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# Rape Myth Acceptance: Implications for Counselor Education Programs

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# Rape Myth Acceptance: Implications for Counselor Education Programs

**Abstract**
Abstract

A sexually violent act or rape is committed every 1.9 minutes in the United States (USDJ, 2009, p.1). Blaming the rape victim for their perceived complicity is one component of the construct known as rape myth, a term identified by Burt (1980). This study explored and examined the perceptions, and understanding of sexual violence, rape, and rape myths by master's level counselors-in-training (n=5). Phenomenology and naturalistic inquiry guided the qualitative design and implementation. Suggestions for implementing rape education and training into counseling curriculums and clinical supervision are provided.

*Keywords:* rape myth, counselors-in-training, phenomenology

**Author's Notes**
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**Keywords**
Rape Myth, Counselors-in-training, Phenomenology, Counselor Education

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Susan Brownmiller's groundbreaking work *Against Our Will: Men, Women, and Rape,* defined rape as a "conscious process of intimidation by which all men keep all women in a state of fear" (Brownmiller, 1975, p. 15). This provocative statement was made over 39 years ago, yet the crime is still prevalent today and the act of rape continues to be a process of violence and intimidation. Rape is defined nationally as "the penetration, no matter how slight, of the vagina or anus with any body part or object, or oral penetration by a sex organ of another person, without the consent of the victim" (Rape Abuse and Incest National Network [RAINN], 2014). It is reported that one rape or attempted rape occurs every 2 minutes (United States Department of Justice [USDJ], 2009, p. 1), and one out of six U.S. women have experienced an attempted or completed rape in their lifetime (RAINN, 2015). Due to the violent, sexual, and personal nature of this crime, many misperceptions about rape and rape victims exist. In the early 1980's, Burt (1980) defined these misperceptions as rape myths.

Rape myths are beliefs held by many individuals within society that surround rape and sexual assault. Rape myths are untrue, can minimize the experience of rape, and are distinguished from rare situations in which the victim has fabricated details. These myths insinuate that victims are lying, imply a rape did not occur, or that the perpetrator was provoked (Franiuk, Seefelt, & Vandello, 2008). Other myths imply that the perpetrator could not control urges or that the victim deserved to be assaulted based on appearance, behavior, or style of dress (Edwards, Turchik, Dardis, Reynolds & Gidycz, 2011; Moor, 2007).

The uncritical acceptance of popular rape myths is a way for at-risk victims (i.e., women) to protect themselves from recognizing their own vulnerability to sexual assault, and for society to justify male sexual aggression against women (Edwards et al., 2011; Lonsway & Fitzgerald, 1994; Ryan, 2011). The same process also allows perpetrators to avoid responsibility for their

actions (Burt, 1980; Edwards et al., 2011). Some popular rape myths may include suggestions that women want or deserve to be raped if they dress provocatively, that "no" really means "yes" (as if playing hard to get), or women who chose to drink alcohol and were raped should have engaged in more appropriate decision making (Women Against Violence Against Women [WAVAW], 2015).

Given the heinous nature of sexual violence, rape victims are three times more likely than the general population to suffer from depression, six times more likely to suffer from Post Traumatic Stress Disorder (PTSD), 13 times more likely to abuse alcohol, 26 times more likely to abuse drugs, and four times more likely to contemplate suicide (RAINN, 2015, Who are the Victims, ¶ 2). Given these statistics, it is likely that counselors will provide services to a client who has survived rape. In fact, Dye and Roth (1990) reported from a sample of therapists and mental health professionals, 93% have treated at least one client who had been sexually assaulted. According to Hensley (2002), many survivors may not seek treatment until symptoms become pervasive and counselors often do not receive formal training in treating symptoms of rape and sexual violence.

Victims of rape may turn to counseling professionals to address their emotional and mental health concerns. These victims are tremendously impacted by the quality of the responses and social reactions to their disclosure of rape from informal (family and friends) and formal (counseling professionals) sources (Ahrens, Cabral, & Abeling, 2009; Campbell, Ahrens, Sefl, Wasco, & Barnes, 2001; Filipas & Ullman, 2001; Golding, Siege, Sorenson, Burnam, & Stein, 1989). The purpose of this study was to identify rape myth acceptance among master's level counselors-in-training. The authors explored the phenomenological experiences of five

master's level counselors-in-training including their perceptions and attitudes towards rape victims and the act of rape.

