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**THE INFLUENCE OF RAPE EMPATHY AND DEMOGRAPHIC VARIABLES ON  
COUNSELOR RAPE MYTH ACCEPTANCE**

by

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B.S. May 2004, Mississippi College  
M.A. May 2008, Regent University

A Dissertation Submitted to the Faculty of  
Old Dominion University in Partial Fulfillment of the  
Requirements for the Degree of

DOCTOR OF PHILOSOPHY

COUNSELOR EDUCATION AND SUPERVISION

OLD DOMINION UNIVERSITY  
December 2010

Approved by:

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Danica G. Hays (Chair)

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Tim Grothaus (Member)

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Laurie Craigen (Member)

## **ABSTRACT**

### **THE INFLUENCE OF RAPE EMPATHY AND DEMOGRAPHIC VARIABLES ON COUNSELOR RAPE MYTH ACCEPTANCE**

Julia M. Forman  
Old Dominion University, 2010  
Dissertation Chair: Dr. Danica G. Hays

In 2007, 248,300 individuals were raped (National Crime Victimization Survey [NCVS], 2007). It is likely that counseling professionals will provide services to rape survivors, and they should be aware of their biases towards survivors so that they can provide the most competent care possible. Some biases and attitudes may stem from the acceptance of rape myths. Rape myth acceptance (RMA) can lead to blaming the survivor for an attack (Campbell & Raja, 1999) and other consequences, including the exacerbation of psychological and physical symptoms (Campbell, Ahrens, Sefl, Wasco, & Barnes, 2001). Furthermore, a lack of rape empathy may inflict injury upon a survivor. The purpose of this quantitative study was to obtain baseline levels of RMA and rape empathy towards survivors among counseling professionals and trainees. The relationship between RMA and rape empathy was also studied, as well as the impact of rape empathy and demographic variables on predicting levels of RMA. No significant differences were found between professionals' and trainees' levels of RMA and rape empathy. A statistically significant correlation was found between rape empathy and female RMA. Male and female RMA were also significantly related. Sexual orientation was found to be a statistically significant predictor of female RMA.

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## INTRODUCTION

The National Crime Victimization Survey (NCVS, 2007) reported that there were 248,300 rape survivors in 2007 alone. This translated into 236,980 females and 11,300 males that were attacked (NCVS, 2007). Such high numbers indicate that approximately every two minutes someone in the United States becomes a survivor of rape (Rape, Abuse and Incest National Network [RAINN], 2010). With so many individuals affected by this crime and 39% of survivors seeking mental health services (Campbell, Wasco, Ahrens, Sefl, & Barnes, 2001), counselors have an obligation to be well-informed of the consequences of rape and self-aware of any biases towards this population. Indeed negative reactions towards a survivor such as blaming them for the rape have been associated with longer healing times, poorer physical health, and exacerbated psychological symptoms (Campbell, Ahrens, Sefl, Wasco, & Barnes, 2001).

The purpose of this quantitative research was to study master's and doctoral counseling students' and counseling professionals' levels of rape myth acceptance (RMA) and rape empathy and further assess the relationship between rape empathy and RMA. Rape myths are prejudicial beliefs about rape survivors, perpetrators, and the attack itself (Burt, 1980), while rape empathy is the ability of an observer to deeply understand the point of view and the emotions of another specifically in regards to rape situations (Smith, 1997). Rape empathy and several demographic variables were also examined to see if they were predictive of RMA. Demographic variables studied included gender, age, counselor level (training/education experience), exposure (whether the participant knows a survivor or is a survivor themselves), sexual orientation, race/ethnicity, and religious/spiritual orientation. Quantitative methods were utilized due

to the exploratory nature of this research, as not many studies exist that statistically examine the concepts under study within the counseling field specifically. This chapter will provide a brief overview of the current body of literature concerning counseling practitioners' and trainees' RMA and rape empathy.

While previous research has investigated students and professionals in other fields, such as psychology, criminology and social work, this study focused on counselor professionals' and counselor trainees' RMA and rape empathy in order to help address this gap in the literature. Conducting research in this area can provide baseline levels of RMA and rape empathy among professionals and trainees. This would allow for the counseling community to see what types of experiences a survivor may have when seeking services. Furthermore, by raising awareness of RMA and rape empathy levels among those in the counseling field, it was hoped that better services can be provided and further injury to the survivor brought on by the mental health community can be reduced. Indeed, previous research has indicated that negative encounters with the mental health system can exacerbate survivor's feelings of self-blame, shame, and lack of control and lead to "secondary victimization", which is further injury to the survivor caused by being the target of negative behaviors and attitudes like survivor blaming (Campbell, 2008; Campbell & Raja, 2005). Additionally, by investigating rape empathy and the various demographic variables under study and their impact on RMA, it was hoped that effective training curriculums could be created tailored from the results. For example, if male students were indicated to have higher RMA, then a training specified for this group could potentially be instilled into their educational program.

## CHAPTER ONE

### STUDY OVERVIEW

#### Background

Counseling professionals and trainees levels of RMA and rape empathy towards survivors were examined in this study. In addition, the impact of demographic variables and rape empathy levels on RMA was investigated. Currently, there is an abundance of research about RMA and the influence of demographic variables on attitudes towards rape survivors. Rape empathy, although present in previous literature, is not covered as extensively. However, in the counseling field, studies are limited.

**Rape myth acceptance definition.** Burt (1980) discussed RMA in the seminal work outlining the creation of the Rape Myth Acceptance Scale (RMAS). Rape myths were defined as “prejudicial, stereotyped, or false beliefs about rape, rape victims, and rapists” that help aid “in creating a climate hostile to rape victims” while serving to “deny or reduce perceived injury or to blame the survivors for their own victimization” (p. 217). Indeed, Melanson (1999) found that 97% of her sample of undergraduate students ( $n = 304$ ) endorsed one or more rape myths. Examples of rape myths include the belief that a rape survivor is promiscuous (Burt, 1980; Melanson, 1999), that many women unconsciously desire to be raped (Burt, 1980), women who dress provocatively deserve to be raped (Burt, 1980), that females cannot rape males (Kassing, Beesley, & Frey, 2005), male rape is perpetrated only by those who are gay (Melanson, 1999), males should be able to escape a male or a female rapist (Melanson, 1999), the only true rape is a violent stranger rape (Campbell, 2008) and that alcohol consumption by the survivor makes them sexually available (Burt, 1980). As far as how the acceptance of rape myths

serves the individual who believes them, Schechory and Idisis (2006) reported that females accept rape myths as a means to protect themselves against the idea that they too could be raped, and males utilize rape myths to legitimize forceful sexual behavior.

Previous research has indicated that RMA can be detrimental to a survivor. For instance RMA is a factor in causing an exacerbation of psychological and physical symptoms (Campbell, Ahrens et al., 2001) and an increased propensity to blame the survivor for the rape (Burt, 1980). Acceptance of rape myths can also increase a male's likelihood to rape (Bohner, Jarvis, Eyssel, & Siebler, 2005). Furthermore, the consequences of RMA, including survivor blaming, being asked what was worn during the rape, and being interrogated regarding previous sexual encounters for example, has been linked to the "second rape" or "secondary victimization" (Campbell & Raja, 1999; 2005). Secondary victimization is defined as the "unresponsive treatment rape victims receive from social systems personnel", including "victim blaming behaviors and practices engaged in by community services providers, which further the rape event, resulting in additional stress and trauma" (Campbell & Raja, 1999, p. 262).

Burt (1980) asserted that cultural sanctions might lead to acceptance of rape myths and seemingly justify rape behaviors. She also believed that RMA leads directly to survivor blaming in society. For example, Burt (1980) concluded that mass media through movies, magazines, and advertisements "supports the objectification of, and violent and sexual abuse of, women" (p. 219). Furthermore, four principles may exacerbate RMA (Burt, 1980). These include (1) sex role stereotyping, or attitudes and beliefs towards the way an individual should behave based on sex; (2) sexual conservatism, or how restrictive a person views sexual acts, partners, and settings under

which intercourse can occur; (3) adversarial sexual beliefs, or the acceptance that intimate relationships are inherently devious and misleading; and (4) acceptance of interpersonal violence, or the belief that it is justifiable to use intimidation and physical might to achieve sexual intercourse. The acceptance of interpersonal violence was the strongest factor related to acceptance of rape myths (Burt, 1980).

Some RMA may stem from the belief in a “just world” (Burt, 1980). From this viewpoint, individuals may blame the survivor for his or her rape because in a “just world” bad things only happen to those who in some way placed themselves into a potentially dangerous situation (Burt, 1980). In other words, a rape survivor may be blamed as the precipitating cause of the attack by his or her own behavior. The “just world” concept can serve as a protective measure for the individuals who espouse these beliefs, as this viewpoint carries with it the notion that if a person behaves “correctly”, unfortunate events such as rape will not happen to them (Burt, 1980).

**Rape empathy definition.** While rape empathy is one of the constructs under examination in this study, a brief discussion of general empathy is warranted so that rape empathy can be fully understood. Empathy in general has been asserted to have two components in two different areas (Smith, 1997). First, empathy has an emotional aspect, with an observer seeking to emotionally match and be present for another’s affective state. Second, empathy has a cognitive level where individuals try to understand mentally another individual’s viewpoint or emotions through perception and interpretation (Smith, 1997).

Rape empathy is defined as “a form of generalized empathy applied to the rape context” (Smith, 1997, p. 11). Furthermore, rape empathy is “the relative tendency for

subjects to assume the psychological perspective of the rape victim or the rapist” (Dietz, Blackwell, Daley, & Bentley, 1982, p. 374). Rape empathy is most frequently thought to be targeted towards the rape survivor (Smith, 1997). However, Dietz et al. (1982) assessed empathy towards the survivor *or* towards the perpetrator of the attack. This either-or idea of being empathic towards one involved party or the other prompted the creation of two newer scales, the Rape-Survivor Empathy Scale and the Rape-Perpetrator Empathy Scale, that measure empathy towards the survivor and the perpetrator, respectively, with the underlying assumption being that they are not mutually exclusive (Smith & Frieze, 2003).

Higher empathy levels are related to more positive attitudes towards rape survivors (Sakalli-Ugurlu, Yalcin, & Glick, 2007). Lower empathy levels towards survivors are predictive of a higher desire to rape a woman (Dietz et al., 1982). Clearly, rape empathy is needed for adequate treatment of rape survivors.

