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# The Effects of Expert Testimony in Sexual Assault Trials

LillyBelle K. Deer  
*Claremont McKenna College*

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**CLAREMONT McKENNA COLLEGE**

**THE EFFECTS OF EXPERT TESTIMONY IN SEXUAL ASSAULT TRIALS**

SUBMITTED TO

PROFESSOR DANIEL A. KRAUSS

AND

DEAN NICHOLAS WARNER

BY

LILLYBELLE DEER

FOR

SENIOR THESIS

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The Effects of Expert Testimony in Sexual Assault Trials

LillyBelle Deer

Claremont McKenna College

### **Abstract**

Recently, expert testimony in sexual assault trials shifted from an emphasis on Rape Trauma Syndrome (RTS) to Posttraumatic Stress Disorder (PTSD) and experts have tied these diagnoses either loosely or tightly to the victim's condition following sexual assault. In the current study, 326 jury-eligible adults completed a survey on Amazon Mechanical Turk in which they read a synopsis of a sexual assault trial and an expert testimony with either RTS, PTSD or neither; along with either no, loose, or tight links made between the diagnosis and the victim's condition. There was no main effect of diagnosis label but testimony linkage did have an effect on verdicts. Women gave more guilty verdicts due to their lower levels of Rape Myth Acceptance (RMA), and the effect of gender partially depended on RMA. Implications for how expert testimony can affect defendants' and plaintiffs' credibility are discussed.

## **Introduction**

### **History of sexual assault trials and legal issues**

In sexual assault cases, the conflict between the defense and prosecution can become a “he-said-she-said” affair. In the absence of clear evidence for either side, the defense often points to flaws in the victim’s actions in an attempt to prove that the assault did not occur. There are many rape myths that the common public endorses, such as “If a girl doesn’t say ‘no’ she can’t claim rape” or “She didn’t contact the police right away so it must not have happened”. To counteract this, the prosecution will occasionally offer a psychological expert, who may proffer expert testimony regarding general rape myths or the victim’s mental state after the alleged assault.

In a trial, expert witnesses, or people who have advanced knowledge about a certain topic, are permitted to testify about that topic in order to educate the judge or jury about that topic, for which the jury may lack sufficient knowledge (Federal Rule of Evidence 702). “Educative” expert testimony is often used in cases where the average juror may lack sufficient knowledge of the topic area. Judges determine whether expert testimony is relevant to the case, and if it will be helpful to the jurors in performing their decision-making. There are certain standards that judges must follow when making this decision. Judges are bound by the rules of evidence adopted in their state to determine whether or not the testimony is necessary and appropriate for the jury to hear (Gemberling & Cramer, 2014). Most states and the federal government follow the Federal Rules of Evidence. According to Federal Rules of Evidence 702, a qualified witness may testify if: “a) the expert’s scientific, technical, or other specialized

knowledge will help the trier of fact to understand the evidence or to determine a fact in issue, b) the testimony is based on sufficient facts or data, c) the testimony is the product of reliable principles and methods, and d) the expert has reliably applied the principles and methods to the facts of the case. Some States, however, follow the Frye standard, which states for expert testimony to be admitted, the evidence presented must be generally accepted by the scientific community (*Frye v. United States*, 1923). In *Daubert v. Merrell Dow Pharmaceuticals* (1993), the U.S. Supreme Court determined that FRE 702 is the standard that should be used by the federal courts. This ruling dictates that judges are the “gatekeepers” of expert testimony and must abdicate which sorts of expert testimony are from relevant and reliable science. Putting judges in this role is controversial. The *Daubert* case also outlined that the methodology used to gather the information for the expert’s testimony needs to be: 1) falsifiable, 2) subjected to peer review and publication, 3) have a known error rate, 4) have general acceptance in a relevant scientific community.

In sexual assault cases, expert testimony concerning a victim’s unusual behavior has been admissible in most courts because it has been shown that jurors do endorse rape myths, stereotypes, and misconceptions that can alter the victim’s credibility in their eyes (Brekke & Borgida, 1985). Judges often allow the expert’s testimony because it is relevant to the case and is helpful to the jurors in making their decisions. Scientific expert testimony on the topic has also been shown to counteract juror’s misconceptions (Brekke & Borgida, 1988). Historically, expert testimony in rape cases is sometimes admissible when it involves general rape myths, and diagnoses such as Rape Trauma Syndrome, and Post-traumatic Stress Disorder in the victim.

### **Constructs in the Study**

**Rape Trauma Syndrome.** Rape Trauma Syndrome (RTS) was developed in 1974 by Burgess and Holmstrom as a two-phase description of commonly shared experiences of rape victims as seen in emergency rooms. The phases describe the reactions that sexual assault victims may exhibit initially after the assault, and the long-term life disruptions that the victims experience (McGowan & Helms, 2003). The acute phase is characterized by disorganization as well as three different components: impact reactions, somatic reactions, and emotional reactions. Impact reactions can manifest in two different ways; either the expressed reaction, which is characterized by fear, anger and anxiety, or the controlled reaction, which is characterized by masked feelings, calm, or composed and subdued nature. Somatic reactions are physical signs of the assault. Emotional reactions are a wide array of feelings shown, from fear, humiliation, and embarrassment to anger, revenge, and self-blame.

The long-term phase is characterized by reorganization of the victim's life. It is also characterized by three different components; motor activity, nightmares, and traumatophobia. Motor activity is a phase in which patients physically move their life by moving residences, taking long trips, changing their telephone numbers, and turning to family not normally seen daily for support. Dreams and nightmares about the event can fall into two different categories: either one where the victim wants to do something about the attack but awakens before she can, or one where the victim was able to fight off the assailant. Traumatophobia is a general term that describes phobias developed in response to the specific circumstances of the rape. These may include fear of

indoors/outdoors, fear of being alone, fear of crowds, fear of people behind them, and sexual fears (Burgess & Holmstrom, 1974).

Historically, Rape Trauma Syndrome was proffered in court in order to combat the “he said she said” nature of sexual assault cases as well as rape myths that the defense may raise, including: “they asked for it” or “it didn’t happen because they didn’t report it right away” in order to say the rape didn’t occur. RTS testimony is offered to combat these claims and also to refute the defenses claims that there was consent. The logic is that if the victim had consented to the sexual act, they would not be showing the signs and symptoms of a victim. The testimony offers evidence about two things: the victim’s emotional and psychological response to the rape and information on group behavior patterns in response to rape (Lauderdale, 1984). In the 1990’s, legal concerns grew with the introduction by experts of RTS and it fell out of favor. There were many cases like those in California, Missouri, and Minnesota where judges ruled the testimony inadmissible because either the testimony would mislead the jury and prejudice them against the defendant or the expert testimony did not pass the evidentiary admissibility standard (Lauderdale, 1984). By the early 1990’s, only a few courts allowed specific expert testimony on RTS testimony, while many others limited the testimony to general rape myth testimony (McGowan & Helms, 2003).

RTS expert testimony also faces difficulties in meeting the evidentiary admissibility standards outlined by FRE 702 and Frye. RTS does not meet FRE 702 because it is not based upon sufficient facts or data. Furthermore, it is not clear if RTS meets the general acceptance standard of Frye. RTS has never been included as a disorder

in any edition of the Diagnostic Statistic Manual of Mental Disorders (American Psychiatric Association, 2013), now in its 5<sup>th</sup> edition (2014), and was based upon limited empirical research (Boeschen et al., 1998). As inclusion in the DSM can be considered as general acceptance in the psychological/psychiatric community, and as RTS has never been included in the DSM, it may not be considered to be generally accepted. Additionally, more recent studies have not replicated many of the descriptions shown in Burgess's and Holmstrom's original study (Frazier & Borgida, 1992).

When the courts disallowed expert testimony on RTS, Posttraumatic Stress Disorder (PTSD) often became the replacement. Since PTSD is the primary trauma-related diagnosis in the DSM, it became the most common diagnosis to use in expert testimony in these cases (Boeschen, Sales & Koss, 1998). Also, among those suffering from PTSD, rape survivors are among the most likely to develop PTSD following their trauma (Norris, 1992; Oltmanns & Emery, 2014).