The authors recognize that men are also victims of sexual violence, however for the purpose of this study, we focus on female victims only. The terms survivor and victim are used interchangeably throughout this study. The authors recognize that many victims / survivors of rape identify as victims after the rape and as survivors as they begin their recovery process. We support that this identification is solely up to the victim / survivor.

**Review of the Relevant Literature**

Lonsway and Fitzgerald (1994) define rape myths as "attitudes and beliefs that are generally false but are widely and persistently held, and that serve to deny and justify male sexual aggression against women" (p. 134). This definition highlights the insidious nature of a process that is generally outside the awareness of most individuals and yet is a continual source of pain and confusion for survivors of sexual aggression. Rape myths come in many forms and are strongly connected to one's beliefs about sex role stereotyping, distrust of the opposite sex, sexist attitudes, acceptance of interpersonal violence (Burt, 1980; Chapleau, Oswald, & Russell, 2007), perceived social competence (Gamper, 2004), and false beliefs about the act of rape, victims, and perpetrators (Hammond, Berry & Rodriguez, 2011). Belief in rape myths is related to an individual's tolerance of interpersonal violence and violence towards women, a belief in traditional and restrictive gender roles for women, distrust of women, and men's hostile views towards women (Aronowitz, Lambert & Davidoff, 2012; Burt, 1980; Edwards et al., 2011; Lonsway & Fitzgerald, 1995). Acceptance of rape myths by society perpetuates the cycle of sexual violence against women.

**Social Support Responses**

Survivors of rape experience a wide range of feelings in response to the traumatic event. The most common feelings reported are fear, shame, guilt, anger, denial, depression, and other typical responses to trauma such as PTSD (Aronowitz, et al., 2012; Moor, 2007). Survivors often develop symptoms of depression, phobias, and sexual dysfunction, and may withdraw socially. Many survivors blame themselves for the assault, feel alienated from others, and become angry and confused about their intimate relationships (Dye & Roth, 1990; McLindon & Harms, 2011; Moor, 2007). Survivors report acceptance, support, empathy, and active listening as the most helpful reactions they receive from those to whom they disclose. Survivors acknowledge a greater sense of healing and lower PTSD and depressive symptoms when they have someone in their social network that believes their accounts of the assault (Campbell et al., 2001; Filipas & Ullman, 2001).

Most survivors will only tell a friend or family member about the assault, fewer will seek help from counselors, and an even smaller percentage will report to law enforcement. Almost two-thirds (59.3%) of rape victims report telling only a family member or close friend about the assault. Mental health professionals are the second most frequently told source (16.1%). Survivors who report to mental health professionals find them to be helpful only 70.1% of the time (Golding et al., 1989). A study by Campbell and Raja (1999) found that 58% of the mental health professionals who participated in the study believed that mental health practitioners engage in harmful therapeutic practices towards victims of rape and sexual assault. The most harmful and detrimental responses are direct and indirect responses that communicate blame towards the victim (Buddie & Miller, 2001; Filipas & Ullman, 2001).

Social responses that endorse rape myths could be perceived as victim blaming and may include responses that imply women are somehow responsible for the rape because of the way they dress or the behaviors they engage in, such as provocative dress or their level of sexual experience (White & Robinson Kurpius, 1999). Social reactions that are perceived as hurtful are also associated with increased distress. Negative reactions include calling the victim "irresponsible" and patronizing the victim (Campbell et al., 2001). Statements such as these make overcoming trauma more difficult and can contribute to poor mental health. Survivors of rape suffer the trauma of the assault itself and also from the effects of negative stereotypes, stigmas, and myths perpetuated by society about rape and victims of rape (Dye & Roth, 1990).

**Rape Myth Acceptance and Counselors**

McLindon and Harms (2011) noted that research which explores the beliefs of mental health workers and their understanding of the relationship between sexual assault and mental health is limited. Mental health professionals are more likely to demonstrate positive attitudes toward rape victims than the general public (Shechory & Idisis, 2006); however, these professionals have been found to hold negative, judgmental attitudes toward sexual assault victims (Dye & Roth, 1990; White & Robinson Kurpius, 1999). In an earlier study by White & Robinson Kurpius (1999), findings revealed that male mental health professionals hold more negative attitudes about rape victims than their female peers. They also concluded that male counselor trainees accept rape myths to a greater extent than their female counterparts especially when those male trainees had never counseled clients who had been sexually assaulted.

