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Answering the Questions of Rape Prevention Research: A Response to Tharp et al. (2011)

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Abstract

Rape prevention programmers and researchers have long struggled to select the most appropriate theoretical models to frame their work. Questions abound regarding appropriate standards of evidence for success of program interventions. The present article provides an alternative point of view to the one put forward by seven staff members from the U.S. Centers for Disease Control and Prevention (Tharp et al., 2011). Questions are posed for readers to consider regarding the appropriateness of the medical model for rape prevention programs, whether randomized control trials are the one and only gold standard, whether programs presented to groups should be evaluated at the group or individual level, whether subscribing to principles of prevention selected by the CDC for other disciplines translate well to rape prevention, what constitutes sufficient dosage, and what constitutes a rigorous research program studying an evolving rape prevention intervention.

Keywords

prevention, sexual assault, rape, alcohol and drugs

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Tharp and her six colleagues from the United States Centers for Disease Control and Prevention have provided the sexual assault prevention field with a valuable opportunity to consider several questions about effective means for reaching shared end goals (Tharp et al., 2011). I am thankful for the opportunity to pose several questions that relate broadly to the themes they address. These questions are of critical importance to those who wish to end rape on college campuses, in the military, and in our nation's communities.

Is the medical model most appropriate to guide rape prevention programs? In their commentary, Tharp and her CDC colleagues cling to a model that views rape as a disease that needs to be treated much like influenza, meningitis, or tuberculosis. One must ask whether rape is more like the flu or if it more like other social problems such as domestic violence, armed robbery, or attempted murder. How this question is answered has dramatic effects on rape-prevention program design. If rape is more like the flu, then it logically follows that we should develop a vaccine-like intervention, inoculate the entire population of offenders with a sufficient medicinal dosage (e.g., 5 doses, 10 doses, 25 doses), and develop effective booster shots as needed. If rape is more like domestic violence, armed robbery, or attempted murder, it follows that we should treat it as a complex social problem involving social interaction that should be approached with theoretical models based in attitude and behavior change theories rooted in the social sciences of psychology and sociology. One such theory in the social sciences is belief system theory. A comprehensive review of the literature on interventions based on belief system theory found that behavior can be changed by a single intervention (Grube, Mayton, & Ball-Rokeach, 1994) and that such changes can last for years. It is critical that we answer the question of whether the medical model is the most appropriate model for rape-prevention programs, particularly in light of other models that hold great, perhaps greater, promise for the field.

Is a randomized control trial the one and only gold standard? If one is trying to determine whether a vaccine prevents AIDS, few would dispute the fact that the answer to this question is yes. If we are studying complex social behavior where measured dependent variables cannot be assessed using a blood test, a broader range of assessment methods seem warranted. Researchers who study social behavior often advocate method triangulation (Hesse-Biber & Leavy, 2008; Jones, Torres, & Arminio, 2006; Patton, 2002). If one limits outcomes research to quantitative methods, a program evaluator imposes a framework of assumptions on what behaviors could be changing among participants. Critical variables where movement occurs can easily be missed. If an evaluation is limited to qualitative methods, results cannot be generalized. However, together, quantitative and qualitative research makes for a powerful, more

complete picture of program impact that alone they cannot produce (Hesse-Biber & Leavy, 2008; Patton, 2002). Indeed a randomized controlled study is a powerful quantitative design that is valuable as one part of a comprehensive evaluation protocol. There are also other important methods that can be used, are of great value, and can be highly informative about program impact. More importantly, evidence for behavior change can be demonstrated using both quantitative and qualitative measures (Hesse-Biber & Leavy, 2008; Patton, 2002). Often if you want to know whether a participant's behavior changed, the best way to determine this is to ask a direct question and permit the participant to answer in his or her own words rather than presuming you know the precise question to ask in the first place.

Should interventions presented to intact groups be evaluated at the group or individual level? Tharp and her CDC colleagues suggest that if a randomized assignment of program condition is made at the group level, rather than the individual level, this constitutes a serious flaw (Tharp et al., 2011). Such an assertion raises the question about whether a program effect in a college environment is primarily at the group or individual level. This largely depends on the group to which a program is presented. With rape-prevention programs, many of which include bystander components (e.g., Foubert, 2011), if a program is presented to a residence hall floor or suite, to athletic teams, or to fraternities, one would expect that effects would occur within the intact social group where such bystander behavior is needed. Thus, it seems reasonable for program evaluators to randomly assign groups to conditions for such programs, rather than individuals. If effects are hypothesized to be primarily at the individual level, then random assignment at the individual level would indeed make sense.

Which "principles of prevention" are most appropriate to use when working to prevent sexual assault? Tharp et al. (2011) are critical of those who do not follow "*the principles of prevention*" (Tharp et al., 2011, p. 2). The logical questions that follow from this statement is what principles, who wrote them, and with what assumptions? In this case, Tharp et al. (2011) put forward a model from the agency that employs them, written based on populations that are outside the realm of rape prevention, set it up as the only acceptable one on which to base a program without offering any evidence that a program based on the model has produced a single outcome in the field of rape prevention. The reader is supposed to make the leap with them that the medical model can be generalized to rape prevention, thus concluding that it is appropriate to use in rape prevention.