**Posttraumatic Stress Disorder.** PTSD can be defined as an anxiety problem that can arise in some people after exposure to significant trauma. This trauma can be anything from a crime to a natural disaster. People with PTSD may experience symptoms such as flashbacks, nightmares, and intrusive memories of the event, avoidance of anything that reminds them of the event, and anxious feelings that they did not previously experience (DSM V, 2014). PTSD was originally developed for veterans returning from war but rape survivors are now among the most common group among PTSD patients (Boeschen et al., 1998; Norris 1992; Oltmanns & Emery, 2014). PTSD has been admitted in the courts because it does meet the evidentiary standards outlined by both the FRE 702

and the Frye standard. It meets the legal standards for the FRE 702 because it is based upon empirically validated research. PTSD also meets the factors described in the Daubert case; the diagnosis of PTSD has been extensively documented and tested, it has been subjected to peer review and publication, it is consistently replicated and updated, and it does have general acceptance in the scientific community. It does not have a known error rate as of yet as there are concerns about malingering. The concept of PTSD is based upon extensive research, and its legitimacy has been documented since 1600's (Trimble, 1985). The process that led to PTSD being included in the DSM has been empirically based and rigorous (Friedman, 2013). It also meets the Frye Standard because it is generally accepted in the field of psychology. A form of PTSD, called Gross Stress Reaction was included in the first version of the PTSD; and PTSD itself has been included in all editions of the DSM since DSM-III so it is considered as generally accepted among the psychological/psychiatric community (DSM I, 1952; DSM III, 1970).

There are, however, a number of problems with the diagnosis of PTSD being used with sexual assault victims and their cases. As is the case with RTS, not all victims will meet the criteria for PTSD, as people with different personalities and experiences react to trauma differently. Some victims may develop depression and some may not develop any psychological illnesses. Also, as PTSD was originally developed based upon the experiences of war veterans in mind, it does not directly explain a myriad of post-sexual assault behaviors. PTSD does include many of the experiences that rape victims may experience, but it does not offer a complete description and account for the complexity of difficulties that sexual assault victims may suffer (Boeschen et al., 1998). PTSD also does

not directly mention many of the rape myths or the unusual behavior that many rape victims exhibit, and that the prosecution may most want to explain to the jury. PTSD may not account for the depression, anger, sexual dysfunction, guilt, humiliation, and core belief disruptions that are also common among sexual assault victims. Additionally, it can also be difficult to show that the victim's PTSD was triggered by the alleged assault in question (Boeschen et al., 1998). If a victim has an especially turbulent past, it can be easier for the defense to say that the victim's PTSD was caused by another event.

However, there are many ways in which PTSD does fit the experience of sexual assault victims. Although some victims may meet criteria for depression rather than PTSD, more victims meet criteria for PTSD than depression overall (Herman, 1992). Although there are these problems with the use of PTSD in this context, it is the most relevant diagnosis in this case because it does encompass many of the experiences and symptoms that sexual assault victims may go through. Unfortunately there has been very little research completed on how PTSD testimony influences juror's perception of the people involved in sexual assault cases and their final verdicts.

**Linkage of Testimony.** One legal factor that is often raised when offering expert testimony in a sexual assault case is the strength of the connection experts can make between the diagnosis (e.g. RTS) and the specific facts of the case at issue. Most courts hold that certain expert testimony's probative value may be outweighed by its potential prejudice on the jury and judges have ruled against allowing certain expert testimony for this reason. Another concern is that expert testimony may usurp the role of the jury. For example, if an expert states that a victim is suffering from RTS then the jury may believe that a rape must have occurred, or why would they be suffering from RTS. Boeschen et

al. proposed five levels of testimony with varying strength of the connection made between the expert's testimony and the facts of the presented case. The first level allows expert testimony on specific behaviors of rape survivors that are described as unusual by the defense. This is often used to rebut the defense's argument that the victim did not act like a rape victim and rebut general rape myths that the jury may hold. The second level of Boeschen testimony is on the common reactions to rape and the general diagnostic criteria of RTS or PTSD. This expert testimony would contain a discussion of common post-rape behaviors and the diagnostic criteria for RTS/PTSD but the expert would not examine the victim or speak to their specific symptoms. The third level of Boeschen's hierarchy offers an opinion about the consistency of a victim's behavior or symptoms with RTS or PTSD. At this level, the expert is allowed to discuss whether the victim's symptoms are consistent with RTS or PTSD. The expert would not diagnose or examine the victim and would not state that they have RTS/PTSD. At the fourth level of Boeschen's scale, the expert states that the victim suffers from RTS or PTSD. The expert would describe the victim's symptoms and state that they suffer from RTS/PTSD, but may not state that the victim has been raped. In the final level, the expert offers an opinion that goes beyond a diagnosis. At this level, the expert would state that the victim is telling the truth and has been raped. Levels one through four expert testimony have been admitted in court cases so they will be the focus of this research. Level five has generally not been admitted in court because it is considered to be far too prejudicial for the jury and usurps their role as triers of fact. Level one testimony will serve as the control condition in the current study.

Past research has demonstrated that jurors are most influenced by evidence when it is explicitly linked to the facts of the case (Brekke & Borgida, 1988). The stronger the connections that an expert makes from the victim and their condition to the case at issue, the more the jurors are hypothesized to be persuaded by such evidence in their decision-making process. Studies involving Battered Woman Syndrome's use in self-defense cases demonstrated a similar outcome; the more explicit the connection between the expert testimony and the facts of the case, the more lenient verdicts were given for the defendant (Schuller, 1992). The more explicit the link, the easier it is for the jurors' mind to follow the connection. Other research examining expert testimony in sexual abuse cases involving children found that when experts made a direct connection through their testimony between a child's specific behavior and the research on the topic, the more likely jurors were to be sympathetic and find against the alleged perpetrator (Kovera et al., 1997). These studies suggest that the more explicit the links between the testimony and facts of the case in dispute, the more persuasive the testimony is to jurors.

**Diagnostic Label.** Along the same lines, it is thought that RTS shows a more direct connection between the diagnosis and the alleged rape than PTSD does (Lauderdale, 1984). There been a dearth of research that investigates this claim directly. With the difficulty of proving that a victim's PTSD resulted from an assault, and the ease of making the link between Rape Trauma Syndrome and rape, it is a worthwhile claim to investigate. The research on linkage shows that people will make connections if the connection is more direct than not. As a result, a diagnostic label of RTS as opposed to PTSD should lead jurors to be more persuaded by the label.

**Rape Myth Acceptance.** There are other factors that are likely to affect the juror's perception of the plaintiff, defendant, and the case as a whole. One of them is rape myth acceptance (RMA). The number of rape myths that someone endorses is called rape myth acceptance. It has been consistently found that males are more likely to endorse rape myths – false beliefs about how rape, the perpetrator, and the victim – than women. This is thought to occur because women have been found to have higher empathy for victims than men, because they can empathize with the women in these situations (Sinclair & Bourne, 1998; Vandiver & Dupalo, 2012). In actual cases, males have been found to be more likely to believe the male perpetrator's version of events and females were more likely to believe the female victim's version of events (Spanos, Dubreuil, & Gwynn, 1991). Also, those jurors with a history of victimization are likely to have greater empathy for victims and those with a history of perpetration, who may have greater empathy for perpetrators (Osman, 2011). The research suggests that people are more easily able to empathize with those most similar to themselves and those most likely to be in identical situations.

RMA is likely to predict the manner in which a juror will decide credibility and guilt in a sexual assault case as well. Lonsway and Fitzgerald (1994) found that people who endorse rape myths are less likely to convict defendants and are also more likely to recommend shorter sentences to defendants who are convicted, when compared to people with low RMA. Süssenbach, Eyssel, and Bohner (2013) determined that mock juror RMA scores predicted defendant's guilt with lower RMA scores predicting higher ratings of defendant's guilt. In contrast, those jurors who are higher RMA were less likely to be

persuaded by expert testimony on sexual assault, but that effect was not seen with those with lower RMA.

RMA can also predict how jurors assign responsibility to parties in the case. Rape myth acceptance has been demonstrated to mediate the relationship between gender and how much responsibility is placed upon the victim and perpetrator. Men were more likely to endorse rape myths, and therefore, assigned less responsibility to the perpetrator and more to the victim (Hammond, Berry, & Rodriguez, 2011). Women are more likely than men to empathize with the victim, endorse less rape myths, and assign more responsibility to the perpetrator than the victim. Men are also more likely than women to empathize with the perpetrator, endorse more rape myths, and assign more responsibility to the victim than the perpetrator.

**Just World Beliefs.** Another factor that may influence jurors' views of the perpetrator and the victim is their endorsement of just world beliefs. Just world beliefs are how much individuals believe that people get what they deserve in life. People who have high just world beliefs believe in statements like, "I feel that people earn the rewards and punishments they get" and "I feel that people who meet with misfortune have brought it on themselves". People who have lower just world beliefs would not agree with these sentiments. Just world beliefs allow people to feel safe in the world because they believe that they have control over their own lives, and bad things happen to other people because of things that they did rather than the randomness of the universe. Just world beliefs may be a predictor of rape myth acceptance. When people have conflicting feelings about a situation, they try to reinforce their beliefs in three different

ways. They will either try to restore justice by punishing the perpetrator, deny or nullify the injustice by blaming the victim, or make the injustice livable (Lerner, Miller, & Holmes, 1976). When a situation like a rape case appears, people's JWB are threatened and they use these three different methods to protect themselves from feeling this discomfort. Past research has shown that men who hold strong just world beliefs are more likely to protect their views by blaming the victim, while women with strong JWB do not follow this trend (Wyer, Bodenhausen, & Gorman, 1985). Just world beliefs have been found to predict rape myth acceptance such that as JWB increases, so does RMA. However, this effect disappears when gender is controlled for, which suggests that gender is a greater predictor of how RMA and JWB interact to affect convictions (Hayes, Lorenz, & Bell, 2013). JWB, RMA and gender have not been studied together when examining at sexual assault cases and how they interact to affect the decision making process of the jurors involved.

