*
FACILITATOR: You all have given us a lot of information about your experiences with the program, and some of the things you’ve liked and haven’t liked so much. Now we would like to ask you about your recommendations for the program.

If you had the power to change things about the program, what would you make different?

Thank you for your participation in this project. You have all been very helpful. Please feel free to stay and ask any questions you have, contact information is also listed on this debriefing text.

Inform them that they will be granted one experiment point via the online sign up system. Then hand them a debriefing form.
Appendix F-2
Focus Group Protocol: Phase II

**Note:** If, at any time, someone asks a question you don’t know how to answer, tell her that you will find the answer, and someone will contact her (be sure to get her number or e-mail address). If less than 4 women show up for the focus group, please explain that you are unable to conduct the experiment because we would not be able to ensure a comfortable discussion environment. Get the woman’s name and explain that she is welcome to sign up for the study again since she was not able to participate this time. Give her experimental credit points.

(5 minutes) Sign-in, Informed Consent and Survey completion
As people come into the room, have them sign their name and e-mail address on the sign-up sheets (check the sign-up sheet as people sign it to be sure everyone fills it out correctly). Remind participants that the sign-in is for the purpose of receiving psychology 101 credits for participation. Ask participants to spread out around the table, so that they have plenty of room and are comfortable. Once everyone is seated say:

**FACILITATOR:** “Hello, my name is (first and last name). I am a (class rank) here at Ohio University. I will be facilitating the focus group this evening. The information we learn from the focus group will help to improve Ohio University’s Sexual Assault Risk Reduction Program. Participation will take 1-hour. During the discussion tonight, you will be asked to provide feedback on several components of program protocol. It is important to remember that a focus group methodology cannot guarantee confidentiality. All topics discussed in the focus group should not be discussed in the session. Understand however, that it is possible that other group members may later disclose information revealed by other group members.”
Disclosure of personal experiences is entirely optional. To protect confidentiality, we ask that you do not use your name during this session. You may also discontinue the discussion at any time without penalty, or may “pass” on discussion topics. Also, the facilitator will be available for 30 minutes following this group to talk about any concerns you might have. This session is being audiotaped so that responses can be coded for later evaluation. However, these responses will be in no way linked to your identity.

**Hand out 2 consent forms and confidentiality agreement:**

**FACILITATOR:** The first two forms are consent agreements. Please read over the consent form. If you agree to participate in the focus group, please sign the forms. The second consent form is yours to keep. *(Show participants the informed consent forms).* The next form is a confidentiality agreement, stressing that you understand the nature of participation, and agree to maintain the confidentiality of the group discussion. It is important that you do not share information discussed during the session with others. Please read the agreement carefully. *(Once participants have signed the form, and remind the participants that the second copy is theirs to keep. Collect confidentiality agreements and consent forms).*

*(10 minutes) Hand out the packets and say:*

**FACILITATOR:** Once again, thank you for coming. Before we begin, we will complete a few questionnaires. Remember, these questionnaires will not be linked
to you in any way. Please open your packet. Write directly on the
questionnaires, and circle the most appropriate answer. When you are finished,
please place your survey form back into the manila envelope, and return the
envelope to this bin. After everyone is finished completing the survey, we will
begin the focus group discussion.

Introduction:

FACILITATOR: Well, let’s get started. So we are all on the same page, let me
tell you a bit about the Ohio University Sexual Assault Risk Reduction Program.
The Ohio University Sexual Assault Risk Reduction Program is a result of
ongoing research and program modification in the Lab for the Study and
Prevention of Sexual Assault. It is designed to reduce college women’s risk for
sexual victimization through the application of theoretical models of behavior and
attitude change. We believe that although it may not be possible to control the
attitudes and behaviors of perpetrators, we can try to induce positive change in
women’s risky behaviors, attitudes, and perceptions of threat—factors that, we as
women, may have more control over.

Instruments:

FACILITATOR: Thinking back to the instruments you just completed, many of
them involve a dating context, and refer to a “dating partner”. We hope that the
questionnaires are clear and valid as possible. Do you think that the phrase
“dating partner” is clear?

What does dating partner mean to you? Is there a better way to phrase “dating
partner”?
Video:

FACILITATOR: We are now going to view a video currently utilized in the Ohio University Sexual Assault risk reduction program, which depicts a series of risky dating situations. During each scenario, the tape is stopped at various points, and participants are asked to discuss ways to handle the situation, and to brainstorm options and strategies they might use if they found themselves in an uncomfortable situation. We will go through the video just as how the participants would during a “real” run of the program. Afterwards, I will ask for your feedback on the process.

FACILITATOR: Go through program.

Questions:

Overall what are the weaknesses of this video?

The strengths?

Is there other more important information that should be covered in vignettes such as these?

Do you think that vignettes will be an effective way to convey this information? (Explain)

Conclusion

FACILITATOR: You all have given us a lot of information about your experiences with the program, and some of the things you’ve liked and haven’t liked so much. Now we would like to ask you about your recommendations for the program.
If you had the power to change things about the program, what would you make different?

Thank you for your participation in this project. You have all been very helpful. Please feel free to stay and ask any questions you have, contact information is also listed on this debriefing text.

*Inform them that they will be granted one experiment point via the online sign up system. Then hand them a debriefing form.*