Counselors who demonstrate biased or judgmental speech or who experience strong emotional reactions to clients who have been raped may unwittingly be engaging rape myths. Negative or victim blaming responses may interfere with client progress and recovery during the

counseling process. It is essential for counselors who work with survivors of rape to carefully examine and reflect upon their attitudes and experiences related to rape so they may help clients understand and address their own guilt or self- blaming responses to the assault (Dye & Roth, 1990; Kassing & Prieto, 2003). The purpose of the present study was to understand the individual experiences and meanings constructed among counselors in training regarding the social phenomena known as rape myths. The researchers identified four guiding research questions (a) What are participants' perceptions and beliefs related to sexual violence and or rape? This included discussions about the causation and prevalence of sexual violence, explanations of its causation (facts and myths), and impact on survivors; (b) What are participants' beliefs regarding the origin of these facts and myths? (c) What are participants' perceptions, expectations and or experiences treating survivors of rape? (d) What do participants need from their training programs to work effectively with survivors of rape?

**Methods**

Phenomenology and naturalistic inquiry guided the qualitative design and implementation of this study. From a phenomenological perspective, knowledge about any complex phenomenon is socially constructed, subjective, and strongly influenced by social, cultural, and historical contexts (Boss, Dahl, & Kaplan, 1996; Merriam, 2009). The authors were influenced by a feminist perspective and an understanding of privilege (McIntosh, 1988), oppression (Hanna, Talley, & Guindon, 2000; Merriam, 2009), and power dynamics (Merriam, 2009). This inquiry focused on the personal experiences of counselors-in-training as they relate to their beliefs, bias, knowledge, and perceived level of comfort concerning survivors of rape. Quantitative data was obtained through the use of the Rape Myth Acceptance Scale (Burt,

1980). This study adhered to the American Counseling Association Code of Ethics (ACA, 2014).

**Role of the Researchers**

Due to the nature of qualitative research and the potential for researcher bias to impact results, the researchers have chosen to share their background information (Merriam, 2009). The personal and professional experiences of the researchers have influenced their interest in the topic of rape myths among counseling trainees. The first author is a white female who has worked with survivors of sexual assault for over fifteen years. She was the director of a rape crisis center and became interested in this line of research and inquiry as a result of clients self-reporting negative counseling experiences within her community.

The second author is a white female counselor educator who worked with survivors of sexual assault for seven years. As a former professional school counselor, she had the opportunity to work with children, military families, and the community around issues of trauma. She became interested in this research as a result of clinical and supervision experiences.

The third author is a white female counselor educator with over 20 years experience providing counseling to clients who have experienced the trauma of sexual violence as children or adults. She has been a counselor educator for over 10 years and served as an auditor on this research study.

**Participants**

Five (n=5) master's students drawn from a convenience sample of university students that were purposefully selected from a counseling program sample of 18 master's level counseling students served as participants for this study. Participants were solicited on a voluntary and uncompensated basis. Women constituted N=3 of the sample population and

males constituted N=2 of the sample population. N=4 participants were Caucasian and N=1 identified as Latino or Mexican American. Criteria for inclusion in the study included: participants who were in good standing in a master's of arts (or education) counseling program accredited by the Council for Accreditation of Counseling and Related Educational Programs (CACREP) within the Rocky Mountain region and current enrollment in a clinical practicum class.

**Data Sources**

**Instrument.** The *Rape Myth Acceptance Scale* (RMA) (Burt, 1980) is designed to measure the acceptance of rape myths and attitudes towards rape. The scale consists of 19 items assessed with a 7-point Likert scale; the items rate from strongly agree to strongly disagree. The scale has a reported Cronbach's alpha coefficient of (.875) on the final scale (Burt, 1980; Lonsway & Fitzgerald, 1994). Individuals' scores were drawn from the mean of their responses across all scale items. Thus, a score of 7 on the scale indicates no rape myth acceptance, while a score of 1 indicates strong agreement with all rape myths (Dye & Roth, 1990). The RMA scale was primarily used as a form of triangulation, which provided additional data and methods to explain the emerging phenomena and establish validity for the qualitative results. No individual level data from the RMA scale is reported (Merriam, 2009).