### **The Present Study**

Past research has mostly focused on Rape Trauma Syndrome or general rape myth testimony. This will be the first study to compare RTS and PTSD directly yet. This study will also examine Boeschen's differing levels of expert testimony and whether the different levels of testimony will offer the perpetrator and victim differing levels of credibility as well as affect the final verdict. Additionally, this study explores how individual difference factors such as beliefs in a just world and endorsement of rape myths will shape participants' opinions.

Based on past research, it is hypothesized that there will be a main effect of testimony linkage, such that Boeschén's level 4 expert testimony will result in more convictions than level 3, which will result in more guilty verdicts than level 2. There will also be a main effect of diagnostic label, such that RTS will result in more guilty verdicts than PTSD, both of which will cause more guilty verdicts than general rape myth testimony. There will also be a main effect of gender, such that women will convict the defendant more often than men, and there will be a main effect of rape myth acceptance, such that people with higher RMA will be less likely to convict the defendant than people with lower RMA. The relationship between gender and convictions will be mediated by jurors' RMA, such that when RMA and gender are accounted for, the effect of RMA should remain strong and the effect of gender should be reduced. Additionally, there will be a main effect of just world beliefs, such that people with higher JWB will be less likely to convict the defendant than people with lower JWB. This effect will be moderated by an interaction between RMA and JWB, such that the effect of RMA depends on JWB. When JWB is high, RMA shouldn't have an effect on verdict and when JWB is low, higher RMA should be associated with lower guilt ratings.

## **Method**

### **Participants**

For this study, 326 participants were recruited using Amazon Mechanical Turk, an online service where participants take surveys for small monetary compensations. After running manipulation checks, the final sample was 193 participants. For this study, participants were compensated one dollar for approximately 30 minutes of their time.

Women accounted for 52.3% of the population as 101 participants were female and 92 were male. The average age of the population was 36.0 years old ( $SD = 10.397$ ).

Approximately 81.3% of the population was Caucasian ( $N = 157$ ), 7.3% was Asian ( $N = 14$ ), 4.7% was African American ( $N = 9$ ), 4.7% was Hispanic ( $N = 9$ ) and the rest were Other 1.6% ( $N = 3$ ). About 38.9% of the participants held a Bachelor's degree as their highest level of education attained ( $N = 75$ ), 25.5% had some college ( $N = 55$ ), 13.5% had an Associate degree ( $N = 26$ ), 10.9% had graduated high school or got a GED ( $N = 21$ ), 7.8% had a Graduate or Professional degree ( $N = 15$ ), and 0.5% had some high school ( $N = 1$ ). All participants were jury-eligible adults from the United States.

### **Procedure and Design**

**Design.** Two independent variables will be manipulated. It is a 2 (diagnostic label: Post-Traumatic Stress Disorder (PTSD) and Rape Trauma Syndrome (RTS)) x 3 (level of expert testimony: Levels 2, 3, and 4) factorial design. The design is fully crossed with a control condition so there are seven conditions. The control condition involves general rape myth testimony.

**Procedure.** Participants were randomly assigned to one of the seven vignette conditions. The participants in the study completed four parts of an online survey. First, they received a vignette about an expert testifying in a sexual assault case in court. Second, they answered some questions related to that vignette, including a manipulation check and some questions regarding the credibility and guilt of each party. Third, they completed the Global Belief in a Just World Scale (GWBJS) and the Illinois Rape Myth Acceptance Scale (IRMA). Lastly, the participants answered demographic questions,

including age, gender, ethnicity, and education level, and past experiences with sexual assault (see Appendix D). The participants were then debriefed and awarded a small monetary compensation of one dollar for their time.

### **Materials and Measures**

**Vignette materials.** First, the participants received information about how to conduct themselves during the court proceeding, which was to “imagine that you are a juror in this case and refrain from making judgments until asked to do so”. They then received information regarding the case itself. The vignettes described a court proceeding in which a young woman allegedly was a victim of acquaintance rape (see Appendix A). In the vignette, the plaintiff and defendant were on a blind date and go back to the defendant’s house, where she claims he assaults her. She claims that it was rape and he claims that he had obtained consent in the situation. The expert who testifies in the case is introduced and his clinical testimony is given. Accounting for the control condition, there are seven conditions in the 2 (diagnostic label: PTSD and RTS) x 3 (level of expert testimony: Levels 2, 3, and 4) design. The participants are randomly assigned to one of the seven conditions and given the corresponding vignette.

In the control condition, the expert testifies concerning general rape myths and dispels them such as, “she asked for it”, and “she didn’t report the crime right away so it did not occur”. He does not offer a diagnostic label for the victim and does not relate these rape myths to the case at hand.

In the six conditions with diagnostic labels, the participants will either read testimony regarding PTSD or RTS. Testimony regarding PTSD will contain general

information about the prevalence of sexual assault victims with PTSD diagnoses as well as information about the diagnostic criteria of the disorder. The extent that this diagnosis is related to the case will vary with the differing levels of testimony. Testimony concerning RTS will contain general information about the syndrome, including the two-phase description of the commonly shared experiences of rape survivors as well as common symptoms of the syndrome. The extent that this diagnosis is linked to the case will vary with the differing levels of testimony.

In the Level 2 condition, the expert discussed general rape myths as well as the diagnostic criteria for the disorder and related the two. He does not link the myths or diagnosis to the facts of the case. In the testimony regarding PTSD, the expert outlines the criteria for PTSD from the DSM-5. In the testimony regarding RTS, the expert outlines the description of RTS as described by Burgess and Holmstrom (1974). At the end of either testimony, the expert states “As you can see, many of these symptoms overlap with common post-rape behaviors of the victim.”

In the Level 3 condition, the expert discussed general rape myths as well as the diagnostic criteria for the disorder and related the two to each other along with stating that the plaintiff does meet the criteria for disorder. This testimony is the same as the Level 2 testimony except it states, “The symptoms that Karen claims that she is suffering from are consistent with those that would be seen in a patient with RTS/PTSD.”

In the Level 4 condition, the expert discussed general rape myths as well as the diagnostic criteria for the disorder and related the two by explicitly linking them to the case and stating that the plaintiff does have the disorder. The expert made direct

connections between the plaintiff's diagnosis and the facts of the case. The expert explicitly explains to the jury the symptoms of either RTS or PTSD and explains how the victim's actions fit those criteria. In all of the conditions where a diagnosis is discussed, it is stressed that the absence or presence of a diagnosis does not prove that rape did or did not occur.

**Vignette measures.** After reading the vignette, the participants answered a series of manipulation check questions; the first asks if the expert testified about a PTSD or RTS. If the participant answered yes to that question they then were asked which one, and if the expert diagnosed the plaintiff. If the participant answered yes to the third question they were then asked if the expert explicitly linked the diagnosis to the plaintiff's behavior. (see Appendix B). The participants then were asked a series of questions addressing their perception of the testimony given in the case and the guilt and credibility of both parties (see Appendix B). The participants were asked to endorse a guilty or not guilty verdict (-1 = not guilty, 1 = guilty) and rate on a 7-point Likert scale how confident they were in their decision (1 = not at all, 7 = extremely). These scores were multiplied such that someone who was extremely confident in their not guilty verdict produced a score of -7 while someone who was extremely confident in their guilty verdict produced a score of 7. Following this, the participants were asked what they thought the likelihood was that the sexual assault had actually occurred on a 7-point Likert scale (1 = very unlikely, 7 = very likely). The participants were then asked how much weight they gave to the expert testimony in their verdict on a 7-point Likert scale (1 = very low, 7 = very high). They were subsequently asked to rate the blame of the victim and the perpetrator as well as the credibility of the expert, victim, and the perpetrator on a

7-point Likert Scale. Lastly, they reported their impressions of the perceived credibility of the victim, perpetrator, and the expert on a 7-point Likert Scale (1 = not at all, 7 = extremely).

**Individual Difference Scales.** After reading the vignette and completing the vignette related questions, participants completed two individual difference scales. Participants first completed the seven-item Global Belief in a Just World Scale (GBJWS) (Lipkus, 1991) (see Appendix C). The GBJWS offers statements that assess the person's level of belief that the world is a just place and people get what they deserve (e.g., "I feel that people earn the rewards and punishments they get," and "I feel that people who meet with misfortune have brought it on themselves"). The GBJWS is scaled on a 6-point Likert-type scale with higher scores indicating higher accordance with just world beliefs (1 = strongly disagree, 6 = strongly agree). The items on the GBJWS scale were added together to form a total GBJWS score that could range from 7-42. Reliability analyses on the sample showed good reliability with Cronbach's  $\alpha = .946$ .