**Rape myth acceptance and rape empathy relationship.** Smith (1997) discussed the conceptual relationship between RMA and rape empathy. Empathizing with another individual involves cognitively perceiving and interpreting another’s viewpoint and affect and matching the person’s emotional state. If these interpretations and perceptions of the survivor are based on engrained stereotypical or biased notions, such as rape myths, this can affect empathic responses towards survivors. Therefore, an observer may have less empathy towards a survivor if a survivor does not behave as they “should” or in accordance with the stereotypical ideas espoused by the observer (Smith, 1997). For example, if a survivor is not tearfully reporting the attack but is instead calm or if the observer believes that the survivor had a subconscious desire to be raped, the attack may



be seen as a more positive experience than a negative one. Indeed, such cognitive and affective misinterpretations by the observer can lead to the inability to properly empathize with the survivor (Smith, 1997). It is also important to note that higher rape empathy towards survivors is associated with lower RMA, decreased levels of survivor blaming, and more positive attitudes towards those who have been raped (Dietz et al., 1982; Jiminez & Abreu, 2003; Sakalli-Ugurlu et al., 2007).

**Rape myth acceptance literature.** It is hoped that counselors and trainees have received education and training regarding rape, thus allowing them to adequately serve survivors. Indeed, the most recent Council for Accreditation of Counseling and Related Educational Programs (CACREP, 2009) standards call for crisis intervention and trauma training to be incorporated throughout the curriculum in master's and doctoral counseling programs. However, even with the potential of having previous training, clinicians and students are not immune to RMA or survivor blaming, although Burt (1980) found that individuals with higher levels of education were less accepting of rape myths.

Consequences of RMA include survivor blaming (Burt, 1980) and decreased quality of care provided by mental health professionals (Campbell, 2008; Campbell & Raja, 1999; 2005). Some practitioners, such as psychologists, social workers, and criminologists, have been shown to accept rape myths (Dye & Roth, 1990), thus creating the potential for secondary victimization (Campbell, 2008). Concerning survivor blaming and gender among practitioners, Idisis, Ben-David, and Ben-Nachum (2007) found that female survivors were blamed by practitioners for the attacks perpetrated against them more often than the male survivors were.

Melanson (1999) conducted a study creating the Male Rape Myth Scale (MRMS), which examined the level to which a person accepts stereotypes about male survivors and rape. The findings demonstrated that males accepted more rape myths than did females, although 97% of the total sample ( $n = 304$ ) of undergraduates pronounced agreement with one or more of the male rape myths. Furthermore, negative beliefs about gay individuals and a belief that males should not express their feelings were both significantly predictive of male RMA (Melanson, 1999).

Kassing and Prieto (2003) reported that mental health students ( $n = 183$ ) accepted rape myths concerning male survivors. The myths that were most commonly accepted in the study were that males should be able to fight off their attacker, that rape is more serious if the survivor is partnered in a heterosexual relationship, and that survivors frequently lie about being raped. The only rape myth categorically rejected by all participants was the myth that it is not rape if it is perpetrated by an acquaintance (Kassing & Prieto, 2003). Morry and Winkler (2001) also found RMA among students. Their findings demonstrated that while participants overall believed that coercion towards women was unacceptable, some students believed that at times manipulation or brute force to obtain a desired end was justified.

**Rape empathy.** Research on empathy towards rape survivors among counseling practitioners is sparse. Hill, Tanney, Leonard, and Reiss (1977) found that female counselors were more empathic and optimistic about treatment of rape survivors than males were. Empathy ratings for four concerns were presented in the study. Counselors indicated higher levels of empathy towards clients who were undergoing an existential crisis than those clients who presented with issues concerning a rape situation, termed a

“feared rape” in the study, even though rape was seen as most serious and needing the longest treatment (Hill et al., 1977).

Although research with counseling trainees is notably absent in the literature, empathy research among students, particularly among undergraduates and those majoring in psychology, is somewhat more common. Chng and Burke (1999) found that empathy levels increased among students when they had been previously exposed to rape, either through an attack on themselves or through knowing a survivor. Furthermore, higher empathy levels among psychology undergraduates were associated with decreased levels of survivor blaming and was a statistically significant predictor of attitudes towards survivors (Dietz et al., 1982).

An additional study by Jiminez and Abreu (2003) found that higher levels of empathy towards rape survivors were associated with decreased levels of RMA. Those with lower empathy were also found to attribute more responsibility to the survivor for the attack (Jiminez & Abreu, 2003). Finally, Sakalli-Ugurlu et al. (2007) used the Attitudes Towards Rape Victims Scale (ARV; Ward, 1988) to assess empathy and beliefs regarding rape. The ARV measures how credible a survivor is perceived to be, how responsible they are thought to be, and how deserving of rape they appear to be (Sakalli-Ugurlu et al., 2007). Their study concluded that males were less empathic and held more negative attitudes towards survivors than did females and that more positive attitudes towards survivors were predicted by rape empathy (Sakalli-Ugurlu et al., 2007).

**Demographic variable influences.** Studies have been conducted examining the relationship between various demographic variables, empathy, and RMA, although literature specifically examining these in the counseling field is scarce. Pertinent to this

study were the demographic variables of gender, age, sexual orientation, religious/spiritual orientation, exposure (whether the participant knows a survivor or is a survivor), race/ethnicity, and counselor level (education/training experience).

Previously, RMA has been found to increase as one gets older (Dye & Roth, 1990). Furthermore, RMA decreases and empathy increases with experience (i.e., counseling rape survivors or exposure to rape through knowing a victim or being raped) and education (Burt, 1980; Chng & Burke, 1999; Kassing & Prieto, 2003). Conversely, Kassing and Prieto (2003) found that younger participants were also accepting of rape myths. For instance, in their study examining college aged participants' acceptance of male rape myths, the younger the participant was, the more inclined to believe that a survivor should not have been out late alone. These findings seem contradictory to the assertions by Dye and Roth (1990) regarding the positive correlation between increasing age and increasing RMA. Both variables of age and counselor level were examined in the current study to see if any solid trends could be identified.

Exposure, defined as knowing a survivor or being a survivor of rape, and its impact on RMA and rape empathy was another variable under study. Individuals who did not know rape survivors personally or who had not experienced a rape themselves were found to have lower levels of empathy (Chng & Burke, 1999). Furthermore, these individuals exhibited more tolerant attitudes towards rape when compared to persons who knew survivors or who have been raped themselves. However, participants who were only acquainted with someone who had survived an attack and who had not been raped exhibited higher rape tolerant attitudes and lower empathy levels compared to those who had themselves been raped (Chng & Burke, 1999).

Overall, the literature on gender is fairly consistent. Males accept rape myths more readily than females do and are inclined to be more indulgent in their attitudes regarding perpetrators (Dye & Roth, 1990; Jiminez & Abreu, 2003; Kassing & Prieto, 2003; Melanson, 1999). Females exhibit more empathy in comparison to male participants (Jiminez & Abreu, 2003) and have more positive attitudes towards rape survivors (Sakalli-Ugurlu et al., 2007). In other words, males exhibited less empathy towards survivors and were more likely to espouse negative attitudes regarding a survivor (Sakalli-Ugurlu et al., 2007).

Sexual orientation plays a role in the perception of rape survivors as well. Heterosexual women and gay males reportedly experience more survivor blaming than do heterosexual males or lesbians (Wakelin & Long, 2003). Furthermore, the personality of a gay male is seen as a contributing more to the rape when compared against the other groups. For example, a stereotypical idea concerning gay males is that they have high sex drives. Those who believe in this notion may be more ready to blame the survivor for the attack (Wakelin & Long, 2003). Gay males and heterosexual women are also thought to have increased unconscious desires to be raped in comparison to heterosexual males and lesbians (Wakelin & Long, 2003). Kassing et al. (2005) and Melanson (1999) also found that homophobia and negative attitudes regarding gay individuals were related to increased levels of RMA.

Not many studies have been conducted examining how the sexual orientation of the participant, as opposed to the survivor, impacts perceptions of rape and RMA. The current literature is sparse, but one study (Davies & McCartney, 2003) asserted that

heterosexual males are the most accepting of rape myths and as opposed to gay males and heterosexual females.

Race/ethnicity was an additional demographic variable under examination as well. A study by Jiminez and Abreu (2003) found that within their sample ( $n = 336$ ), European American women were less accepting of rape myths and were more positive towards survivors than were Latinas. While European Americans held more positive attitudes towards survivors than did Latinas, European American females were more sympathetic towards a European American survivor than they were towards a Latina who had been raped (Jiminez & Abreu, 2003). Furthermore, Donovan (2007) demonstrated that European American undergraduate students ( $n = 431$ ) were more prone to believe that African-American survivors were more promiscuous than European American survivors when the race of the perpetrator was European American. However, there were no differences in attributed promiscuity when the perpetrator was African American. Lee, Pomeroy, Yoo, and Rheinboldt (2005) demonstrated that Asian students, when compared to European American college students, were more likely to blame the survivor for a rape and believe that the survivor somehow caused the attack. Asian individuals were also more prone to believing that rape is primarily perpetrated by strangers and that sex is the main motivation for rape, both beliefs which are indeed rape myths. It is important to note that while previous research did find variations in attitudes towards survivors, another study (Bell, Kuriloff, & Lottes, 1994) found no significant differences in survivor blaming among African-Americans, Asians, and European Americans.

There is minimal research related to religious or spiritual orientation and its relationship to RMA and rape empathy. The literature that is available suggests that there

is no clear relationship between religious/spiritual orientation and RMA (Carr, 2006; Hunt, 2000), although Aosved and Long (2006) did find that religious intolerance was associated with RMA. Furthermore, while Christian fundamentalism did not have a direct impact on RMA, participants who espoused more firm beliefs in fundamentalism believed more in traditional gender roles, which was found to be associated with increased levels of RMA and less sympathetic attitudes towards rape survivors (Carr, 2006).

### **Significance of the Study**

Although many studies exist examining RMA towards rape survivors, the literature is scarce or nonexistent when specifically addressing these concepts among counseling practitioners and counseling trainees. The literature in regards to rape empathy is also limited. As many counseling professionals and students will experience a professional relationship with survivors, it was important to investigate the degrees to which professionals and trainees espouse rape myths and to assess their levels of rape empathy. As previous research has indicated that training and experience counseling survivors, being a survivor, or knowing a survivor can lower levels of RMA (Burt, 1980; Kassing & Prieto, 2003) and increase empathy (Chng & Burke, 1999), the findings of this research could impact how master's and doctoral students are educated in our counseling programs and how practitioners choose to obtain their continuing education units. Even if the results of this study indicated that amount of training or education did not affect levels of RMA, this research will contribute to the field by describing the RMA levels and rape empathy levels among counseling practitioners and trainees, allowing for a snapshot of the current counseling field and the types of experiences survivors may have

when they seek services. As there is virtually no literature addressing these concepts in the counseling field specifically, this research was needed for an accurate representation of the discipline.