**Semi-structured interviews.** In addition to the four research questions, participants were also asked to respond to 10 structured questions or statements regarding their beliefs and experiences with sexual violence and rape. The following questions formed the basis of the semi-structured interview: (a) What is your knowledge or experience of sexual violence? (b) What did you hear growing up about women who were raped or sexually assaulted? (c) In your opinion, how or from where did these beliefs originate? (d) As of late, there have been high

profile cases in the media, what are your thoughts about these cases and their outcomes? (e) Describe any situations, circumstances or events where you believe a woman is responsible for rape. (f) Describe any situations, circumstances or events where you believe a perpetrator would be responsible for rape. (g) Describe your beliefs about rape within marital or committed relationships. (h) Describe your thoughts and feelings regarding the term date rape. (i) Describe gender roles for men and women in our society. (j) Tell me what you know and believe about stranger or non-acquaintance rape.

**Vignettes.** In addition to the 10 questions participants were asked to verbally discuss their responses to two vignettes. The first vignette involved a stranger rape scenario and the second vignette described an acquaintance rape scenario. Participants were read the two vignettes and then were asked to verbally discuss their responses about any similarities and differences between a stranger and acquaintance rape.

## Procedures

**Efforts to control bias.** Prior to interviewing participants, the researchers documented their personal assumptions, biases and beliefs about possible participant responses in an epoch to control for bias. The epoch also served as a check against unintended bias during the coding and analysis of participant interviews. Accuracy of details and information and control of personal bias throughout was insured by use of an auditor, an audit trail and detailed field notes. Upon approval from the Institutional Review Board, the first and second authors contacted practicum students to recruit voluntary participants. As a result, 5 out of 18 voluntarily agreed to participate and were provided with informed consent and a pseudonym to insure confidentiality. The research team was comprised of three counselor educators. The first and second authors made

initial contact with participants to schedule an interview time; the third author had no contact with participants.

At the initial meeting participants were asked to complete the RMA scale (Burt, 1980). The RMA scale was used to quantify participants' acceptance of rape myths and provide a point of triangulation with respect to the qualitative data derived from the semi-structured interviews. Interviews were conducted during the fall semester with the member checking follow-up interviews completed in the spring. Each interview included verbal responses to the semi-structured interview questions and dialogue about the scenarios described in the vignettes. Each of the five interviews lasted on average 45 minutes with the follow-up interviews lasting from 30 minutes to one hour.

In order to provide interviewer congruence, the first and second author conducted the first interview conjointly. Either the first or second author conducted the remaining interviews. The third author served as a research advisor and auditor and had no contact with participants—however, all three authors reviewed the interviews to identify major themes and findings. The individual interviews were audiotaped and then transcribed verbatim. Four of the five interviews were transcribed by the first and second authors, and one was transcribed by a professional transcriptionist.

**Data Analysis**

Formal analysis of the data began with the research team's collaborative use of an open coding process in order to identify themes that emerged from the first two transcripts. Participant statements were reviewed then grouped into 15 overarching categories. The research team reviewed and discussed the content and meaning of each statement. Through this process, thematic categories were collapsed and reformulated utilizing open coding procedures (Creswell,

2007) to insure that each member of the research team had a guide for coding the remaining transcripts. After identifying codes, the first and second authors conducted member checks and follow up interviews. Participants were asked to evaluate the accuracy of transcripts and the general themes applied in an individual meeting with the first or second author. There were no corrections or deletions made during follow up interviews. The auditor reviewed the transcripts, codes and statements from the member checking process; and after this process, the research team met a final time to solidify general themes.

**Results**

All participants attempted to complete the RMA scale; however, only three out of five (60%) completed all 19 items. It is unknown why the other two participants did not fully complete the RMA scale. The three participants (n=3; 2 males and 1 female) who completed the scale in its entirety appeared to have low overt acceptance of rape myths. Each participant scored between 20 and 25 out of a possible 140 total where M=23. A high score of 140 indicates strong acceptance of rape myths. There was no way to control for the influence of social desirability; therefore, these scores were used solely for the purpose of triangulation of the interview and member checking of data.

**Themes**

Initially, there were 15 themes present in the interviews. Six recurring themes were identified. The six themes included contradiction, silence, feelings of professional helplessness, gender expectations, victims' using poor judgment, and not calling rape, rape.