Participants then completed a shortened, 12-item version of the Updated Illinois Rape Myth Acceptance Scale (IRMA) (Payne, Lonsway, & Fitzgerald, 1999; McMahon & Farmer, 2011) (see Appendix C). The IRMA assesses four specific subscales of Rape Myths: she asked for it (e.g., "When a girl gets raped, it's often because the way they said 'no' was unclear"), he didn't mean to (e.g., "If a guy is drunk, he might rape someone unintentionally"), it wasn't really rape (e.g., "If a girl doesn't say "no" she can't claim rape"), and she lied (e.g., "Rape accusations are often used as a way of getting back at guys"). Items in the IRMA are scored on a 5-point Likert scale, with higher scores

indicating higher agreement with the rape myths (1 = strongly disagree, 5 = strongly agree). The items on the RMA scale were added together to form a total RMA score that could range from 12-60. Reliability analyses on the sample showed good reliability with Cronbach's  $\alpha = .900$ .

## **Results**

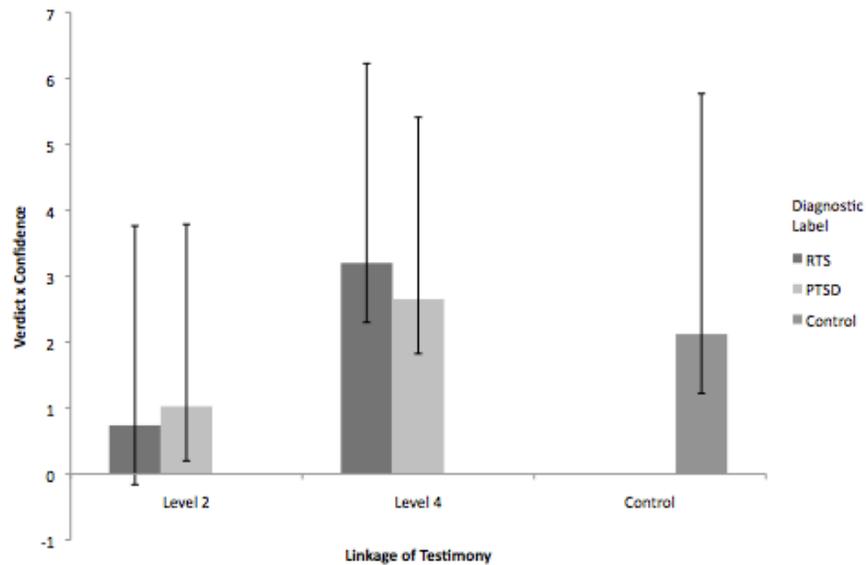
### **Manipulation Check**

Participants were asked a series of questions concerning the vignettes to determine if the experimental manipulations were effective. For example, they were asked if the expert mentioned a specific diagnosis, if they diagnosed the plaintiff, and if the expert explicitly tied the victim's diagnosis to their behavior (see Appendix B). From the initial sample of 326 participants, 114 of them failed one of the manipulation checks and were excluded from the analysis. Close to 75% of the participants who received the level 3 expert testimony condition for both PTSD and RTS labels failed the question. As a result participants who received that manipulation were removed from analyses. These exclusions left a participant population ( $N = 193$ ) that had received the control condition, and both RTS and PTSD of level 2 and 4 expert testimony. Education and past experience with sexual assault were significantly related to passing the manipulation checks so they were added in as a covariates in any model that testimony level was assessed in.

### **Diagnostic Label and Testimony Level**

To test the first two hypotheses and determine if diagnostic label and testimony had an effect on the final verdict, a series of chi squared tests were run. There was no

effect of diagnostic label ( $p > .05$ ), but there was a significant effect of testimony level,  $\chi^2(1,193) = 6.12, p = .047$ , such that participants who received the more detailed and linked to the case expert testimony were more likely to provide a guilty verdict than participants who received the less detailed testimony. To further test the first two hypotheses and determine if diagnostic label and testimony level had an effect on the dependent variable of verdict confidence, an ANCOVA analysis was run. It was expected that different levels of expert testimony would affect participant's perceptions of guilt/innocence and their confidence in the verdicts themselves. There was not a significant main effect of diagnostic label, or a significant interaction effect ( $p > .05$ ). There was, however, a significant main effect of testimony level,  $F(1,182) = 8.18, p = .005, \eta^2 = .043$ , such that participants who received the more detailed expert testimony ( $M = 2.91, SD = .52$ ) and the control condition ( $M = 2.12, SD = 4.26$ ) were more likely to provide a guilty verdict and be confident in that verdict than participants who received the less detailed testimony ( $M = .85, SD = .50$ ). There was not a significant difference between the level 4 testimony and the general rape myths testimony (see Figure 1).



*Figure 1:* Bar graph showing the relationship between testimony level, diagnostic label, and verdict x confidence with error bars at 95% confidence intervals.

### **Likelihood of Sexual Assault**

Additionally, the participants' perception of the likelihood that a sexual assault occurred was measured. An ANCOVA was used to determine the effects of the diagnosis label and testimony on the participants' belief of the likelihood that the sexual assault occurred. There was a significant main effect of testimony level on the perceived likelihood that the assault occurred,  $F(1,182) = 14.97, p < .001, \eta^2 = .076$ , such that participants who received the level 4 expert testimony ( $M = 5.41, SD = 1.55$ ) thought the likelihood of the assault was higher than participants who received the level 2 testimony ( $M = 4.44, SD = 1.54$ ), but not significantly higher than participants who received the

control condition ( $M = 4.95$ ,  $SD = 1.50$ ). Diagnosis label was not significant nor was the interaction between diagnosis label and testimony label ( $p > .05$ ).

### **Perceptions of involved parties**

The weight afforded to the expert testimony, credibility of the expert, credibility of the victim, blame placed on the victim, credibility of the perpetrator, and blame placed on the perpetrator were measured and analyzed. An initial correlation analysis was run and all of these factors were significantly correlated at the  $p < .001$  level. The weight of the expert testimony and the credibility of the expert were significantly correlated ( $r(191) = .71$ ,  $p = .000$ ) so they were combined. Reliability analyses on these outcome variables showed high reliability with Cronbach's  $\alpha = .83$ . To test how the testimony and the expert were perceived by the participants, an ANCOVA was used to determine the effects of the diagnosis label and testimony linkage. There was not a significant main effect of diagnostic label ( $p > .05$ ), or a significant interaction effect ( $p > .05$ ). There was a significant main effect of testimony level,  $F(1,182) = 4.91$ ,  $p = .028$ ,  $\eta^2 = .026$ , such that participants who received level 4 ( $M = 5.72$ ,  $SD = 1.34$ ) expert testimony gave more weight to the expert testimony and perceived the experts credibility as more credible than people who received less detailed expert testimony ( $M = 5.24$ ,  $SD = 1.13$ ) or the control condition ( $M = 5.11$ ,  $SD = 1.54$ ). There was not a significant difference between the control condition and level 2.

Perceptions of the victim's credibility and perceptions of the perpetrator's blame were also highly correlated ( $r(191) = .74$ ,  $p < .001$ ) and were combined to create a scale. Reliability analyses on these outcomes indicated high reliability with Cronbach's  $\alpha = .85$ .

To test the extent to which the participants believed the victim, an ANCOVA was used to determine the effects of diagnosis label and testimony linkage. There were no significant effects for diagnostic label, or a significant interaction effect ( $p > .05$ ). However, there was a significant effect of testimony level,  $F(1,182) = 7.08, p = .009, \eta^2 = .037$ , such that participants who received level 4 ( $M = 5.51, SD = 1.37$ ) expert testimony had a stronger belief in the victim's version of events than people who received level 2 ( $M = 4.92, SD = 1.47$ ) testimony. There was not a significant difference between the control condition ( $M = 5.33, SD = 1.39$ ) and level 4.