Effective practices in the areas of violence, delinquency, substance abuse, sexual risk, and school failure might be helpful when considering the field of rape prevention. However, one must ask if they are *the principles of prevention*

to the exclusion of all others. In the field of rape prevention, excluding innovative ideas that fall outside a questionable set of principles that are not based on rape-prevention research could lead to dismissing an idea that could end rape. Is that wise?

Tharp and her CDC colleagues are highly critical of research rooted outside the medical model, including studies funded by the U.S. Department of Education that are both based in the social sciences and have shown evidence of decreasing sexual assault behavior as shown by both quantitative and qualitative studies (e.g., Foubert, Godin, & Tatum, 2010; Foubert, Newberry, & Tatum, 2007). They continue to defend a medical model that thus far has not produced a single intervention demonstrating evidence of a lasting decrease in sexual assault behavior among college men for an academic year. This raises the question for all researchers about how best to handle information when it contradicts our assumptions. Instead of dismissing results driven by another model because it does not fit our chosen theoretical model, sometimes it is necessary to reconsider the theory we cling to in our work if it is not working or consider another one that is working better.

What constitutes sufficient dosage? Many rape-prevention programs, evaluated or not, last for 1 hr. This is roughly the maximum attention span of a traditionally aged college student and, sadly, is also the maximum amount of time that many college campuses and military units will provide to a program. Still, several pieces of evidence support the conclusion that after exposure to a 1-hr program, including The Men's Program (Foubert, 2011), behavior change occurs. This can lead a discerning scholar to any number of conclusions. One possibility is to reexamine preconceived notions driven by the medical model that behavior change is impossible through a 1-hr presentation. Another possibility is that the results of research with a Solomon 4 square design with a randomly selected control group of participants that showed 40% fewer acts of sexual assault committed by program participants relative to a control group 7 months after program participation constitutes sufficient treatment dosage and sufficient evidence to suggest behavior change (Foubert et al., 2007). One also must ask whether 79% of men are telling the truth or are lying when they respond affirmatively and in detail to open-ended questions 2 years after participating in The Men's Program about ways in which their attitudes and/or behavior changed as a result of program participation (Foubert, Godin, et al., 2010).

One must have a great deal of faith in the medical model to believe that several hundred men are lying about their experience. Those interested in working toward the goal of ending rape, not just decreasing it, should indeed advocate for multiple interventions. However, the a priori assumption that a

single program constitutes insufficient dosage is contradicted by the quantitative and qualitative data and of several hundred research participants (Foubert, Godin, et al., 2010; Foubert & Newberry, 2006; Foubert et al., 2007; Foubert & Perry, 2007; Langhinrichsen-Rohling, Foubert, Brasfield, Hill, & Shelley-Tremblay, 2011).

What constitutes a rigorous research program studying an evolving rape prevention intervention? It is a limitation within the field of sexual violence prevention that many programs remain static, are not evaluated, and moreover that institutions continue to use programs that have no desired or even negative outcomes. If prevention programs do not keep evolving in light of recent research on their effectiveness, we have no hope of meeting their objectives to end sexual violence.

Published evaluations of The Men's Program (Foubert, 2011) provide one example of how to use data to accomplish the mutual objectives of revising a program to improve its efficacy and to demonstrate its progressively more comprehensive effects. For example, the earliest version of The Men's Program was evaluated in progressively more complex studies and found to result in a decline in rape myth acceptance for 2 months (Foubert & Marriott, 1997) and then a decline in rape myth acceptance and likelihood of raping for 7 months (Foubert, 2000). Qualitative research clarified the latter result, which help determine the attitudes and behaviors that changed as a result of program participation (Foubert & LaVoy, 2000). These findings informed a revision of the program script, together with a new stimulus video that was produced with feedback from a national constituency of experts, in an attempt to increase program efficacy.

Next, in an unpublished study, focus groups were held with college men who saw a revised version of The Men's Program and were then asked a series of questions designed to determine what else needed to be added to the program to change their sexually aggressive behavior. The major result from this inquiry is that the program in its current form lacked information about alcohol. This information was then integrated into another new version of The Men's Program.

This new version was then tested on 4 focus groups, two groups of fraternity men and two groups of student athletes (Foubert & Cowell, 2004). A 5-month follow-up was also conducted using open-ended questions with each participant, every one of whom responded (Foubert & Perry, 2007). These studies suggested strong attitude change and lasting behavior change, respectively. They also suggested the need for further program revisions to document changes in sexually aggressive behavior.

In an unpublished study, three experimental program modules were designed as additions to the then current version of The Men's Program. The modules were presented to focus groups of college men, who reacted to each. Two received favorable reactions, and one did not. Either of these two program modules were then added to the end of The Men's Program and were presented to randomly selected fraternities on a campus and were compared with an untreated control group (Foubert & Newberry, 2006). All fraternities on that campus volunteered to participate in the study and were randomly assigned to the three conditions. A program version emphasizing bystander intervention outperformed the version that emphasized defining consent and also outperformed a control group on measures of rape myth acceptance, likelihood of raping, and likelihood of committing sexual assault. Therefore, a bystander intervention component was made a permanent fixture of yet another new version of The Men's Program.