**Contradiction.** All participants engaged in some form of contradictory or discordant speech. These contradictions were typically outside the awareness of the participants at the time of the interview. These contradictions came in many forms, such as, the initial denial of any

knowledge of sexually violent events and later in the interview subsequent acknowledgment of an emergent realization that particular events were sexually violent. For example, a female participant recounted, "My knowledge is, mostly probably from movies, books, television, a few acquaintances, [with] very little personal experiences [with sexual violence] . . . which is weird because my grandfather (step-grandfather), was a sex addict and actively molested my sister, and it was not discussed."

Participants overtly rejected rape myth beliefs (RMA scale) while simultaneously and seemingly unwittingly relating stories, demonstrating acceptance of such beliefs. A male participant, when asked about his knowledge of sexual violence shared,

> experience, I don't think any [then later stated] I was seeing this girl and her friend took a, brought a couple of guys 3 or 4, I don't know back to her dorm room and she ended up getting raped by all four of them … I was scared to death!

He continued by stating, "…so even though rape was not brought up [in the home], I was exposed to domestic violence. Later in my teen years, I heard of an aunt who was raped by her husband." This participant initially denied any personal experiences or knowledge of rape or sexual violence then later recounted several sexually violent events.

A female participant, who disclosed that she herself had been a victim of rape, later went on to contradict herself when she discussed two popular media cases. She stated, "I actually think she set him up, I think she was going for kicks and then she was going for money … I know she got badly traumatized." These contradictions may perpetuate acceptance of rape myth, particularly that a woman's behavior contributes to her victimization or that women often lie about rape for revenge or financial gain.

**Silence.** In an effort to understand the origins of rape myths, participants were asked to describe what they heard about rape and rape victims and to identify the origins of those beliefs. Participants disclosed that rape wasn't spoken of in the home, was a family secret, was too taboo a topic, or was affected by religious values and cultural perspectives. Out of respect for family and authority, participants believed they did not have permission to question family and religious norms about sexual violence. It appeared that participants were responding to the institutional, cultural, familial and personal unspoken rules to not acknowledge or discuss sexual matters, thus silencing them. For example, one participant disclosed,

> … I don't think it was talked about while I was growing up and where I grew up it wasn't a big problem. I could walk around the streets of my town at midnight and be safe [then] I was raped when I was 17 … um, so probably at that point it became very real to me.

Clearly the culture of silence and perceived safety was shattered by a violent personal experience. When referencing the intersection of religious beliefs and culture a second participant noted,

> There was none [rape], it had to be the Catholic religion, I mean it wasn't just being brought up Catholic, it was being brought up Mexican Catholic, in an all white community, so things were a little bit different there. So I would say that, well, if you don't talk about it, then it doesn't exist [rape] … there was a certain way [unspoken norm], you didn't question.

A majority of participants demonstrated an awareness and understanding that sexual violence or sexual assaults were not a part of everyday conversation. Not speaking about these events seemed to keep them from being real or acknowledged.

**Feelings of professional helplessness.** Participants were asked to consider, given their level of training, how comfortable they would be if they were to counsel a client who had experienced a sexual assault. Understandably, as counselors-in-training in a practicum experience, we anticipated a low level of comfort. Participants stated they would prefer not to work with a survivor, if presented with the choice. One participant responded to the question about working with a sexual assault survivor and stated,

> … that would scare the crap out of me … being raped, I haven't experienced it. I can read on it, I can do whatever, but there's just certain things, that unless you experience first- hand for yourself you will just never know what it's like.

Participants believed that no amount of training was sufficient for them to address the client's experience of sexual assault. Clients were viewed as so damaged and their experience so pervasive and traumatic that no one could be of assistance, certainly not a counselor in training. Participants perceived clients as *unable* to recover from such a trauma. Participants noted that they lacked the skills, understanding, and tools necessary to assist in a client's recovery. Another participant stated,

> Never having been there I can't say how, for sure how hard or easy it would be. I feel it would be hard just because it is such a profound thing that happens to a person like, it's so hurtful, you know, and it's so damaging.

In summary, one participant stated,

> …but the victims, the survivors, there's no coming back from that [rape]. You can't fix it. You know, you set a broken bone and it'll heal, but you won't be able to see the break… but in rape, it's in the mind, it's the soul, it's the person's whole that is altered and there is no coming back from that.