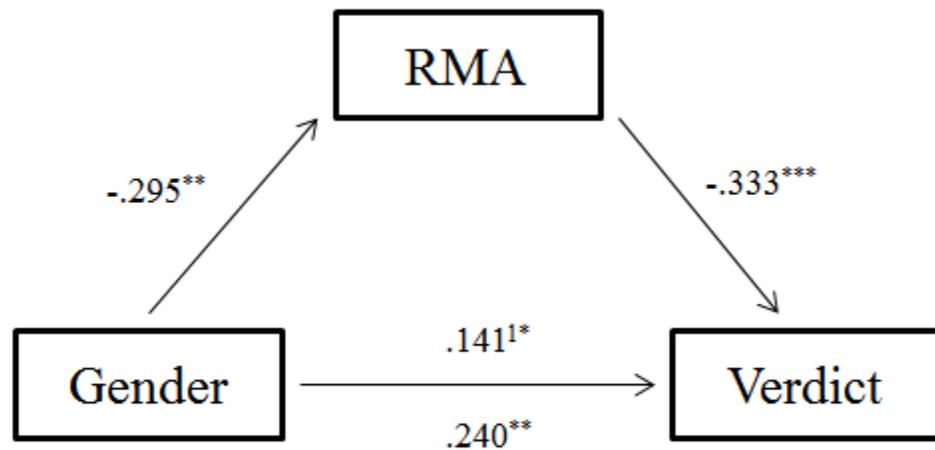
Perceptions of the perpetrator's credibility and perceptions of the victim's blame in the situation were also highly correlated ( $r(191) = .51, p < .001$ ) and were used to create a scale. Reliability analyses on the sample showed good reliability (Cronbach's  $\alpha = .67$ ). To test how the extent to which the participants believed the perpetrator, an ANCOVA was used to determine the effects of diagnosis label and testimony linkage. There was not a significant main effect of diagnostic label, testimony level, or a significant interaction effect ( $p > .05$ ).

### **Gender and RMA**

It was hypothesized that there would be a main effect of gender, such that women would convict the defendant more often than men. Additionally, it was hypothesized that there would be a main effect of rape myth acceptance (RMA), such that people with higher RMA would be less likely to convict the perpetrator than people with lower RMA. It was also hypothesized that RMA would act as a mediator of the gender effect on decisions, such that the participant's level of RMA accounts for the effects of gender on

verdict confidence. To test these hypotheses and this model, a mediation analysis was run using Baron and Kenny's (1986) mediation procedure. First, a linear regression was run using verdict confidence as the criterion and gender as the predictor. Gender significantly predicted verdict confidence, ( $\beta = .240, t(191) = 3.41, p = .001$ ), such females were more likely to offer a guilty verdict than males. Second, a linear regression was run using RMA as the criterion and gender as the predictor. Gender significantly predicted RMA, ( $\beta = -.30, t(191) = -4.27, p < .001$ ), such that females had lower RMA scores than males.

Finally, gender and RMA were entered together as predictors with verdict as the criterion. The overall model was significant,  $F(1,191) = 17.91, MSE = 16.65, p < .001, R^2 = .16$ . With the mediator variable of RMA ( $\beta = -.33, t(191) = -4.78, p < .001$ ) entered into the model, gender was less significant ( $p = .044$ ) so RMA partially explains the relationship between gender and verdict confidence (see Figure 2).



NOTE: 1= The effect of gender on verdict with RMA in the model.  
 $*$  =  $p < .05$ ,  $**$  =  $p < .01$ ,  $***$  =  $p < .001$ .

*Figure 2: Mediation Model between gender, RMA and verdict x confidence*

### **RMA and JWB**

In order to test the final hypothesis, whether JWB and RMA have an interactive effect on the participant's decisions, a series of correlations were run. There was no effect of JWB on verdict confidence ( $p > .05$ ). As stated previously, there was also a significant effect of RMA on verdict. JWB and RMA were positively correlated ( $p = .001$ ). A mediation model was run to further test this hypothesis, but JWB did not mediate the relationship between RMA and verdict confidence.

### **Discussion**

The present study investigated the effects of expert testimony on mock jurors' verdict in a sexual assault case, as well as their belief that the sexual assault occurred, and their perceptions of the parties involved. This study is the first to directly examine PTSD and RTS as diagnostic labels and also adds to the existing literature concerning the detail to which expert testimony is linked to individual facts in court cases. The study also explored the effects of rape myth acceptance (RMA), gender differences, and just world beliefs (JWB) in sexual assault trials.

In this experiment, diagnostic label did not affect mock jurors' verdicts. Contrary to our hypothesis, there was no significant difference between verdict and ratings of confidence when the diagnostic labels, RTS and PTSD were employed. This null result has several implications. One of the reasons that RTS is seldom admitted in court is because it is believed to be prejudicial. That is, if the jury hears it they will assume a rape/sexual assault has occurred, usurping the jury's role. These results indicate that this may not be the case and that jurors are not affected by the diagnostic label. Although RTS may not meet the evidentiary admissibility standards outlined by FRE 702 and *Frye*, it is interesting to note that the expert testimony does not change jurors' perception regarding guilt or innocence.

This could be caused by the similarity of the diagnoses. They both describe what someone would go through after an extremely traumatizing event, such as a sexual assault. Another possible reason for the null effect is that although it is easier to make the direct link between RTS and rape, PTSD is more recognizable to jurors. Since RTS is largely not well known in today's culture, and PTSD has gained significant media

attention in the past few years, it could be that PTSD is just more easily recognized. Jurors may mistrust the RTS label and diagnosis because they have no prior knowledge of it and it may sound like a made up diagnosis to them. This effect could offset the effects of RTS's seemingly prejudicial name.

The second hypothesis that linkage of expert testimony to the case would have an effect on verdicts was mostly supported. Consistent with the hypothesis, there was a significant effect of linkage such that when the expert testimony was more detailed, participants were more likely to convict the defendant and be more confident in that verdict. However, inconsistent with the hypothesis, the control condition, which had no diagnostic information and only discussed general rape myths, was not significantly different from the more detailed condition. People who oppose the use of more detailed expert testimony being admitted in court, like that seen in level 4, argue that this more detailed testimony may unduly prejudice the jury and may even usurp the jury's role. This result suggests that that may not be the case and that jurors can parse the facts that they need from the expert testimony and aren't biased by the mere presence of more detailed expert testimony.

Although no specific hypotheses concerning the likelihood of the sexual assault occurring and the jurors' perceptions of the involved parties were generated, analysis of these variables adds in an important aspect to the story. The expert testimony level had an effect on what the participants' perceptions of the likelihood of the sexual assault occurring. Diagnostic label did not have any effect on this outcome. Participants who received the control condition and more detailed level 4 condition vignettes were more

likely to believe the sexual assault occurred than the participants who received than the less detailed level 2 condition. Similar results were observed in verdict confidence ratings and this possibly indicates that jurors are not unduly persuaded by the extra information.

The participant's perception of the expert and the expert testimony itself was also effected by detail level of the expert testimony and its link to the facts of the case, such that participant's gave more weight and credibility to the expert when they received level 4 expert testimony rather than level 2 expert testimony or the control condition.

Diagnostic labels did not have any effect here as well. This means that the more detailed the testimony the participant's received, the more likely they were to weigh it and believe the expert. This supports previous research that has found that people were more likely to believe more detailed expert testimony and links it to the case when making a multitude of decisions (Brekke & Borgida, 1988; Schuller, 1992; Kovera et al., 1997). One explanation for this result is that the more information an expert is able to offer, the more knowledgeable they may seem on the subject, and thus their credibility is enhanced.

The participant's beliefs in the victim's version of events were effected by testimony level but not diagnostic label. Participants who received the level 4 expert testimony rated the defendant's blame as higher and credibility as lower than in the control condition. Participants in the control condition rated the defendant's blame higher and victim's credibility higher than participants who received the level 2 testimony. This may imply that talking about a diagnosis does not bolster the plaintiff's credibility any more than talking about general rape myths does. However, when the plaintiff's actions are directly tied to a diagnosis it does effect perceptions of the plaintiff's credibility.

The third hypothesis, which predicted that women would convict the defendant more often than men, was supported. Women jurors were more likely to convict the defendant and be more confident in that verdict than men. This is consistent with prior research on the topic. Past research has found that women are more likely than men to empathize with the plaintiff and assign more blame to the perpetrator than the victim (Hammond, Berry, & Rodriguez, 2011; Sinclair & Bourne, 1998; Vandiver & Dupalo, 2012). One possible explanation for this effect in the current study is that women are more likely to empathize with the female victim more often than men so they are therefore more likely to convict the male perpetrator.

The fourth hypothesis predicted that people with higher RMA would be less likely to convict the defendant than people with lower RMA, was also supported. RMA was highly related to verdict confidence, so that people with lower RMA were more likely to convict the defendant. Past research has often found this effect (Lonsway & Fitzgerald, 1994; Süßenbach, Eyssel, & Bohner 2013). People with higher RMA may not utilize information that would conflict with their beliefs system to avoid cognitive dissonance (Kilmartin & Allison, 2007). By dismissing this information about the alleged sexual assault, the person with RMA keeps their belief system in tact and avoids the discomfort that comes with holding two contradictory ideas.

The meditational model that was hypothesized about between gender, RMA, and verdict confidence was partially supported. Inconsistent with the hypothesis, RMA only partially explained the relationship between gender and verdict confidence, meaning that the relationship between gender and verdict confidence was less significant but still

significant when RMA was entered into the model. The direction of this effect is consistent with previous research. Males have consistently been found to have higher RMA scores than women and have also been found to convict the defendant less often than women. This is the first study to study this mediational model directly effecting verdict. Past research has focused on the relationships between responsibility and credibility assigned to the perpetrator and victim by jurors (Hammond, Berry, & Rodriguez, 2011). This effect has implications for how male jurors will use information concerning sexual assault. Men and those with higher RMA are more likely to dismiss information that is inconsistent with their beliefs.