With funds from a U.S. Department of Education grant, a series of studies was then undertaken to evaluate the impact of this improved version of The Men's Program. A multimethods study was used to gain the most complete picture of possible program effects. Randomized assignment of 1st-year students by residence hall floor was used to assess the impact of our program within intact communities. Both quantitative and qualitative measures were used at several checkpoints including immediately after, 7 months after, and 2 years after program participation. Control group assessments were made when program participants saw The Men's Program and at the time of the 7-month follow-up. Immediately after the control group 7-month assessment, they saw The Men's Program. For ethical reasons, we could not justify delaying presentation of a rape-prevention program to 1st-year students in college beyond the end of their 1st year. Though it would have been valuable to our 2-year research design to delay presentation to the end of their sophomore year, this was palatable neither to the institution nor to our consciences, given the known positive effects of the program involved.

To facilitate transparency and sharing results with the scholarly community throughout our research process, several evaluations were shared in the scholarly literature based on this 2-year study. The first evaluation of this new version of The Men's Program that added a bystander intervention component was qualitative, to shed light on how a newly redesigned program affected men's attitudes and behavior. Results showed that half of the 1st-year men wrote that they intended to change their behavior by intervening to help prevent rape or by changing their own behavior so as not to be a perpetrator (Foubert, Tatum, & Donahue, 2006). Putting these accounts in their own words helped researchers determine the precise intent of the participant, instead of guessing ahead of time what the effects could be.

The next study published demonstrated through a Solomon 4 design that a year after seeing The Men's Program, 40% fewer men who joined fraternities reported committing sexually aggressive acts compared with fraternity men in a control group (Foubert et al., 2007). Moreover, the severity of sexual aggression among untreated fraternity men was eight times higher compared with men who saw The Men's Program. This study was the first study to show a decline in sexually aggressive acts among college men when compared with a control group, and it remains the only published study of its kind that shows a year-long effect on the sexually aggressive behavior of college men.

Two additional studies were shared with the scholarly community to amplify on and then extend these findings. First, a qualitative study used in method triangulation at the 7-month follow-up found that two thirds of participants reported either attitude or behavior change during the preceding academic year or that the program reinforced their current beliefs. Participants attributed these affects to The Men's Program, with many describing specific incidents of either intervening to prevent a rape or stopping themselves from engaging in risky behavior (Foubert, Tatum, et al., 2010). Next, a 2-year follow-up was conducted on only those participants who originally saw The Men's Program during the fall of their 1st year in college (Foubert, Godin, et al., 2010). Comparisons to a control group were no longer possible as the control group had been treated at the end of their 1st-year to comply with ethical standards. This study revealed that 2 years after seeing a 1-hr program, 79% of 184 1st-year men reported that due to seeing this program they had experienced either attitude change, behavior change, or both during their first 2 years of college. Specific ways in which these attitude and behavior changes manifested themselves were written out by participants in detail. These included ways men prevented rapes from happening and how they modified their behavior to avoid committing sexual assault.

If one assumes The Men's Program has remained the same since it was first written in 1993, one could incorrectly conclude that the same program has been evaluated for the last two decades using similar methods. As one can see, the most recent version of The Men's Program is the product of extensive refinement through strategic research. Published results surpass everything in the current literature about college men.

Conclusion

Ultimately, each individual will decide whether to use theory to guide practice, whether to heed the results of research when evaluating which intervention to use, and how to make decisions about evaluating what works. As the

field of rape prevention grapples with these complex questions, and how to answer them, it is of paramount importance to listen to the voices of our target populations and to look at the numbers when gauging program impact. It is also critical that we be willing to set aside allegiances to models if they do not produce the results that we expect, particularly when they do not apply to the field of rape prevention very well to begin with.

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Bio

John D. Foubert, PhD, is associate professor of college student development and Anderson, Farris, and Halligan professor of educational studies at Oklahoma State University. He teaches courses in college student development theory, advanced student development theory, group and cultural interventions, introduction to student affairs administration, master's theses, and supervision of internship experiences. He is the author of eight books including *The Men's and Women's Programs: Ending Rape Through Peer Education* and *Lessons Learned: How to Avoid the Biggest Mistakes Made by College Resident Assistants*. His more than 25 refereed articles have appeared

in journals such as the *Journal of American College Health*, the *Journal of College Student Development*, the *Journal of Personality and Social Psychology*, *Sex Roles*, the *Journal of Interpersonal Violence*, and *Violence Against Women*. He conducts research in several areas with the goal of bridging research and practice to promote social change. He is best known for his research in the area of sexual assault prevention. He also conducts research on college student development (psychosocial, moral, and spiritual) and on the connections between pornography use and violence against women. As principal investigator for a US\$275,000 U.S. Department of Education grant he found that The Men's Program is the only program in history ever shown to lead to a decline in sexual aggression for an academic year among high-risk college men who saw a program relative to a control group.