**Gender expectations.** Participants were asked to identify gender expectations and roles for women and men, which is a contributing factor in acceptance of certain rape myths (Burt, 1980; Chapleau et al., 2007). For example, the belief that a man cannot control himself or his sexual urges is a rape myth based in gender norms or expectations. Each participant described characteristics that would be consistent with traditional female and male roles. For instance, participants described rape as a misunderstanding of the differences between men and women (i.e., mostly date rape). One male participant noted, when referencing men and women, "… equal yes, but with differences … boys and girls think differently." A second female participant put it more pointedly:

> We have a Puritanical culture, which assumes that women, are at fault if they sexually attract men, that men can't control themselves, and so if a woman makes herself look sexy, or available, or gets herself in the wrong situation that a man literally can't help himself and the woman has done something wrong in the situation.

Other participants revealed a sense that even though men were perceived as the aggressor, it was to some degree a societal expectation. Participants seemed to identify rape and sexual assault as a form of sexual relations. Males were expected to be in the role of 'protector' and 'warrior', which seemed to give permission for them to 'take' or 'conquer' the submissive female. No participant recognized or articulated this contradiction. A female participant stated, " … men are more wired up to be the warrior, strong protector and the woman nurturer, caregiver." Another female participant indicated,

> I think our society expects men to be providers … look at men to be like their expectation of their desire for sex and that it's manly to want to have sex and to have sex and it's kind of fun to conquer …

Although these were the counselors-in-training's opinions about the culture of gender norms and expectations, it seemed evident that these cultural stereotypes perpetuate acceptance of rape myths.

**Poor judgment.** The fourth theme that emerged was the belief that victims of rape may have exhibited poor judgment. "Victim" is used here because participants seemed to identify that an individual's lack of judgment or impaired judgment led to their victimization. Poor judgment centered on their decision-making, style of dress (i.e., too revealing), and engagement in risky situations (i.e. drinking). In relation to appearance or dress one male participant noted, "You know some young women … you know showing too much skin, I don't think they are asking to be raped, but they're not using the best judgment for their safety." A female participant stated, "I think there are mixed messages about whether or not the woman was putting herself in a place where she was partially responsible or partially at fault [for the rape]." She also believed that "the media definitely tries to send those kinds of messages [that women are responsible for their own safety]." Other participants noted that women might be naïve or too trusting in that they either did not understand or expect that men had other intentions. A male participant spoke to this idea when he stated:

> … I think a lot of times women have good intentions … an invitation over [to one's home] implies sex for a lot of men. I think if women weren't as nice and were more, I want to say apprehensive, or not as trusting they wouldn't put themselves in situations as much."

Beliefs and perceptions, such as the above statements, may perpetuate forms of victim blaming by counselors.

A male participant's comments represent the dynamic tension individuals feel when attempting to assign responsibility for a sexual assault:

> I think guys use dating and alcohol to take advantage of women and if a women says "no" it means "no" even if there's some leading on or you know petting or necking. You know no is no and I don't cut the perpetrator any slack for that. Maybe the woman was not thinking well, … [but] the mating call for the college coed [is] … "I'm so drunk" … that kind of invites things to happen, it doesn't mean that it is ok or that she's doing that, but I think it would be not wise for coeds to get you know to the point of blackout because it is very hard [for the man] to resist.

All participants commented on the potential for victims to use bad or poor judgment alluding to the possibility that they could potentially be responsible for being assaulted. These statements represent an unintended acceptance and promotion of rape myths among a group of caring educated professionals.

**Not calling rape "rape".** In response to the questions or prompts, there were several times when participants hesitated or refrained from using the term rape when describing rape or sexual assault. Reluctance to use the term rape appeared to center around discomfort with the term and the violence it connoted. When asked to describe or define the term "rape," participants could not even use the term. For example, one participant stated,

> The closest to *that* [rape] would be if a woman agrees to have sex and starts the process and then backs out, um, even then I don't think it's appropriate for the man to continue, but that would be the closest to *that*.

Another participant shared, "*It's* a crime, *it's* a violation. *It's* too common and *it's* going to traumatize her very, very seriously for a long time." A third participant needed to distance her comment even further stating, "…*this kind of thing* happens to people."

The six themes identified and supported by participant statements seem indicative that counselors-in-training are susceptible to accepting societal rape myths. As a result, it is imperative that practitioners and supervisors maintain a heightened awareness of these widely accepted myths.