Finally, it was hypothesized that JWB would have an effect on verdicts and that it would moderate the effect of RMA, but this effect was not found. JWB was not related to verdict confidence, and although it was related to RMA, there was no such moderation effect on the verdict. This is an especially interesting effect because it was thought that JWB would function similarly to RMA. Past research had found that JWB is related to RMA. Additionally, it has been theorized that JWB would act similarly to RMA, such that when a person's just world beliefs are questioned; they would reject the information that contradicts that belief. A possible explanation for this effect is that RMA is a more specific belief system that is relevant to sexual assault while JWB contains more general attitudes that may or may not be specific to sexual assault. Most research suggests the more specific the attitudes are the more closely they relate to specific behavior like verdicts in a sexual assault case (Ajzen & Fishbein, 1977).

### **Strengths and Limitations**

The current study has many theoretical and methodological strengths. First, this is the first study that examines diagnostic labels, as well as diagnostic label with expert testimony detail together. Much of the literature on diagnostic label is theoretical and there is a dearth of research that has directly tested the effects. Another strength of the study is that it is the first to investigate the mediational model between gender, RMA, and verdict. Finally, the insertion of JWB in a potential moderation model with RMA and verdict showed that RMA as a more specific belief set is a greater predictor of verdict than a global belief such as JWB.

There were also a number of limitations to the study. The finding that the control condition was more effective than the less detailed and linked expert testimony in some of the analyses may have occurred because the explanation of the manipulations was much longer in that condition than in the control condition. There may be a limit to the amount of information that people can use efficiently. The level 2 expert testimony offered the same information concerning rape myths as the control condition but included additional information concerning RTS or PTSD, without tying that information to the plaintiff. Since the information was not specifically linked to the plaintiff, they may have not been able to use it and that expert testimony may have functioned very similarly to the control condition. Since level 4 explicitly links the diagnosis and behavior to the plaintiff's behavior and facts, it may have been easier for participants to use.

Another limitation of the study was that most of the participants failed the level 3 manipulation checks. This may have been caused by the manipulation check question itself. In the level 3 condition vignette, the expert stated at the end that the plaintiff had

PTSD or RTS, while in the level 4 condition vignette the expert went on to explain how the plaintiff's behavior was consistent with the diagnosis. The manipulation check that many of the people in the 3<sup>rd</sup> level failed was "Did the expert explicitly link their condition to the way the plaintiff acted in the case?". Since the participant population was administered the study online and getting paid for their time, they may have failed to adequately focus on this important but small detail. Their thinking may have been that since the expert diagnosed the plaintiff; that necessarily linked the condition to their behavior.

A final limitation of the current study involves ecological validity. The participants were answering these questions and making decisions in a very different setting than they would be in court. Although the vignettes were created to be as similar as possible to what a participant would see in court, in the interest of time and brevity, they had to be much shorter than what an actual juror would experience in court. As a result, the generalizability of the results to a more complex real life situation and an invested group of jurors is suspect.

### **Future Research**

Future research should examine two major topics: how expert testimony effects the jurors' perceptions of the involved parties, and the utility of diagnostic labels. The effect of expert testimony on jurors' perception of involved parties was not hypothesized about in this study. However, these variables were measured and the results have interesting results with legal implications. These effects should be further investigated so that we can have a better understanding of how these perceptions jurors gain about the

involved parties effect their decision-making process. The diagnostic labels in this study were a novel variable and should be further investigated, especially the difference between general rape myth testimony and PTSD.

### **Conclusions**

The current study adds to the literature on the effects of expert testimony by adding in new aspects such as diagnostic labels and the interactions between those labels and linkage of testimony. This study also replicated gender effects and the effects of RMA that have been found in previous studies. This study found that the linkage of the testimony to the victim's behavior had an effect on the final verdict, the participants' belief that the sexual assault occurred, and perceptions of the involved parties. Future research is needed to understand further the link between the linkage variable and perceptions of the involved parties, which has legal implications. Future research should also study jurors' perceptions of general rape myth expert testimony versus PTSD expert testimony as this also has legal implications.

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## Appendices

### Appendix A: Vignettes

The first part of the Vignette participants receive:

The following is a summary of a Sexual Assault case. Your job is to assume the role of juror, and determine, based on the evidence presented, whether the defendant is guilty or not guilty. Please pay careful attention to the materials provided and refrain from making judgments about the case until asked to do so.

As a juror, pay attention to the facts of the case as they are presented to you. Do not let your personal feelings or political leanings about the case and its implications sway your judgment about the case.

In the court of law, an expert who is qualified by education or experience may testify to aspects of a case that they are knowledgeable about. You, as a juror are not bound by this testimony and are free to use it or reject it as you please.

You will now read information about the case.

On the night in question, the defendant (John) and the plaintiff (Karen) were on a blind date that had been set up through mutual friends. They had finished dinner and were having a good time so John invited Karen back to his house for coffee and dessert. Karen claims that when they were done with their coffee, John initiated contact by kissing her. She claims that she returned kissing but she tried to stop further advances. Karen claims that this was when John sexually assaulted her by having intercourse with her. Karen left the apartment shortly after the incident. She did not tell anyone about the incident until

she told her best friend three days after the incident because she did not want to think about what happened. Her friend encouraged her to file a police report. John claims that Karen had returned his advances and said that she wanted to have intercourse with him. John says that Karen was just embarrassed that she had had sex on the first date and that she's saying he raped her so people will not think that she's promiscuous. Karen claims that she has suffered psychological trauma from this incident. She claims that she cannot sleep, cannot eat, has nightmares about the event, cannot seem to care about her work, feels like nobody can understand her, and is devastatingly angry with herself for going on that date.

You will now read the expert testimony from Dr. Williams, who was hired by the prosecution. He has a PhD in clinical psychology and has twenty years of clinical experience.

Condition Specific parts of the vignettes:

Vignette #1: No diagnosis

Dr. Williams: "The general public holds some mythical beliefs about rape victim's behaviors during and after the assault occurs because they may seem unusual or counterintuitive. I am here today to give you all some more information on those myths. There are some 'unusual' behaviors that a victim may exhibit during the assault, such as failing to fight or resist during the assault, not actually saying no to the assailant, and having a relationship with the perpetrator prior to the assault. It has been demonstrated that all of these behaviors are actually quite common during sexual assault scenarios. The victim does not need to say no or physically fight back for rape to occur. Similarly,

sexual assault is more often carried out by acquaintances of the victim than by strangers, so there is a strong possibility that the victim had a relationship with her rapist. There are also many behaviors that may occur after the fact that the general public finds confusing or unusual. They might include having no physical injuries from the assault, delaying a report to the police or not reporting at all, not being able to recall parts of the assault, being unable to identify their attacker, exhibiting no emotion about the assault, giving inconsistent statements regarding the assault, blaming oneself for the assault, or recanting their statement. Again, these have empirically been proven to be common reactions to sexual assault. They may seem counterintuitive to the general public but they are validated reactions to sexual assault.”

This concludes Dr. Williams’ testimony.

#### Vignette #2: PTSD Level 2

Dr. Williams: “The general public holds some mythical beliefs about rape victim’s behaviors during and after the assault occurs because they may seem unusual or counterintuitive. I am here today to give you all some more information on those myths. There are some ‘unusual’ behaviors that a victim may exhibit during the assault, such as failing to fight or resist during the assault, not actually saying no to the assailant, and having a relationship with the perpetrator prior to the assault. It has been empirically proven that all of these behaviors are actually quite common during sexual assault scenarios. The victim does not need to say no or physically fight back for rape to occur. Similarly, sexual assault is more often carried out by acquaintances of the victim than by strangers, so there is a large possibility that the victim had a relationship with her rapist.

There are also many behaviors that may occur after the fact that the general public finds confusing or unusual. They might include having no physical injuries from the assault, delaying a report to the police or not reporting at all, not being able to recall parts of the assault, being unable to identify their attacker, exhibiting no emotion about the assault, giving inconsistent statements regarding the assault, blaming oneself for the assault, or recanting their statement. Again, these have empirically been proven to be common reactions to sexual assault. They may seem counterintuitive to the general public but they are validated reactions to sexual assault.