### **Purpose of the Study**

The purpose of this quantitative study was to investigate master's and doctoral counseling students' and counseling professionals' levels of RMA and rape empathy towards both male and female survivors of rape. The relationship between RMA and rape empathy was also analyzed. Demographic variables and rape empathy were examined to determine if they were predictive of RMA levels among trainees and practitioners. These demographic variables included gender, age, sexual orientation, religious/spiritual orientation, exposure (whether the participant knows a survivor or is a survivor), race/ethnicity, and counselor level (education/training experience). Levels of RMA and rape empathy were assessed via descriptive statistics, while the relationship between rape empathy and RMA were investigated with the Pearson Product Moment Correlation analysis. A stepwise regression was used to examine whether rape empathy and the various demographic variables under study were predictive of RMA. Quantitative methods were chosen as the best course for this research because of the exploratory nature of this study, as literature that statistically examines the concepts under study within the counseling field is sparse.

### **Research Questions**

*Research Question 1:* What is the degree of rape myth acceptance and rape empathy in master's and doctoral counseling students and counseling practitioners towards male and female rape survivors?



H<sub>1</sub>: There will be a significant difference in RMA and rape empathy levels between master's and doctoral counseling students and counseling professionals towards male and female survivors.

*Research Question 2:* To what degree are demographic variables and rape empathy predictive of RMA towards females?

H<sub>2</sub>: Gender, age, sexual orientation, religious/spiritual orientation, exposure (whether the participant knows a survivor or is a survivor), rape empathy, race/ethnicity, and counselor level (education/training experience) are significantly predictive of RMA towards female rape survivors by master's and doctoral counseling students and counseling professionals.

*Research Question 3:* To what degree are demographic variables and rape empathy predictive of RMA towards males?

H<sub>3</sub>: Gender, age, sexual orientation, religious/spiritual orientation, exposure (whether the participant knows a survivor or is a survivor), rape empathy, race/ethnicity and counselor level (education/training experience) are significantly predictive of RMA towards male rape survivors by master's and doctoral counseling students and counseling professionals.

*Research Question 4:* Is there a significant relationship between rape myth acceptance and rape empathy?

H<sub>4</sub>: There will be a significant relationship between RMA towards females and RMA towards males and levels of rape empathy displayed by master's and doctoral counseling students and counseling professionals towards both male and female rape survivors. The researcher assumes that there will be a relationship

between low levels of RMA and high levels of empathy towards rape survivors and between high RMA and low rape empathy.

### **Assumptions of the Study**

The researcher has previous experience working with rape survivors. This experience includes individual counseling, group counseling, and working a 24 hour hotline for rape survivors. Furthermore, the researcher has worked as a hospital companion for rape survivors, meaning that she has been on call to go out to hospitals to sit with survivors during the Physical Evidence Recovery Kit (PERK) process.

The researcher believed that, overall, counseling professionals and students would not express high degrees of RMA but would express generally high levels of empathy towards rape survivors. The researcher did assume that the sample would indicate acceptance of some rape myths, which would be in agreement with previous investigations (Dye & Roth, 1990; Idisis et al., 2007; Kassing & Prieto, 2003). It was assumed, however, that professionals would show significantly less RMA than students since previous research has indicated that education and experience counseling survivors are associated with lower RMA (Burt, 1980; Kassing & Prieto, 2003). The researcher assumed that there would be a relationship between low levels of RMA and high levels of empathy towards rape survivors and between high RMA and low rape empathy.

Rape and beliefs regarding rape can be emotionally charged issues, and therefore it may have been tempting for individuals to provide more socially desirable answers, or “fake good”, on the assessments (Marczyk, DeMatteo, & Festinger, 2005). As there was no safeguard in place to check for such false answers, the potential for socially desirable answers has been noted as limitation in the study. It was also assumed that, since the

sample would utilize only individuals who were working or were training to work in the counseling field, the participants who responded would primarily identify as either a counselor educator, counseling practitioner, a master's student, or a doctoral student. This question was specifically addressed on the demographic sheet, and participants were required to choose a primary identity.

### **Definition of Terms**

- **Gender:** As opposed to sex which is the biological aspect of males and females, *gender* comprises an individual's social and life experiences, mentality, and emotions that are based upon male or female characteristics (ACA, 2010). Many individuals base their behaviors and other decisions on what is traditionally associated with masculinity or femininity (ACA, 2010).
- **General Empathy:** *General empathy* is defined as deeply understanding the experiences, feelings, beliefs, and ideas of another individual (ACA, 2010). Empathy further involves both matching another's affective state and cognitively processing and interpreting another's situation (Smith, 1997). Rape empathy was the specific concept being measured in this study.
- **Professional:** Also known as a practitioner, a *professional* is one who self-identifies as a counselor, who is working as a licensed professional counselor or licensed professional school counselor or is working towards licensure, or as a counselor educator.
- **Race/Ethnicity:** *Race* is based on genetic, biological components (ACA, 2010). Ethnicity is defined as "a person's affiliation with a particular ethnic group of people who share a social or cultural history" which includes a "cultural patterns"

such as location, language, religious/spiritual orientation, ancestry, or customs (ACA, 2010, p. 180).

- **Rape:** *Rape* is “sexual contact against the will of one of the participants, and is one of the most common forms of assault” (Idisis et al., 2007, p. 103).
- **Rape Empathy:** *Rape empathy* has been defined as general empathy applied specifically to rape situations. (Smith, 1997). Additionally, rape empathy is “the relative tendency for subjects to assume the psychological perspective of the rape victim or the rapist” (Dietz et al., 1982, p. 374).
- **Rape Myth Acceptance:** *Rape myths* are defined as “prejudicial, stereotyped, or false beliefs about rape, rape victims, and rapists” that help aid “in creating a climate hostile to rape victims” while serving to “deny or reduce perceived injury or to blame the survivors for their own victimization” (Burt, 1980, p. 217).
- **Religious/Spiritual Orientation:** *Religious/Spiritual Orientation* is the religion or spiritual background espoused by a trainee or practitioner. *Spirituality* is defined as a “meaningful experience” that “may or may not involve a religion”, “transcendence of the material world”, a “relationship to God or a divine being as well as a relationship to nature, other individuals, or the infinite” and is considered to be “an essential element of humanness” (ACA, 2010, p. 519). *Religion* may or may not include spirituality and is defined as the “practice of faith individually or with an organized group and usually includes authority figures, sometimes a hierarchical structure, moral concepts and values, and specific forms of rituals or behaviors” (ACA, 2010, p. 519).

- **Sexual Orientation:** *Sexual orientation* is defined as “a person’s sexual or affectional attraction to another person, specifically identified by gender, and this attraction can be opposite sex (heterosexually oriented), same sex (homosexually oriented, or both sexes (bisexually oriented)” (ACA, 2010, p. 488).
- **Trainee:** Also known as a student, a *trainee* is an individual who is currently enrolled in a master’s or a doctoral counseling program and must identify as a counselor or counselor in training.

### Overview of Methodology

**Research design.** This study used non-experimental survey research methods. Survey research examines phenomena as they occur and does not manipulate any variables in the study (Wiersma & Jurs, 2009). This non-experimental design was advantageous for the current research as it could describe relationships among variables (Wiersma & Jurs, 2009), provide access to large amounts of data from large samples, and is inexpensive (Marczyk et al., 2005). A parallel-samples design was utilized, which is similar to that of a cross-sectional design. The main difference between a cross-sectional design, which is defined as a one-time data collection with a population, and a parallel-sample design is that two populations are assessed in parallel-sample designs as opposed to one in a cross-sectional design (Wiersma & Jurs, 2009). The two populations under study were counseling professionals (i.e., counselors or counselor educators) and counselor trainees (i.e., master’s or doctoral students).

**Participants.** The groups of participants were randomly selected counseling professional and counseling trainees. For the purposes of this study, a professional was a counselor or a counselor educator. They must not have self-identified as any other type of

helper, such as a psychologist or social worker. A trainee is a student who is currently enrolled in a master's or doctoral counseling program.

**Data Collection.** A randomized list from the American Counseling Association (ACA) was obtained which included the contact information for 2,000 professionals and trainees. There were 1,000 from each group. The list was divided into groups of three via stratified random sampling, and these groups were assigned to one of three links to the assessments. Following selection, chosen participants were sent an email to participate in the study (See Appendix G). This email thanked them for considering participating in the study and provided them with a link to SurveyMonkey, which was utilized as the platform for instrument distribution. To control for ordering bias, assessments were uploaded into SurveyMonkey in varying orders under three different links. These assessments included the demographic collection sheet, the Rape Empathy Scale (RES), the Myths and Attitudes about Rape Scale (MARS), adapted from Burt's (1980) Rape Myth Acceptance scale (RMAS), and the Male Rape Myth Scale (MRMS). The name of the RMAS was changed to the MARS at the author's request. A follow-up email was sent two weeks after the initial contact to further solicit participation in this research.

**Data analysis.** Following the collection of data from the needed number of participants ( $n = 107$ ), results were uploaded into SPSS. Descriptive statistics were utilized to highlight the demographic makeup of the sample as well as degrees of rape empathy and RMA. An independent *t*-test was used to calculate any statistically significant difference between the two groups. A Pearson product moment correlation was run to assess the relationship between rape empathy and RMA, and a stepwise

regression analysis was conducted to assess whether rape empathy and demographic variables were predictive of RMA.

### **Summary**

While literature does exist that investigates rape empathy and RMA, very few studies examined the degree to which counselors, counselor educators, and counseling trainees accept rape myths or exhibit rape empathy towards rape survivors. This study sought to fill in this gap in the current research by examining these constructs specifically in regards to the counseling field. This work also sought to add to the literature in regards to the demographic variables of gender, age, sexual orientation, religious/spiritual orientation, exposure (whether the participant knows a survivor or is a survivor themselves), race/ethnicity, and counselor level (education/training experience) among this sample. The importance of this work lies in the direct implications for improved client care as well as increased rationale for training for practitioners, as many clients have been and may continue to be harmed by RMA and lack of rape empathy (Burt, 1980; Campbell, Ahrens et al., 2001; Dietz et al., 1982). Indeed, by becoming more aware of, and thus hopefully reducing, counselor biases in the form of rape myths, it was hoped that better quality services can be provided to survivors, since previous research has shown that positive encounters with the mental health system can help reduce symptoms of PTSD (Campbell, Sefl et al., 1999).

## **CHAPTER TWO**

### **LITERATURE REVIEW**

#### **Introduction**

This research addressed RMA, rape empathy, and demographic variables among counseling professionals and trainees. Rape is defined as “sexual contact against the will of one of the participants, and is one of the most common forms of assault” (Idisis et al., 2007, p. 103). Rape myths are defined as “prejudicial, stereotyped, or false beliefs about rape, rape victims, and rapists” that help aid “in creating a climate hostile to rape victims” while serving to “deny or reduce perceived injury or to blame the survivors for their own victimization” (Burt, 1980, p. 217). Rape empathy has been defined as general empathy applied specifically to rape situations. (Smith, 1997). Additionally, rape empathy is “the relative tendency for subjects to assume the psychological perspective of the rape victim or the rapist” (Dietz et al., 1982, p. 374).