**Discussion and Implications**

Violence against women occurs nationally and internationally. Rape is only one form of such violence against women, wherein the emotional effects are devastating. In addition to the pernicious nature of such an act, the societal misperceptions and false beliefs may further contribute to the emotional effects experienced by survivors of this form of violence. Since women make up the majority of clients seeking counseling services (Choate, 2008; Kopala & Keitel, 2003), and given that one out of six U.S. women have experienced an attempted or completed rape in their lifetime *(USDJ, 2006; USDJ, 2000*), it is very likely that counselors will encounter several clients with histories of rape and other forms of sexual assault.

Limited research has been conducted in the area of counselor awareness or acceptance of rape myths, beliefs about rape and survivors of rape, and the impact these perceptions have on the client's recovery and the therapeutic relationship. Indeed, the participants in this study were often unaware of the discordant nature of the narratives. This research supports the need for curriculum development in counselor training programs and attention to this issue in clinical supervision.

Curriculum that includes coursework addressing trauma was added to the standards for programs accredited by the Council for Accreditation of Counseling and Related Educational Programs (CACREP) (2009), yet not all counseling programs nationwide are accredited. The degree to which rape and rape myths are discussed are currently unknown, yet an essential component to the curriculum.

Counselors-in-training may benefit from increased self-exploration and critical thinking in the areas of rape and rape myths. Counselors who do not receive specific training on sexual assault and sexual trauma may not be aware of their beliefs or assumptions and their potential negative impacts on clients or may not understand the need to address the assault, or how to address the assault therapeutically in a nonjudgmental and unbiased manner. Consistent with the ethical codes and standards for the profession (American Counseling Association, 2014), counselors-in-training are expected to provide a safe and non-judgmental environment for clients to identify and explore their assumptions, biases, and beliefs about sexual assault and victims and survivors. Clinical supervision can help to address these issues with counselors-in-training and explore their assumptions specific to rape myths.

As new counselors graduate into the field, are they prepared, trained and equipped to handle working with clients who have experienced sexual assault? Many licensed counselors who did not receive training or supervision in violence affecting women (including sexual assault) in their graduate programs have sought additional training on sexual assault out of personal interest, and for professional development (Campbell, Raja, & Grining, 1999). In a recent study, mental health workers reported that sexual assault is an issue they frequently work with; however, the majority of participants had not received professional training on sexual

assault, and are not comfortable responding to disclosures of sexual assault (McLindon & Harms, 2011).

Clients should be able to seek counseling without worry or fear that they will be blamed or judged for what has been done *to* them. The counselors-in-training who participated in this study disclosed feelings of professional helplessness and a desire for more specific and targeted coursework or training that would address clients who have experienced sexual assault. They reported believing that treating survivors of sexual violence could be an area of specialization, yet we view it as a core training need.

Clinical implications from these findings include a need for increased awareness of the nature and impact of rape myth acceptance on the part of counselors, supervisors, and counselor educators. There is an increased need for practitioner training specific to sexual assault, rape, and trauma as well as the need for critical conversations between supervisors, counselors-in-training, and early career counseling professionals about their personal assumptions and biases specific to victims/survivors of sexual assault. At that same time, we need to examine how the failure to identify and address these myths may lead to a perpetuation of misogyny, rape myths and false beliefs about sexual assault and survivors of sexual assault. These beliefs may impede the client's recovery process and continue to perpetuate violence against women in society.

**Limitations**

The researchers sought to identify the experiences and beliefs held by counselors-in-training regarding participants' perceptions and understandings of sexual violence, rape, rape myths and training expectations. This study was limited by a small sample size of participants who were selected from a convenience-based sample, from the same institution and the limited professional counseling experiences of the counselors-in-training. Additional limitations include

incomplete data on the RMA scale from two participants, the use of self-reported data, and the likelihood that participants experienced interpersonal discomfort and the requisite social desirability that accompanies the discussion of sensitive topics. Each of which can limit the generalizability of the results of this study to all counseling professionals.

**Directions for Future Research**

Participants in this study reported a desire for additional training. We encourage seasoned practitioners and supervisors to be prepared to address the needs of counselors-in-training and new counselors who express a low level of comfort when working with clients who have survived a sexual assault. Supervisors will also need to address their own assumptions, biases, stereotypes, and acceptance of rape myths. Because national prevalence rates indicate that one in six women will experience a sexual assault, counselor educators have a profound responsibility to their clients, to invite and support dialogue and training about issues related to sexual violence. By refusing to be complicit in the silence about rape myths, counselors fulfill their roles as advocates and helping professionals.

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