I am also here today to speak about Posttraumatic Stress Disorder (PTSD). PTSD is a common diagnosis for rape victims to have following a sexual assault. To put some numbers to this claim, 90% of rape victims experience PTSD symptoms immediately after the rape and about 15% of rape survivors are diagnosed with lifelong PTSD. This means that rape victims are the most common group of trauma victims who suffer from PTSD. There are eight diagnostic criteria for a PTSD diagnosis to be warranted. The first is exposure to a stressor, such as death, threatened or actual serious injury, or threatened or actual sexual violence. The second criterion is that the person persistently re-experiences the event in at least one of the following ways: recurrent, involuntary and intrusive memories, traumatic nightmares, dissociative reactions (flashbacks), intense or prolonged distress after being exposed to triggers, or marked physiological reactivity after exposure to triggers. The third criterion is persistent effortful avoidance of at least one of the following triggers: trauma-related thoughts or feelings, or trauma-related external reminders. The fourth criterion is negative alterations in cognitions and mood that began or worsened after the traumatic event. The person

must exhibit at least two of the following: inability to recall key features of the traumatic event, persistent negative beliefs about oneself or the world, persistent distorted blame of self or others, persistent negative trauma-related emotions, diminished interest in pre-traumatic activities, feeling alienated from others, or inability to experience positive emotions. The fifth criterion is alterations in arousal and reactivity, in which the person must show at least two of the following: irritable or aggressive behaviors, self-destructive or reckless behavior, hypervigilance, exaggerated startle response, problems in concentration, and sleep disturbance. The sixth criterion states that the persistence of symptoms must be longer than one month. The seventh criterion states that these symptoms must be severe enough to interfere with daily life. The last criterion states that these disturbances cannot be due to other factors.

As you can see, many of these symptoms overlap with common post-rape behaviors of the victim. However, some do not and the absence or presence of a PTSD diagnosis does not indicate that the rape did or did not occur.

This concludes Dr. Williams' testimony.

### Vignette #3: PTSD Level 3

Dr. Williams: "The general public holds some mythical beliefs about rape victim's behaviors during and after the assault occurs because they may seem unusual or counterintuitive. I am here today to give you all some more information on those myths. There are some 'unusual' behaviors that a victim may exhibit during the assault, such as failing to fight or resist during the assault, not actually saying no to the assailant, and having a relationship with the perpetrator prior to the assault. It has been empirically

proven that all of these behaviors are actually quite common during sexual assault scenarios. The victim does not need to say no or physically fight back for rape to occur. Similarly, sexual assault is more often carried out by acquaintances of the victim than by strangers, so there is a large possibility that the victim had a relationship with her rapist. There are also many behaviors that may occur after the fact that the general public finds confusing or unusual. They might include having no physical injuries from the assault, delaying a report to the police or not reporting at all, not being able to recall parts of the assault, being unable to identify their attacker, exhibiting no emotion about the assault, giving inconsistent statements regarding the assault, blaming oneself for the assault, or recanting their statement. Again, these have empirically been proven to be common reactions to sexual assault. They may seem counterintuitive to the general public but they are validated reactions to sexual assault.

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to triggers. The third criterion is persistent effortful avoidance of at least one of the following triggers: trauma-related thoughts or feelings, or trauma-related external reminders. The fourth criterion is negative alterations in cognitions and mood that began or worsened after the traumatic event. The person must exhibit at least two of the following: inability to recall key features of the traumatic event, persistent negative beliefs about oneself or the world, persistent distorted blame of self or others, persistent negative trauma-related emotions, diminished interest in pre-traumatic activities, feeling alienated from others, or inability to experience positive emotions. The fifth criterion is alterations in arousal and reactivity, in which the person must show at least two of the following: irritable or aggressive behaviors, self-destructive or reckless behavior, hypervigilance, exaggerated startle response, problems in concentration, and sleep disturbance. The sixth criterion states that the persistence of symptoms must be longer than one month. The seventh criterion states that these symptoms must be severe enough to interfere with daily life. The last criterion states that these disturbances cannot be due to other factors.

As you can see, many of these symptoms overlap with common post-rape behaviors of the victim. However, some do not and the absence or presence of a PTSD diagnosis does not indicate that the rape did or did not occur.

The symptoms that Karen claims that she is suffering from are consistent with those that would be seen in a PTSD patient.

This concludes Dr. Williams' testimony.

Vignette #4: PTSD Level 4

Dr. Williams: “The general public holds some mythical beliefs about rape victim’s behaviors during and after the assault occurs because they may seem unusual or counterintuitive. I am here today to give you all some more information on those myths. There are some ‘unusual’ behaviors that a victim may exhibit during the assault, such as failing to fight or resist during the assault, not actually saying no to the assailant, and having a relationship with the perpetrator prior to the assault. It has been empirically proven that all of these behaviors are actually quite common during sexual assault scenarios. The victim does not need to say no or physically fight back for rape to occur. Similarly, sexual assault is more often carried out by acquaintances of the victim than by strangers, so there is a large possibility that the victim had a relationship with her rapist. There are also many behaviors that may occur after the fact that the general public finds confusing or unusual. They might include having no physical injuries from the assault, delaying a report to the police or not reporting at all, not being able to recall parts of the assault, being unable to identify their attacker, exhibiting no emotion about the assault, giving inconsistent statements regarding the assault, blaming oneself for the assault, or recanting their statement. Again, these have empirically been proven to be common reactions to sexual assault. They may seem counterintuitive to the general public but they are validated reactions to sexual assault.

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There are certain diagnostic criteria for a PTSD diagnosis to be warranted. The first is exposure to a stressor, such as death, threatened or actual serious injury, or threatened or actual sexual violence. The second criterion is that the person persistently re-experiences the event in at least one of the following ways: recurrent, involuntary and intrusive memories, traumatic nightmares, dissociative reactions (flashbacks), intense or prolonged distress after being exposed to triggers, or marked physiological reactivity after exposure to triggers. The third criterion is persistent effortful avoidance of at least one of the following triggers: trauma-related thoughts or feelings, or trauma-related external reminders. The fourth criterion is negative alterations in cognitions and mood that began or worsened after the traumatic event. The person must exhibit at least two of the following: inability to recall key features of the traumatic event, persistent negative beliefs about oneself or the world, persistent distorted blame of self or others, persistent negative trauma-related emotions, diminished interest in pre-traumatic activities, feeling alienated from others, or inability to experience positive emotions. The fifth criterion is alterations in arousal and reactivity, in which the person must show at least two of the following: irritable or aggressive behaviors, self-destructive or reckless behavior, hypervigilance, exaggerated startle response, problems in concentration, and sleep disturbance. The sixth criterion states that the persistence of symptoms must be longer than one month. The seventh criterion states that these symptoms must be severe enough to interfere with daily life. The last criterion states that these disturbances cannot be due to other factors.

As you can see, many of these symptoms overlap with common post-rape behaviors of the victim. However, some do not and the absence or presence of a PTSD diagnosis does not indicate that the rape did or did not occur.

The symptoms that Karen claims that she is suffering from are consistent with those that would be seen in a PTSD patient. The alleged sexual violence would qualify her for the first criterion. The second criterion is satisfied by her nightmares concerning the assault. The third criterion is met by her avoidance of thinking about the event. The fourth criterion is met as she blames herself for going on that date and feels alienated from others. The fifth criterion is met as she cannot sleep and cannot concentrate on her work. She has had these symptoms since the assault occurred six months ago and they impair her daily life.”

This concludes Dr. Williams’ testimony.

#### Vignette #5: RTS Level 2

Dr. Williams: “The general public holds some mythical beliefs about rape victim’s behaviors during and after the assault occurs because they may seem unusual or counterintuitive. I am here today to give you all some more information on those myths. There are some ‘unusual’ behaviors that a victim may exhibit during the assault, such as failing to fight or resist during the assault, not actually saying no to the assailant, and having a relationship with the perpetrator prior to the assault. It has been empirically proven that all of these behaviors are actually quite common during sexual assault scenarios. The victim does not need to say no or physically fight back for rape to occur. Similarly, sexual assault is more often carried out by acquaintances of the victim than by

strangers, so there is a large possibility that the victim had a relationship with her rapist. There are also many behaviors that may occur after the fact that the general public finds confusing or unusual. They might include having no physical injuries from the assault, delaying a report to the police or not reporting at all, not being able to recall parts of the assault, being unable to identify their attacker, exhibiting no emotion about the assault, giving inconsistent statements regarding the assault, blaming oneself for the assault, or recanting their statement. Again, these have empirically been proven to be common reactions to sexual assault. They may seem counterintuitive to the general public but they are validated reactions to sexual assault.

I am also here today to speak about Rape Trauma Syndrome (RTS). Rape Trauma Syndrome is a two-phase description of the commonly shared experiences of rape survivors as seen in the emergency room. There is an “acute” stage that covers the symptoms of extreme fear, as well as other emotional, physical, and psychological symptoms as seen immediately after a rape. In the acute stage, a victim may be in shock or disbelief of what occurred. Once the victim moves past this, they will be hit with extreme fear. The victim then may experience a wide range of feelings from humiliation, guilt, anger, or depression. Victims may have sleep and appetite issues. They may have trouble doing everyday tasks or may completely overhaul their life and change everything that reminds them of the assault. There is a second “reorganizational” stage that outlines the long-term recovery process. In this stage, victims may attempt to return to their lives as if nothing had happened. They may avoid all reminders of the assault and appear as though they have moved on from the assault even though there are still many emotional issues associated with it. They may have difficulty concentrating and may exhibit

depression. The victim may also develop extreme phobias and/or feelings of self-blame. Eating and sleep disturbances can also continue into this time.