The overall purpose of this chapter is to outline the current literature pertinent to this study. First, CACREP standards regarding trauma training will be examined, followed by a discussion of the consequences of rape, statistics regarding incidence and prevalence, and help seeking behaviors. Following this section is an overview of RMA and rape empathy among practitioners and trainees, including the relationship between RMA and rape empathy. An examination of survivor interactions with various systems (legal, medical and mental health) is then provided, followed by an assessment of the current research regarding the demographic variables under study, which include gender, age, sexual orientation, religious/spiritual orientation, exposure (whether the participant



knows a survivor or is a survivor themselves), race/ethnicity, and counselor level (education/training experience).

## **Review of Literature**

### **CACREP Standards and Trauma: A Call to Action**

The Council for Accreditation of Counseling and Related Educational Programs (CACREP) 2009 standards call for infusing crisis training, trauma education and disaster response education into program coursework. The standards call for trauma education incorporated into various counseling courses, including addictions, human growth and development, marriage and family, diagnosis, school and college counseling. Also stressed is the need for trainees to learn about interventions useful for treating those in crisis and to recognize the impact of trauma on individuals (CACREP, 2009).

These new standards highlight the importance of trauma training for both master's and doctoral students in counseling programs. Since rape is a form of trauma, the more information available to students regarding rape, the more likely this education can be. Having research that provides a description of counseling trainees' and professionals' levels of RMA and rape empathy can present a snapshot of the beliefs espoused by those in the counseling field regarding rape and can also allow a glimpse into what clients may be experiencing when in session. Furthermore, by having examined the influence of rape empathy and the demographic variables under study on RMA a clearer picture may be presented of the makeup of our field and identify those who may require more extensive training.

### **Consequences of Rape and Risk Factors**

Rape can be perpetrated by persons whom victims know, such as a friend or intimate partner, or by a stranger (Basile, Chen, Lynberg, & Saltzman, 2007). The consequences of rape are extensive. Physically, survivors who have been attacked are at greater risk to experience sleep issues and to utilize tobacco (World Health Organization [WHO], 2002). Urinary tract infections, fibroids, bleeding and pain also occur post-assault. Survivors may become pregnant, contract HIV, or become infected with other sexually transmitted diseases (WHO, 2002). Emotionally, those who have been attacked also are more likely to develop depression, anxiety, stress and anger (Center for Disease Control [CDC], 2007). Furthermore, survivors of rape are more likely to develop Post Traumatic Stress Disorder (PTSD), especially if an injury is incurred during the attack (CDC, 2007). In some instances, the attack itself results in death. Rape survivors are also more likely to complete or attempt suicide. Survivors may display other troubling behavioral issues, such as engaging in criminal activity or becoming more aggressive. Survivors may develop an eating disorder or abuse drugs or alcohol. Those who have been raped may also participate in sexual activities that are risky, thus potentially experiencing more harm (CDC, 2007).

The WHO (2002) outlined risk factors that may increase the likelihood of being raped and for being a perpetrator of rape. Risk factors that may increase the probability of rape occurring include poverty, using drugs or alcohol, having previous rape experiences, having multiple sexual partners, working in the sex industry, and being young. Women who are more educated are also at an increased risk of being raped, as more education is thought to lead to increased empowerment of the female and increased resistance of norms in a male-dominated society (WHO, 2002). This increased risk of rape due to

education is especially seen in regards to intimate partners, who are more likely to attack the empowered female in an attempt to regain control. Risk factors increasing the likelihood of being a male perpetrator include poverty, overall cultural approval of rape, unemployment, sexually aggressive friends, substance abuse, past personal sexual victimization, and espousing negative attitudes towards females (WHO, 2002).

Much of the data available regarding risk factors focuses on male perpetrators and female survivors and it is important for counselors to be aware of such risks to aid in treatment of both offenders and survivors. Furthermore, the myriad of consequences following a rape highlight the importance of effective interventions from medical and mental health systems. The current research may be useful for enhancing services provided by counselors through the illumination of empathy levels and degrees of RMA.

### **Statistics**

Rape is a common occurrence in the United States, with 1 in 6 women and 1 in 33 men reporting that they had experienced an attempted or completed rape over the course of their lifetime (National Violence against Women Survey [NVAWS], 2000). In 2007 alone, 248,300 individuals were raped. Approximately 11,300 were males and 236,980 were females (NCVS, 2007). These statistics translate into an individual being raped every two minutes in the United States (RAINN, 2010). Furthermore, nearly 3 % of women and 1% of men have experienced an attempted, although not completed, rape (NVAWS, 2000). Rape may involve the use of a weapon or may involve further injury to the survivor beyond the actual rape. During a rape, 31.5% of females were injured, as opposed to 16.1% of males (NVAWS, 2000). Approximately 11% of female survivors and 8% of male survivors reported the use of a weapon during their attack (NVAWS,

2006). Even with these statistics, rape is an underreported crime and available data may not capture the true breadth of the issue (CDC, 2007). Indeed, 64% of rapes are thought to go unreported (Rennison, 2002).

Ages vary at the time of rape. For instance, 69% of males and 60% of females ( $N = 9,684$ ) experienced rape prior to age 18 (Basile et al., 2007). Of these surveyed individuals, approximately 25% of females and 41% of males were attacked prior to the age of 12. Such early rape experiences influence the probability of being raped later in life, with females who were raped prior to the age of 18 being twice as likely to be revictimized later as an adult (NVAWS, 2000).

Statistics are available for adult survivors as well. Annually, 1 of every 1,000 adult males over the age of 18 and 9 of every 1,000 women over 18 will be raped (NVWS, 2000). Female college aged students seem to experience rape at a higher rate with 35 out of every 1,000 female students being attacked during an academic year (Fisher, Cullen, & Turner, 2000).

Perpetrators of rape are generally known to the survivor. For example, 9 out of 10 college aged survivors will know their assailant, with 23% of completed rapes occurring on a date (Fisher et al., 2000). For female rape survivors, the first attack they experienced was committed by a romantic partner 30% of the time, a family member 23% of the time, and an acquaintance 20% of the time (Basile et al., 2007). For males' first attack, acquaintances (32%) family (18%), friends (18%), and partners (16%) were reported offenders (Basile et al., 2007). Stranger rapes occur as well. Indeed, 31% of females in one sample ( $n = 236, 980$ ) reporting rape were attacked by someone unknown to them, as were 42 % of males ( $n = 11, 300$ ) (NCVS, 2007).

With practitioners and students likely to see a survivor for treatment, it is important to know statistics regarding how many are seeking services, who is coming in for treatment and what types of services they typically seek. Regarding survivors seeking mental health services, Campbell, Wasco et al. (2001) found that 39% of their female sample ( $n = 157$ ) sought mental health services. About 18% utilized resources provided by a religious organization, and 21% sought help from a rape crisis center. Stranger rape survivors were more likely to reach out for help, especially legal or medical assistance, than were nonstranger rape survivors. Ullman (2007) found that in an extensive review of the literature less than 35% of survivors utilize mental health services. Instead, two-thirds of survivors tell informal networks of support, such as family or friends, approximately a year after the attack has occurred.

Wasco et al. (2004) examined mental health service utilization among rape survivors and found that of those who called a crisis hotline, 73% were the primary survivors, or the actual individual who was raped, and 27% were secondary survivors, or those who were also affected by the rape but were not the survivor themselves (e.g.- friends or family). The main reason reported for individuals calling the hotline was because they were in crisis, followed by the need for referrals. Services utilized by survivors included medical or legal companionship, advocacy, and counseling (Wasco et al., 2004). About half of the study's total sample ( $n = 231$ ) participated in 10 or more counseling sessions, thus indicating that some survivors are receiving more extensive services.

Counselors should be aware of discrepancies among various racial and ethnic groups utilizing services as well. For example, 69% of White survivors contacted a

mental health provider for help, while only 31% of ethnic minority women sought treatment post-rape in an all female sample of 157 survivors (Campbell, Wasco et al., 2001). This trend was seen for rape crisis centers as well, with 91% of White survivors and only 9% of ethnic minority survivors reaching out to rape crisis centers for help (Campbell, Wasco et al., 2001).

This trend in help-seeking among ethnicities is alarming because statistics indicate that some marginalized populations are more likely to be raped (NVAWS, 2000). Indeed, American Indian/Alaska Native women (34.1%) and females of mixed racial descent (24.4%) are more likely to be raped over their lifetime than White (17.9%) or African-American (18.8%) females. However, women of Hispanic origin (14.6%) are less likely than those of non-Hispanic origin (18.4%) to report a rape over the course of their lifetime (NVAWS, 2000).

As is evident, rape can occur regardless of gender, ethnicity, or age. The available data highlights the frequent occurrence of rape, even though the numbers are under reported (CDC, 2007). Furthermore, with survivors seeking mental health services at the current rate, counselors have an ethical obligation to remain current on effective interventions and to be self-aware regarding their own biases and empathy levels towards survivors.

### **Rape Myth Acceptance**

Rape myths are stereotypical or prejudicial beliefs regarding rape, rapists, and rape survivors that can have detrimental effects on the survivor (Burt, 1980). RMA can lead to survivor blaming (Burt), enhanced psychological and physical distress (Campbell, Ahrens, et al., 2001), and increased likelihood to rape among male believers (Bohner et

al., 2005). Furthermore, RMA has been linked to secondary rape, which is defined as poor treatment of survivors by workers in social systems that results in further harm to the survivor (Campbell & Raja, 1999). This is indeed alarming as one study (Melanson, 1999) found that 97% of her sample of undergraduates ( $n = 304$ ) believed a rape myth about a male survivor. Examples of rape myths include that male survivors have lost their manhood by being raped, that females secretly desire to be raped, that males or females who are raped are generally promiscuous, that women who visit the residence of a man on the first date or wear revealing clothing are bringing the rape on themselves, and that males cry rape if consensual same sex intimacy was engaged in but they later changed their mind (Burt, 1980; Melanson, 1999). For a more extensive list, see Table 1.

Table 1  
*Rape Myth Examples*

Rape Myths
<ol style="list-style-type: none"> <li>1. A woman who goes to the home or apartment of a man on their first date implies that she is willing to have sex. <sup>a</sup></li> <li>2. One reason that women falsely report a rape is that they frequently have a need to call attention to themselves. <sup>a</sup></li> <li>3. Women who get raped while hitchhiking get what they deserve. <sup>a</sup></li> <li>4. If a woman gets drunk at a party and has intercourse with a man she's just met there, she should be considered "fair game" to other males at the party who want to have sex with her too, whether she wants to or not. <sup>a</sup></li> <li>5. Any healthy woman can successfully resist a rapist if she really wants to. <sup>a</sup></li> </ol>

6. When women go around braless or wearing short skirts and tight tops, they are just asking for trouble. <sup>a</sup>
7. In the majority of rapes, the survivor is promiscuous or has a bad reputation. <sup>a</sup>
8. Many women have an unconscious wish to be raped and may then unconsciously set up a situation in which they are likely to be attacked. <sup>a</sup>
9. A woman who is stuck-up and thinks she is too good to talk to guys on the street deserves to be taught a lesson. <sup>a</sup>
10. If a girl engages in necking or petting and she lets things get out of hand, it is her own fault if her partner forces sex on her. <sup>a</sup>
11. Any healthy man can successfully resist a rapist if he really wants to. <sup>b</sup>
12. Most men who are raped by a man are somewhat to blame for not escaping or fighting off the man. <sup>b</sup>
13. If a man had told me that he had been raped by another man, I would suspect that he is homosexual. <sup>b</sup>
14. Male rape is more serious when the survivor is heterosexual than when the survivor is homosexual. <sup>b</sup>
15. Men who parade around nude in a locker room are asking for trouble. <sup>b</sup>
16. Most men who are raped by a woman are somewhat to blame for not being more careful. <sup>b</sup>
17. I would have a hard time believing a man who told me that he was raped by a woman. <sup>b</sup>
18. Most men who have been raped have a history of promiscuity. <sup>b</sup>
19. No self-respecting man would admit to being raped. <sup>b</sup>



20. Women who rape men are sexually frustrated individuals.<sup>b</sup>
21. The extent of a man's resistance should be a major factor in determining if he was raped.<sup>b</sup>
22. Male rape is usually committed by homosexuals.<sup>b</sup>
23. A man who has been raped has lost his manhood.<sup>b</sup>
24. If a man engages in necking and petting and he lets things get out of hand, it is his own fault if his partner forces sex on him.<sup>b</sup>
25. Most men who are raped by a woman are somewhat to blame for not escaping or fighting off the woman.<sup>b</sup>
26. If a man obtained an erection while being raped it probably means he started to enjoy it.<sup>b</sup>
27. A man can enjoy sex even if it is being forced upon him.<sup>b</sup>
28. Many men claim rape if they have consented to homosexual relations but have changed their mind afterwards.<sup>b</sup>

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Note. <sup>a</sup> = Burt, 1980; <sup>b</sup> = Melanson, 1999.

While there is some research on RMA among undergraduate students or practitioners, the literature that focuses solely on counseling professionals' and trainees' levels of RMA is limited. The available literature primarily includes research measuring attitudes of participants towards portrayed survivors. For example, multiple studies (Dye & Roth, 1990; Jiminez & Abreu, 2003; Shechory & Idisis, 2006) utilized the Rape Myth Acceptance Scale (RMAS; Burt, 1980), which contains several statements that participants either agree or disagree with, thus indicating their attitudes towards rape

survivors. Portrayed survivors were often presented in the form of a vignette, and participants responded to assessments measuring their attitudes regarding the survivors following reading the case study (Jiminez & Abreu, 2003; Kassing & Prieto, 2003).

Dye and Roth (1990) investigated the attitudes towards rape survivors and the rape treatment knowledge base of psychologists, social workers, and psychiatrists ( $n = 257$ ). Results showed that the respondents generally exhibited low levels of RMA as indicated by the RMAS (Burt, 1980) and knew common symptoms associated with being raped, as well as the more prevalent treatment approaches. The study did conclude, however, that participants held negative stereotypes about survivors, such as placing blame on them for their role in the rape, as well as conflict over how to treat a rape survivor ( $M = 6.30$ ,  $SD = .51$ , Range = 3.7-7.0, with this study calculating the mean of responses to assess RMA, with a score of 7 showing no RMA and 1 indicating full acceptance of RMA). Those who were more prejudiced against rape survivors tended to focus on the rape and the survivor's role in the attack during a session more so than those who were less prejudiced. While findings indicated overall low levels of RMA, it should be noted that the authors reported low response rates from clinicians who had not treated rape survivors (7%), males (45.9%) and psychiatrists (30.3%) which may have in turn misrepresented RMA levels (Dye & Roth, 1990).

Idisis et al. (2007) assessed the degree of blame assigned to a rape survivor based on gender and on how well the survivor knew their perpetrator. They utilized a sample ( $n = 72$ ) they termed as "therapists" ( $n = 36$ ), which included psychiatrists, clinical criminologists, psychologists, and social workers, and "non-therapists" ( $n = 36$ ), which included undergraduate students who had no previous mental health or criminal training.

While overall attribution of blame was low, women were blamed more for rape than male survivors. This is indicative that females are held more responsible for their rapes due to the “perception that women are vulnerable, exposed, and more aware of their vulnerability” so “they are expected to act with extra caution to avoid rape, and are therefore judged more harshly when they are actually victimized” (p. 114). The study also found that female participants exhibited less blame towards the female survivors and more blame towards male survivors, and male participants blamed the male survivors less for their rape when compared to female survivors. The blaming of the survivor serves to protect individuals from feeling that this attack could happen to them due to the survivor doing something wrong and is in line with the “just world” theory (Idisis et al., 2007).

Regarding the context of the rape and its impact on blaming, the perpetrator was held more accountable for their actions when raping an acquaintance than when raping a stranger (Idisis et al., 2007). This may be due to the view that the survivor somehow attributed to the attack. For example, the study indicated that survivors were blamed more in the stranger rape scenario potentially because the scenarios portrayed the survivors as hitchhiking which may have been viewed as a risky behavior (Idisis et al., 2007). In the same study, when asked to rate the severity of a rape, therapists rated the portrayed rapes as more severe than the non-therapist sample did. This tendency was similarly found when participants were asked to rate how harshly a perpetrator should be punished for the attack. Again, the therapists wanted harsher penalties for the rapists as opposed to more lenient ratings from the non-therapists. There were no differences, however, between therapists and non-therapists for degrees of blame assigned to the survivor, a

phenomenon the authors attribute to the sample being highly educated (Idisis et al., 2007).

Schechory and Idisis (2006) investigated female therapists ( $n = 51$ ), which included social workers and criminologists, and female students' ( $n = 125$ ) acceptance of rape myths about survivors and perpetrators and social distance towards them. Social distance is the inclination to be in contact with someone and also includes the amount of understanding found between groups (Schechory & Idisis, 2006). The results indicated that therapists exhibit less stereotypical attitudes towards survivors and offenders and accepted fewer rape myths. Both female groups of participants were more willing to accept rape myths about male survivors, however, which was significant at the .05 level (Schechory & Idisis, 2006). When investigating social distance, significant results were found that indicated both students and therapists were more willing to be closer to survivors ( $r = .42, p < .01$ ) than they were offenders ( $r = .44, p < .01$ ), but therapists indicated a greater willingness to be closer to both populations more so than the students did (Schechory & Idisis, 2006). To qualify this, however, more conservative attitudes espoused by the participants towards survivors were associated with less willingness to be closer to a survivor.

Kassing and Prieto (2003) examined counselor trainee ( $n = 183$ ) attitudes and beliefs regarding male rape. Participants indicated some degree of acceptance of all but one of the rape myths addressed within the Acceptance of Rape Myth Scale (ARMS, Gilmartin-Zena, 1988). On the ARMS a mean score of 4.0 or higher signifies rejection of rape myths (Kassing & Prieto, 2003; i.e., higher scores refer to lower myth acceptance and thus greater views of rape as more serious or severe). While overall the mean was

high for the sample indicating lower rape myth acceptance ( $M = 3.93$ ), certain items' means showed higher acceptance of rape myths. For example, the authors found that rape is perceived as a more critical event if the survivor is partnered, as opposed to not being in a relationship, regardless of gender ( $M = 2.48$ ), that people can do things to protect themselves thus preventing an attack ( $M = 2.79$ ), and that individuals are believed to frequently falsely accuse/report rape ( $M = 2.97$ ). The one rape myth that no trainee reported accepting was that of acquaintance rape not being a real rape due to the attacker and the survivor knowing each other ( $M = 4.92$ ). Results additionally showed that participants believed that male survivors should not have been out alone and that the male survivor's behaviors contributed to the rape. The subscription to such myths highlights the imperative nature of discussing rape with trainees, as believing that false reports are often made can lead to trainees doubting the assertions of their clients (Kassing & Prieto, 2003). Furthermore, trainees were reported to believe that a male survivor should have shown more resistance towards their perpetrator if low resistance behaviors were exhibited. By placing stock in the traditional male stereotype that men can fight off any attack, trainees are potentially discounting the rape experiences of male survivors which may include shock and an inability to resist (Kassing & Prieto, 2003).

Melanson (1999) investigated undergraduate students' ( $n = 304$ ) levels of male RMA following the creation of the MRMS. This study demonstrated that the belief that males should be inexpressive regarding their emotions and having negative beliefs about gay individuals are predictive of male RMA levels. Furthermore, regarding gender differences in the sample, the author (1999) concluded that males had higher levels of RMA than females did.

Ford, Liwag-McLamb, and Foley (1998) examined 108 psychology students' perceptions of rape based on the survivor's gender and sexual orientation. Results indicated that male participants were more likely to view an occurrence as rape if it happened to a heterosexual female or a gay male. Females viewed gay males as less the victim than the portrayed heterosexual female. The authors asserted that students' beliefs indicate acceptance of "stereotypical" rapes and rape myths, with the survivors being the object of a heterosexual man's desire (a gay male or a heterosexual female) or with the heterosexual male supposedly being more capable of fighting off an attack than any other portrayed survivor. Furthermore, the female portrayed in the rape scenario was seen as being partially at fault for the attack due to her going voluntarily over to the perpetrator's residence (Ford et al., 1998). Concerning sexual orientation, participants attributed more blame for the attack to heterosexual females and gay males, as opposed to gay females and heterosexual males, which indicated that "participants primarily blame persons perceived to be sex objects of the perpetrator" (p. 261). Once again, as is seen in the previous finding from this study about what constitutes rape (e.g.- more likely to be seen as rape with a heterosexual female or with a gay male), gay males and heterosexual females are blamed more because of stereotypes that state what a typical survivor should be. Even though one belief seems supportive (viewing an incident as rape) and another detrimental (blaming the survivor), both stem from the same place: acceptance of the stereotypical beliefs known as rape myths (Ford et al., 1998).

Ford et al. (1998) also investigated the belief in a just world among the participants. Males in this study who had a high just world belief found less fault in the perpetrator's actions than those who scored lower in believing in a just world, although

the high scoring males and low scoring males did not score differently on how much they blamed a survivor for the attack. Female participants who had a high degree of just world belief tended to believe that the attacker was responsible for the rape only when the survivor was heterosexual. This finding suggests that the female psychology trainees may not as easily relate to lesbian survivors and believe that these survivors deserved the rape somehow (Ford et al., 1998).

Morry and Winkler (2001) assessed RMA, gender, and acceptance and expectation of rape among undergraduates. Expectation was defined as the belief that violence is or is not likely to occur after assessing the situation, and acceptance is whether or not an individual believes that violence was permissible in the situation, thus allowing for the perpetrator to receive less blame (Morry & Winkler, 2001). The results indicated that while overall bullying behavior towards women was not permissible, individuals with higher RMA scores believed that at times force or manipulation was acceptable. Even though these manipulative behaviors were generally seen as unacceptable, the results showed that sometimes coercion was expected, thus aligning with previous research discussing how rape is culturally sanctioned (Burt, 1980). This expectation of violence to occur can lead to blaming the survivor for being in the situation at all (Morry & Winkler, 2001).