As you can see, many of these symptoms overlap with common post-rape behaviors of the victim. However, some do not and the absence or presence of a RTS diagnosis does not indicate that the rape did or did not occur.”

This concludes Dr. Williams’ testimony.

#### Vignette #6: RTS Level 3

Dr. Williams: “The general public holds some mythical beliefs about rape victim’s behaviors during and after the assault occurs because they may seem unusual or counterintuitive. I am here today to give you all some more information on those myths. There are some ‘unusual’ behaviors that a victim may exhibit during the assault, such as failing to fight or resist during the assault, not actually saying no to the assailant, and having a relationship with the perpetrator prior to the assault. It has been empirically proven that all of these behaviors are actually quite common during sexual assault scenarios. The victim does not need to say no or physically fight back for rape to occur. Similarly, sexual assault is more often carried out by acquaintances of the victim than by strangers, so there is a large possibility that the victim had a relationship with her rapist. There are also many behaviors that may occur after the fact that the general public finds confusing or unusual. They might include having no physical injuries from the assault, delaying a report to the police or not reporting at all, not being able to recall parts of the assault, being unable to identify their attacker, exhibiting no emotion about the assault, giving inconsistent statements regarding the assault, blaming oneself for the assault, or

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As you can see, many of these symptoms overlap with common post-rape behaviors of the victim. However, some do not and the absence or presence of a RTS diagnosis does not indicate that the rape did or did not occur.

The symptoms that Karen claims that she is suffering from are consistent with those that would be seen in a patient with RTS.”

This concludes Dr. Williams’ testimony.

#### Vignette #7: RTS Level 4

Dr. Williams: “The general public holds some mythical beliefs about rape victim’s behaviors during and after the assault occurs because they may seem unusual or counterintuitive. I am here today to give you all some more information on those myths. There are some ‘unusual’ behaviors that a victim may exhibit during the assault, such as failing to fight or resist during the assault, not actually saying no to the assailant, and having a relationship with the perpetrator prior to the assault. It has been empirically proven that all of these behaviors are actually quite common during sexual assault scenarios. The victim does not need to say no or physically fight back for rape to occur. Similarly, sexual assault is more often carried out by acquaintances of the victim than by strangers, so there is a large possibility that the victim had a relationship with her rapist. There are also many behaviors that may occur after the fact that the general public finds confusing or unusual. They might include having no physical injuries from the assault, delaying a report to the police or not reporting at all, not being able to recall parts of the assault, being unable to identify their attacker, exhibiting no emotion about the assault, giving inconsistent statements regarding the assault, blaming oneself for the assault, or recanting their statement. Again, these have empirically been proven to be common reactions to sexual assault. They may seem counterintuitive to the general public but they are validated reactions to sexual assault.

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As you can see, many of these symptoms overlap with common post-rape behaviors of the victim. However, some do not and the absence or presence of a RTS diagnosis does not indicate that the rape did or did not occur.

The symptoms that Karen claims that she is suffering from are consistent with those that would be seen in a patient with RTS. In the acute stage, she exhibited many of the feelings that are common to this stage such as disbelief, humiliation, guilt, and

depression. She also exhibited sleep and appetite issues at this stage as well as an inability to function in her normal routine. In her reorganizational stage, she has tried to get back to life as usual, although she still exhibits difficulty with concentration and depression. The feelings of self-blame as well as eating and sleeping disturbances have continued as well.”

This concludes Dr. Williams’ testimony.

## **Appendix B: Vignette measures**

### Manipulation Checks

Did the expert offer a diagnosis of any sort during the testimony?

- A. Yes
- B. No

What diagnosis did they speak about?

- A. Posttraumatic Stress Disorder (PTSD)
- B. Rape Trauma Syndrome (RTS)

Did the expert diagnose the plaintiff?

- A. Yes
- B. No

Did the expert explicitly link the plaintiff’s condition to the way the plaintiff acted in the case?

- A. Yes
- B. No

### Items

1. How do you find the defendant?
  - Guilty
  - Not Guilty



1	2	3	4	5	6
Strongly					Strongly
Disagree					Agree

I feel that a person's efforts are noticed and rewarded.

1	2	3	4	5	6
Strongly					Strongly
Disagree					Agree

I feel that people earn the rewards and punishments they get.

1	2	3	4	5	6
Strongly					Strongly
Disagree					Agree

I feel that people who meet with misfortune have brought it on themselves.

1	2	3	4	5	6
Strongly					Strongly
Disagree					Agree

I feel that people get what they deserve.

1	2	3	4	5	6
Strongly					Strongly
Disagree					Agree

I feel that rewards and punishments are fairly given.

1	2	3	4	5	6
Strongly					Strongly
Disagree					Agree

I basically feel that the world is a fair place.

1	2	3	4	5	6
Strongly					Strongly
Disagree					Agree

Updated Illinois Rape Myth Acceptance Scale

If a girl acts like a slut, eventually she is going to get into trouble.

1	2	3	4	5
Strongly				Strongly
Disagree				Agree

When girls get raped, it's often because the way they said "no" was unclear.

1	2	3	4	5
Strongly				Strongly
Disagree				Agree

If a girl initiates kissing or hooking up, she should not be surprised if a guy assumes she wants to have sex.

1	2	3	4	5
Strongly				Strongly
Disagree				Agree

Guys don't usually intend to force sex on a girl, but sometimes they get too sexually carried away.

1	2	3	4	5
Strongly				Strongly
Disagree				Agree

If a guy is drunk, he might rape someone unintentionally.

1	2	3	4	5
Strongly				Strongly
Disagree				Agree

If both people are drunk, it can't be rape.

1	2	3	4	5
Strongly				Strongly
Disagree				Agree

If a girl doesn't physically fight back, you can't really say it was rape.

1	2	3	4	5
Strongly				Strongly
Disagree				Agree

A rape probably didn't happen if a girl doesn't have any bruises or marks.

1	2	3	4	5
Strongly				Strongly
Disagree				Agree

If a girl doesn't say "no" she can't claim rape.

1	2	3	4	5
Strongly				Strongly
Disagree				Agree

A lot of times, girls who say they were raped agreed to have sex and then regret it.

1	2	3	4	5
Strongly				Strongly
Disagree				Agree

Rape accusations are often used as a way of getting back at guys.

1	2	3	4	5
Strongly				Strongly
Disagree				Agree

A lot of times, girls who claim they were raped have emotional problems.

1	2	3	4	5
Strongly				Strongly
Disagree				Agree

#### **Appendix D: Demographic Questions**

1. What is your Gender?
  - a. Male
  - b. Female
  - c. Other
2. What is your age? \_\_\_\_\_
3. What is your ethnicity?
  - a. Caucasian
  - b. African American
  - c. Asian
  - d. Hispanic
  - e. Pacific Islander
  - f. Other
4. What is your highest level of education attained?
  - a. Some high school
  - b. Graduated high school/GED
  - c. Some college
  - d. Associate degree
  - e. Bachelor's degree
  - f. Graduate or Professional degree
5. Have you been sexually assaulted?
  - a. Yes
  - b. No
6. Has someone close to you been sexually assaulted?
  - a. Yes
  - b. No

7. Have you been accused of sexual assault?
  - a. Yes
  - b. No
8. Has someone close to you been accused of sexual assault?
  - a. Yes
  - b. No

### **Appendix E: Debriefing Form**

Thank you for participating in the study. We would now like to tell you a little more about what we were studying today.

We are interested in understanding how expert testimony concerning specific disorders in sexual assault cases affects jurors perceptions of the people involved in the case and their verdict decisions. In sexual assault cases, especially when the details are ambiguous, it tends to become a he said she said situation. Expert testimony can help to clear up some of the ambiguity for the jury. Therefore, it is essential that we know as much as possible about the subject.

For this reason, we had to make the process as realistic as possible and therefore explicitly outlined a sexual assault. We understand that this may have made you uncomfortable and we apologize for that. However, this is very important research and it was essential to the methodology that the vignette be so explicit. In sexual assault cases, experts can testify about the victim having Posttraumatic Stress Disorder (PTSD) or Rape Trauma Syndrome (RTS). It has been shown that an expert testifying about RTS can give the plaintiff higher credibility so I'm interested if PTSD will have a similar effect. There has not been any research done on PTSD in this context yet. Since PTSD is the common diagnosis being used in court today, it is imperative that more research be done on it.

If you feel like you need support following this survey, please contact the National Sexual Assault Hotline (RAINN) at 1.800.656.HOPE or <https://www.rainn.org/get-help/national-sexual-assault-hotline>.

Thank you for your participation!