Overall the literature on RMA illustrates that acceptance of rape myths is generally low (Dye & Roth, 1990; Idisis et al., 2007). However, negative stereotyping does exist (Dye & Roth; Ford et al., 1998; Idisis et al., 2007; Kassing & Prieto, 2003). Results were mixed regarding practitioner and student levels of RMA. One study found that practitioners were less likely to accept rape myths than students were (Schechory &

Idisis, 2006), while another study did not find a significant difference between trainees' and practitioners' levels of blaming a survivor (Idisis et al., 2007). Professionals were shown to espouse negative attitudes towards those that had been raped, however, and indicated confusion over how best to treat a survivor (Dye & Roth, 1990). Counseling students also accepted rape myths (Kassing & Prieto, 2003) and tended to blame heterosexual females and gay males more for their rapes than lesbians or heterosexual males (Ford et al., 1998). Responses from both professionals and trainees showed that they tended to blame opposite sexed survivors for their rape more so than a survivor who was the same sex as them (Idisis et al., 2007; Shechory & Idisis, 2006). The reported degrees of RMA, even though they overall are low, among practitioners and trainees highlights the importance of this study for the counseling field in particular, where limited research has been conducted on this topic. This is due to the detrimental effects of any level of RMA and lower rape empathy levels to a survivor (Burt, 1980; Dietz et al., 1982).

### **Rape Empathy**

Rape empathy is general empathy applied specifically to the rape context (Smith, 1997) and is "the relative tendency for subjects to assume the psychological perspective of the rape victim or the rapist" (Dietz et al., 1982, p. 374). General empathy is deeply understanding the experiences, feelings, beliefs, and ideas of another individual (ACA, 2010). Both general and rape empathizing involves both matching another's affective state and cognitively processing and interpreting another's situation (Smith, 1997).

Previous research on rape empathy is somewhat limited, particularly for counselors and counselor trainees. What is available includes studies utilizing primarily



undergraduate students, although one study (Hill, Tanney, Leonard, & Reiss, 1977) does examine counselors' levels of rape empathy. The literature primarily highlights attitudinal research with portrayed survivors, occasionally portrayed on videotape by actresses (Barnett et al., 1992; Hill et al., 1977). Available works exploring rape empathy among students and practitioners are discussed below.

Even with limited literature, empathy has been shown to have an impact on client treatment (Jiminez & Abreu, 2003). Higher levels of empathy towards rape survivors were associated with decreased levels of RMA. Those with lower empathy were also found to attribute more responsibility to the survivor for the attack (Jiminez & Abreu, 2003).

Concerning professionals, Hill et al. (1977) investigated rape empathy among 36 counseling professionals and 52 graduate students in "counseling related fields" (Hill et al., 1977, p. 61). The authors (1977) utilized four videotapes with actors (i.e., 20 and 35-year old females), portraying four issues: (1) "feared rape" (2) existential anxiety (3) career needs, leaning towards becoming a social worker and (4) career needs, leaning towards becoming an engineer. It is important to note that "feared rape" was not defined for this study, and therefore it is unknown whether feared rape meant fear of rape or a victim fearing that they may have been raped.

Results indicated that the issue of existential anxiety received the highest empathic responses from the participants, with rape having the second highest (Hill et al., 1977). Existential anxiety was also seen as the issue that would gain the most from therapy, even though rape was reported as the most serious concern. Female respondents saw therapy to be more beneficial for rape than the male participants did, and the older

portrayed client was indicated as having increased need for more sessions than the younger client. Furthermore, male counselors were less empathic towards the survivors, while female participants were more optimistic and empathic about the rape survivors. The younger portrayed rape survivor, rather than the older survivor, elicited more empathic responses from both participant genders (Hill et al., 1977).

Chng and Burke (1999) investigated business, education, and arts and sciences college undergraduates' ( $n = 30$ ) rape empathy and found that levels of empathy towards rape survivors increased with exposure, including previous rape experience personally or by knowing a rape survivor. Indeed, males and those with no prior history with rape had lower empathy levels and higher rape tolerant attitudes. However, those who simply knew a survivor had lower empathy levels and higher rape tolerant attitudes in comparison to those who had actually been attacked (Chng & Burke, 1999). There was no significant relationship between age, which for this sample ranged from 18-22 years old, and empathy levels within the study.

Barnett et al. (1992), using a sample of 298 psychology undergraduates, showed two videotapes and assessed rape empathy levels towards the individuals portrayed. One videotape was a control with an actress discussing non-rape related life issues, such as divorce and alcoholism, and the other videotape showed an actress discussing her life post rape. The findings indicated that the female participants and those who knew a survivor had higher empathy levels towards both actresses than other participants (Barnett et al., 1992). Females also rated the actresses in the videos more likeable than the males did. The authors hypothesized that females were more empathic towards both actresses because of perceived similarity, which is an assertion supported by previous

research (Barnett, Tetreault, Esper, & Bristow, 2001). However, participants, regardless of gender, showed more empathic responses towards the control video actress than the rape video actress. The rape survivor was also assessed as being more emotionally unstable than the control video actress.

Turkish undergraduates have also been the subjects of similar empathy investigations (Sakalli-Ugurlu et al., 2007). The results showed that males again exhibited less empathy towards rape survivors and espoused more negative attitudes. Higher levels of empathy towards survivors by both female and male participants indicated more positive attitudes towards survivors. Interestingly, when assessing the relationship between empathy and the belief in a just world, no correlation was found. However, higher degrees of belief in a just world were related to less positive attitudes regarding survivors and increased survivor blaming (Sakalli-Ugurlu et al., 2007).

Dietz et al. (1982) conducted a study to create the Rape Empathy Scale (RES), which measures the amount of empathy exhibited towards a rape survivor or the perpetrator. They found that empathy was higher among females than among males. Furthermore, women who had been exposed to rape had higher levels of empathy than those who had not been. Higher degrees of empathy were associated with less traditional and conservative attitudes towards women, including less stereotypical thinking about what constitutes the construct of a woman (Dietz et al., 1982). Lower empathy levels among males were associated with higher desires to rape a woman.

The RES examined empathy towards perpetrators as well. Among the pool of students ( $n = 639$ ) and jurors ( $n = 260$ ) higher empathy levels were associated with the desire for increased prison time for the defendant and higher levels of assurance that the

defendant was guilty (Dietz et al., 1982). Higher empathy was associated with lower survivor blaming among the sample. A relationship was also found between high empathy and increased identification with and more positive attitudes towards the survivor, more negative emotions towards the perpetrator, and a greater belief that the survivor had no personal responsibility for the attack but was involved rather due to chance (Dietz et al., 1982). Participants who showed more empathy towards the survivor also acknowledged the severity of rape and recognized the immense effects that rape could have on a survivor's well-being.

Smith and Frieze (2003) conducted a study with 213 psychology undergraduate students to investigate empathy levels towards a rape survivor and towards a rape perpetrator. The findings indicated that both male and female participants in the research had lower empathy towards the perpetrator and higher empathy towards the survivor. Furthermore, the participants attributed less responsibility for the rape to the survivor. Females in the study were generally more empathic towards the survivor, whereas the male participants exhibited more empathy towards the perpetrator. Those who had been raped were shown to be more empathic than those who had never been previously raped. Additionally, results showed that as empathy levels are more favorable, the level of responsibility attributed to the survivor for the rape decreases (Smith & Frieze, 2003).

The rape empathy literature demonstrates that males, both practitioners and students, exhibit less empathy towards rape survivors than did females (Barnett et al., 1992; Chng & Burke, 1999; Dietz et al., 1982; Hill et al., 1977; Sakalli-Ugurlu et al., 2007; Smith & Frieze, 2003). Further, male counselors were less optimistic about counseling outcomes for rape survivors and viewed counseling as less beneficial for

survivors as well (Dietz et al., 1982). Students who knew survivors of rape or who had been raped themselves were more empathic towards survivors (Barnett et al., 1992; Chng & Burke, 1999; Dietz et al., 1982). Furthermore, as student empathy levels increased, survivor blaming decreased (Smith & Frieze, 2003). This study will seek to further expand the literature regarding both counseling practitioners' and trainees' rape empathy levels.

### **Relationship between Rape Myth Acceptance and Rape Empathy**

The literature on the relationship between RMA and rape empathy is somewhat older (Dietz et al., 1982; Smith, 1997) and is not specifically geared towards counselors (Jiminez & Abreu, 2003; Sakalli-Ugurlu et al., 2007). Smith (1997) demonstrated in a conceptual writing how RMA and rape empathy are related. She asserted that accurately empathizing with another involves two aspects: a cognitive aspect and an affective aspect. An observer must be able to meet the one suffering a trauma where they are emotionally. Furthermore, the observer must be able to interpret and perceive cognitively the individual's situation (Smith, 1997). Errors may be made in these cognitive processes if the interpretations are made relying on biased ideas like rape myths. Indeed, misinterpretations due to prejudiced attitudes and beliefs such as rape myths alter the ability to accurately respond with empathy towards survivors (Smith, 1997). When the observer is basing their interpretations on external cues, such as crying or other behaviors that survivors "should" exhibit, the absence of what is expected in accordance with these behavioral stereotypes may indeed lower rape empathy (Smith, 1997).

In addition to the conceptual relationship asserted by Smith (1997), the relationship between RMA and rape empathy has also quantitatively been explored. For

example, higher empathy levels among psychology undergraduates were associated with decreased blaming of rape survivors for the attack (Dietz et al., 1982). Rape empathy was also found to be a statistically significant predictor of social perceptions of rape and rape survivors (Dietz et al., 1982). An additional study by Jiminez and Abreu (2003) found that higher levels of empathy towards rape survivors were associated with decreased levels of RMA and with the less likelihood to blame the survivor for the rape. Furthermore, a study by Sakalli-Ugurlu et al. (2007) concluded that males were less empathic and held more negative attitudes towards survivors than did females and that more positive attitudes towards survivors were predicted by rape empathy when using the ARV (Ward, 1988) which assesses survivor blaming and believability.

In this study, RMA was the main variable under examination. RMA was chosen as the main outcome variable, as opposed to rape empathy, due to previous research finding a predictive relationship between rape empathy and RMA (Sakalli-Ugurlu et al., 2007). This study also sought to investigate whether rape empathy predicted RMA among counselors. Furthermore, due to the assessments chosen to measure RMA, both male and female rape myths could be investigated.

### **Survivor Interactions with Various Systems**

RMA and rape empathy were important aspects to examine in relation to this study. However, it was also important to review the literature in regards to the various systems a survivor may cycle through following a rape. Survivors may come in contact with three systems: the legal, or law enforcement system, the medical system (often through the physical evidence collection process), and the mental health system through counselors or advocates who may be at the hospital during a post-assault examination

(Campbell, 2008). Positive interactions with these systems can help aid with healing. However, negative encounters can compound a survivor's already overwhelming emotions of self-blame, shame and lack of control and lead to "secondary victimization" or "second rape", which is defined as behaviors and attitudes that result in survivor blaming and further injury to the survivor (Campbell, 2008; Campbell & Raja, 2005).

Secondary victimization has been shown to occur through blame based behaviors stemming from interactions with the three systems (Campbell, 2008; Campbell & Raja, 2005; Campbell, Sefl et al., 1999; Campbell, Wasco et al., 2001). Indeed, the legal system has perpetuated revictimization by seeming to buy into various rape myths. Survivors have been asked about what they were wearing at the time of the rape, asked about their sexual histories or about their biological response to the rape (Campbell; Campbell & Raja, 2005). Survivors may have also been discouraged by law enforcement to make a report of the attack as well (Campbell & Raja, 2005). The medical system may also further traumatize a survivor by denying information regarding STD prevention or pregnancy or by asking questions that are blaming in nature (Campbell, 2008). This proven potential for secondary victimization from systems ultimately designed to help a survivor highlights the urgent need for professionals to be adequately able to handle a survivor's post-assault needs. It should be noted, however, that one study found that encounters with any of the formal systems that yielded positive reactions from the system's personnel resulted in positive growth for the survivor (Borja, Callahan, & Long, 2006).

Conversely, some previous research has indicated that the interaction with the mental health system results in an overall positive experience for the rape survivor, thus

decreasing their potential for secondary victimization from this system (Campbell, 2008; Wasco et al., 2004). For instance, survivors who had negative experiences with legal and medical system personnel were shown to have extensive PTSD symptoms due to both the rape and the secondary victimization (Campbell, Sefl, et al., 1999). However, following positive contact with mental health providers, the PTSD symptomology decreased and some of the secondary victimization was counteracted. Another study found that when survivors had positive reactions within their social systems, defined by the authors as family, friends, and social service providers, PTSD levels were lowered (Campbell, Ahrens, et al., 2001). Furthermore, a study investigating survivors' experiences with the mental health system in the state of Illinois found that survivors generally reported becoming more educated and supported and more aware of the various decisions they could make concerning their treatment and other aftereffects of rape (Wasco et al., 2004).

Even with the overall positive influence of mental health providers on a survivor's well-being, some studies demonstrated that experiences with the mental health system have detrimentally affected survivors. For example, Campbell, Wasco et al. (2001) found 25% of the women utilized in their sample ( $n = 157$ ) who had contact with mental health services characterized this interaction as "hurtful." Five percent of the sample rated their experiences with mental health providers as neither hurtful nor helpful. Furthermore, 12% of their respondents characterized their interactions with rape crisis centers as hurtful, while 13% rated rape crisis centers as neither hurtful nor helpful. Assessing survivor usage of religious resources, 15% of the survivors rated these services as hurtful as well (Campbell, Wasco et al., 2001).



Indeed, highlighting the potential harmful nature of mental health services for rape survivors, one survivor was quoted as saying, and “My therapist kept talking about my need for attention. How I made bad choices in life because of my need for attention. How I got myself raped for attention. Those words hurt as much as the rape itself” (Campbell et al., 1999, p. 847). Mental health professionals even acknowledge themselves that mental health experiences can be hurtful to survivors, with one study finding that 58% of clinicians believe that harm is caused to the survivors by the mental health system and that survivors do not receive much benefit from service utilization (Campbell & Raja, 1999). Kimerling and Calhoun (1994) found that, a year after the rape, utilization of mental health services did not have any moderating effect on the physical or psychological symptoms of rape survivors. These findings contrast with previous studies (Campbell, Ahrens et al., 2001; Campbell, Sefl et al., 1999) demonstrating positive impacts of interaction with mental health professionals, thus indicating potentially inconsistent ways of treating survivors. More research examining treatment methods and survivor experiences may be beneficial.

Further, Ullman (1996) asserted that negative reactions from supports, such as being treated differently, having someone take away control, or the listener being distracted, can affect survivors in detrimental ways. First, survivors may utilize avoidance as a coping mechanism. Second, survivors may blame themselves more for the attack when faced with survivor blaming attitudes from others, thus slowing recovery. Third, the combination of the previous two detrimental factors, avoidance and self-blame, can create an increase in mental health symptomology (Ullman, 1996). Indeed, negative reactions from providers, family and friends are shown to outweigh the benefits of

positive reactions, so preventative measures and proper training are clearly needed to minimize further trauma to rape survivors (Campbell, Ahrens et al., 2001). Furthermore, the fear of negative reactions may delay or halt survivors from seeking mental health services (Ullman, 2007).

Indeed, as the literature demonstrates, negative experiences do exist for survivors in the mental health system (Campbell, Ahrens et al., 2001; Kimerling & Calhoun, 1994). Furthermore practitioners have expressed their agreement over the potentially harmful effects of survivors seeking services (Campbell & Raja, 1999). These negative encounters should serve as a wakeup call to practitioners and students regarding needed changes in client care.

While overall a positive experience, some survivors choose not to seek help from mental health practitioners (Patterson, Greeson, & Campbell, 2009), citing a number of reasons for not seeking services. These reasons included the belief that systems could not be helpful to them, that they would be rejected by the system because they did not qualify for services due to their rape not being the stereotypical violent stranger rape, or that they would be harmed through systems interactions, especially if they had utilized a substance prior to their attack (Patterson et al., 2009). These findings have implications for mental health practitioners and trainees by helping them to understand barriers to survivors seeking services. Furthermore, Ullman (2007) asserted that survivors may have had negative experiences with the mental health system in the past, thus deterring them from disclosing their rape to a service provider. Finally, professionals should keep in mind the discrepancy of who is seeking treatment among racial and ethnic groups. Indeed, White

rape survivors are more likely than non-Whites to contact a rape crisis center or seek post-rape mental health services (Campbell, Wasco et al., 2001).

Generally speaking, mental health systems have a positive impact on survivors seeking services (Campbell, 2008). Mental health systems have even been shown to remediate the harmful effects of secondary victimization that can occur from negative experiences with legal and medical systems (Campbell, Sefl et al., 1999). However, not all encounters with the mental health system are positive (Campbell, Sefl et al., 1999; Campbell, Wasco et al., 2001; Kimerling & Calhoun, 1994). With such negative experiences reported, it was important to investigate the attitudes and empathy levels of professionals and students with the hope of using the findings to decrease the likelihood of any further injury to clients. By having conducted such an investigation, this raises awareness of RMA and rape empathy levels among those in the counseling field. By bringing such beliefs into the light and showing where any deficits lie, perhaps continuing education seminars for professionals can be created and increased training can be added to counseling programs for students to help reduce secondary victimization, increase rape empathy, and lower RMA.

### **Demographic Variables' Relationships to Rape Myth Acceptance and Rape Empathy**

Dye and Roth (1990) examined the impact of demographic variables (i.e., gender, age, degree held, and number of clients seen) on attitudes towards and knowledge of rape survivors among practitioners. RMA was found to increase as age increased.

Furthermore, males exhibited higher levels of RMA than did female clinicians. In regards to training and experience, the more clients seen per week, the more knowledgeable a

practitioner was found to be regarding rape treatment (Dye & Roth, 1990). There was no relationship found among gender, years of experience, and age with a practitioners' knowledge base of rape symptomology. Also, no significant relationship was found between degree held and knowledge base (Dye & Roth, 1990).

Kassing and Prieto (2003) investigated amount of time in a graduate program, age, numbers of semesters of counseling completed, rape clients seen, and rape counseling sessions completed, and sex. Regarding age, the findings indicated that the younger the participant in the study, the more they believed that the survivor should not have been out without others, particularly in the evening (Kassing & Prieto, 2003). Males were found to have higher levels of RMA than were female trainees, particularly if they had not worked with survivors before. Indeed, the study revealed that levels of RMA decreased as experience working with survivors increased, a finding which has implications for counselor training protocols (Kassing & Prieto, 2003).

Jiminez and Abreu (2003) conducted a study examining the impact of race and gender on levels of RMA and empathy towards rape survivors. Utilizing the Rape Empathy Scale (Dietz et al., 1982) and the Rape Myth Acceptance Scale (Burt, 1980), the authors found that females exhibited lower levels of RMA than did the male participants in the study. Furthermore, females within their sample ( $n = 336$ ) were also found to exhibit higher levels of empathy towards rape survivors than males, who were shown to be more tolerant of rape (Jiminez & Abreu, 2003). In regards to race/ethnicity, Latinas were found to be more accepting of rape myths and to hold more negative attitudes towards rape survivors than did European American women. This finding may be due to the more traditional gender roles and cultural values within the Latina/o culture, a culture

which is more patriarchal in nature (Jiminez & Abreu, 2003). However, European American females were more positive towards European American survivors than Latina survivors, a results which may stem from stereotypical ideas regarding the Latina culture as being flirtatious and passionate (Jiminez & Abreu, 2003).

Lee et al. (2005) demonstrated that, among their sample of Asian and European American undergraduate and graduate students ( $n = 216$ ), Asian students were more likely to believe that a survivor should be able to prevent a rape from occurring. Furthermore, European Americans were less likely to believe that the survivor was a factor in precipitating the attack. The authors (2005) asserted that the Asian students were more prone than European Americans to believing in the culpability of the survivor for the rape due to the emphasis placed on virginity and chasteness in Asian society (Lee et al., 2005). As such, the survivor may be viewed as one who was flirtatious and thus receive negative responses, which may serve as a deterrent for service seeking or discussions regarding the rape. Asian individuals also were more prone to believe that strangers are more likely to rape than acquaintances and that sex is the primary motivation for an attack, both of which are stereotypical ideas regarding rape. The Asian sample was more likely to seek harsher penalties for rapists than were European American students, however (Lee et al., 2005).

Donovan (2007) further supplemented the literature in regards to race/ethnicity and gender. Utilizing an all European American undergraduate sample ( $n = 431$ ), the author found that males were less likely to blame the perpetrator for the attack and were more likely to view the survivor as being promiscuous. Additionally, this study demonstrated that male participants were more likely to believe that African-Americans

who had been raped were more promiscuous than European American survivors when the race of the perpetrator was European American. When the perpetrator's race was portrayed as African-American, participants did not view either the European American or the African-American survivor as more promiscuous than the other (Donovan, 2007).

An additional study (Lefley, Scott, Llabre, & Hicks, 1993) investigated Hispanics, African-Americans, and European Americans' levels of survivor blaming and severity of symptomology following a rape. Hispanic individuals in the sample ( $n = 190$ ) were found to exhibit the most survivor blaming attitudes. African-Americans espoused less blaming attitudes than Hispanics but more than European Americans did, who espoused the least blaming attitudes. Among those who reported they had been raped of the three racial/ethnic groups, Hispanics were found to have the most severe symptomology, including using avoidance to deal with the rape and obsessive/compulsive behaviors (Lefley et al., 1993). African-Americans were again second in regards to levels of psychological distress, with European Americans reporting the least symptomology of the three groups (Lefley et al., 1993).

Bell et al. (1994) examined survivor blaming among a sample of undergraduate students ( $n = 303$ ), with particular attention paid to participant race/ethnicity and gender. Also investigated was how similar a participant felt towards, or how much they identified with, a portrayed survivor or perpetrator. Males in this study were found to identify more with the rapist, while females felt more similar to the survivors. Males also were more prone to survivor blaming. The racial/ethnic groups under examination (African-Americans, Asians, and European Americans) did not indicate any significant differences regarding who they identified with more. Furthermore, there were no significant

differences in how much a survivor was blamed for their rape among Asians, European Americans, and African-Americans (Bell et al., 1994).

Davies and McCartney (2003) explored gender and sexual orientation and the effects on RMA concerning male rape. A sample of gay males, heterosexual males, and heterosexual females were examined. Findings indicated that heterosexual men were the most anti-survivor of the sample, while females were less anti-survivor than heterosexual males. Gay males, however, were the most pro-survivor and were less likely to exhibit RMA or blame the male survivor. Gay males believed that the rape was more severe than either the heterosexual males or females. All participants reported generally low endorsement of RMA, however, regardless of their gender or sexual orientation (Davies & McCartney, 2003).

Wakelin and Long (2003) further examined gender and sexuality. Men were found to blame survivors more so than female participants did, while gay males and heterosexual women received more blame from all participants for the rape than did heterosexual males or lesbians. The characters of gay males were attributed to be more cause worthy of a rape than were those of lesbians or heterosexual males or females (Wakelin & Long, 2003). For example, a stereotypical idea concerning the personality of a gay male is that they have high sex drives, and if an individual believes this stereotype they may blame the gay male survivor more (Wakelin & Long). Men believed more that survivors secretly held unconscious desires to be raped, with heterosexual women and gay males being judged as having the highest levels of unconscious desire. Interestingly, female participants blamed gay males and lesbians for the attack as opposed to heterosexual survivors, while males blamed heterosexual females more so than the other

groups. Gay males and lesbians were also thought to be able to prevent or avoid the attack more easily in comparison to heterosexuals. In regards to blaming the perpetrator for the attack, women indicated higher levels of perpetrator blame in comparison to male participants, while individuals who raped gay males were seen as less responsible for perpetrating the attack than those who raped lesbians (Wakelin & Long, 2003).

Kassing et al. (2005) conducted a study examining the relationship between levels of male RMA and several variables (i.e., age, education, and homophobia) among a sample of males. Results from this article showed that higher levels of RMA were associated with homophobia. Furthermore, older men and less educated men were associated with higher levels of RMA as well. Melanson (1999) found similar results, with her study indicating that males had higher male RMA levels than females and that negative attitudes about individuals who are gay predicted male RMA levels.

Similar results were found in another recent study, also indicating that older individuals had more negative attitudes towards rape survivors, while those who were more educated and with higher incomes were more sympathetic (Nagel, Matsuo, McIntyre, & Morrison, 2005). Also examined in this study were gender and race. African-Americans were found to be more negative in their attitudes towards rape survivors than were European Americans. Furthermore, African American males were the least sympathetic towards survivors, followed by European American males. African-American females were less sympathetic than were European American females (Nagel et al., 2005).

Additional research has shown gender differences related to empathy towards a survivor (Idisis et al., 2007). Males have been shown to not perceive an event as rape that



women have perceived as rape. Furthermore, males have been shown to be less empathic towards a survivor and ultimately have viewed the survivor as a willing participant in the sexual activities that took place (Idisis et al., 2007). These gender differences are additionally supported by results from previous research again indicating that males have less empathy than females and less positive attitudes towards rape survivors (Sakalli-Ugurlu et al., 2007). This same study also found that sexist attitudes, whether espoused by males or females, were related to more negative attitudes towards survivors.

Regarding exposure to rape through knowing a survivor or being raped oneself, those who know survivors of rape have higher degrees of rape empathy than those who do not know a survivor (Barnett et al., 1992; Dietz et al., 1982). Previous research has also found that being a survivor of rape increases levels of empathy towards survivors as well (Chng & Burke, 1999; Smith & Frieze, 2003). Persons who did not know a survivor or who had not been raped revealed more tolerant attitudes towards rape (Chng & Burke, 1999). Degree of exposure to rape may have some impact on how empathic one is towards survivors or how tolerant attitudes are towards rape. For example, individuals who only knew a survivor and were not survivors themselves had lower levels of empathy and more tolerant rape attitudes than those who had themselves been attacked (Chng & Burke, 1999). Furthermore, Dye and Roth (1990) found that the more clients seen presenting with rape issues by the therapist, the more knowledge a practitioner had regarding rape, thus potentially indicating that exposure through work experiences (e.g.- seeing a client in a therapy session) may also have impacts on levels of RMA and rape empathy. Kassing and Prieto (2003) reported similar findings, stating that RMA decreases as experience working with survivors increases.

Literature focused on religion/spiritual orientation, RMA, and rape empathy is limited. Hunt (2000), however, assessed the relationship between religion and the general belief in a just world, which is related to survivor blaming and rape myths (Burt, 1980). This work did not find any support that there was any impact of religious/spiritual orientation on a belief in a just world. Aosved and Long (2006) demonstrated that religious intolerance, or prejudice against members of particular religions or the religious group in general, was related to higher levels of RMA. Homophobia was also found to increase RMA (Aosved & Long, 2006).

RMA and attitudes towards rape survivors related to Christian fundamentalism has also been investigated (Carr, 2006). This study found no significant impact of Christian fundamentalism on levels of RMA or on attitudes towards rape survivors. Nevertheless, those who scored higher in Christian fundamentalism were more prone to traditional sex roles, and the study found that espousing traditional sex roles was related to higher RMA and more negative attitudes. Also, those who were rated higher in authoritarianism tended to believe in more traditional sex roles, accepted more rape myths, and held more negative attitudes towards survivors. Furthermore, the study found that greater acceptance of rape myths was linked with more negative attitudes towards rape survivors (Carr, 2006).

The final demographic variable under study is that of counselor level, as indicated by training and educative experience. Counseling students receive many hours of training on various counseling related topics during their educational programs, as do counseling professionals who are obtaining CEUs. However, previous research has indicated that trainees and professionals are not receiving adequate amounts of information on how to

properly work with rape survivors (Campbell, Raja, & Grining, 1999). Out of a sample of 415 counselors, social workers, and psychologists, 14% had never received training on rape or domestic violence. Of those 14%, 43% had worked with survivors previously even without any training (Campbell, Raja et al., 1999). Furthermore, those who had received training usually did it voluntarily through continuing education and not through any mandatory requirements in their educational programs. Often, the clinical aspects of how to work with survivors had been covered with these professionals, but education was sorely lacking on the process survivors go through when reaching out to medical personnel or law enforcement (Campbell, Raja et al., 1999). Clinicians were generally unaware, too, of the detrimental effects utilizing these systems can have on the survivor (see Campbell, 2008, for a review).

Additionally, Adams and Riggs (2008) found that 25% of a counseling psychology graduate student sample ( $n = 129$ ) indicated that they had received no formal trauma training before working with traumatized clients. This same work (Adams & Riggs, 2008) found that a lack of training on trauma can increase the likelihood of trainees becoming vicariously traumatized, a condition which can lead to counselor impairment and thus client mistreatment (McCann & Pearlman, 1990). Previous research underscores the importance of adequate training and education. For instance, experience working with rape survivors and increased education levels has been shown to lower levels of RMA (Burt, 1980; Carr, 2006; Kassing & Prieto, 2003). These findings have implications for more positive client care.

The literature on demographic variables highlights that males, particularly heterosexual males, overwhelmingly exhibited less empathy and higher RMA towards

rape survivors (Davies & McCartney, 2003; Dye & Roth, 1990; Jiminez & Abreu, 2003; Kassing & Prieto, 2003; Melanson, 1999). The literature further suggests that as age increases, RMA and negative attitudes increase (Dye & Roth, 1990; Nagel et al., 2005) and as experience and education increases, RMA decreases (Burt, 1980; Kassing et al., 2005; Kassing & Prieto, 2003). Regarding sexual orientation, gay males and heterosexual females were found to be the most pro-survivor with lower acceptance of rape myths (Davies & McCartney, 2003). These same two groups also received the most survivor blaming as well when compared to heterosexual males and lesbians (Wakelin & Long, 2003). It is important to note that participant sexual orientation is understudied and that most of the literature focuses on survivor sexual orientation.

Knowing a survivor and/or being a survivor oneself was also investigated. Findings indicated that exposure through knowing someone or being personally raped increased empathy levels, although those who had been raped themselves had higher levels of empathy than those who simply knew a survivor (Barnett et al., 1992; Chng & Burke, 1999). Concerning race/ethnicity, the literature overall suggests that European Americans espouse less survivor blaming attitudes than do Hispanics, Latinas, African-Americans, and Asians (Jiminez & Abreu, 2003; Lee et al., 2005; Lefley et al., 1994). However, one study found no significant differences in survivor blaming levels among African-Americans, Asians, and European Americans (Bell et al., 1994). The impact of religion and spiritual orientation on RMA and empathy has not been demonstrated in the current literature. However, religious intolerance, the belief in traditional sex roles, and authoritarianism were associated with more negative attitudes towards rape survivors (Aosved & Long, 2006; Carr, 2006).

## **Critique of Relevant Literature**

While there is a good deal of literature on RMA, rape empathy, and demographic variables, there are gaps in the current research. For instance, the majority of the studies done, whether it be to investigate RMA, rape empathy or the impact of demographics, examined populations other than counseling professionals or counseling trainees. While Dye and Roth (1990) investigated RMA among “practitioners”, these clinicians were from other helping fields like psychology, social work or psychiatry. Idisis et al. (2007) examined rape empathy and utilized a sample that included criminologists, social workers, psychologists, psychiatrists and undergraduate students who have had no mental health or forensic background. Concerning student research, many studies only contained a sample of undergraduates majoring in various disciplines, the majority of which were psychology majors (Barnett et al., 1992; Carr, 2006; Chng & Burke, 1999; Jiminez & Abreu, 2003; Morry & Winkler, 2001; Sakalli-Ugurl et al., 2007).

A few studies, however, did contribute to the current body of knowledge specifically in regards to those in the counseling field. Kassing and Prieto’s (2003) study investigated rape myth acceptance, particularly regarding male survivors, among counselor trainees. The Hill et al. (1977) study was the only one that could be found regarding counselors’ levels of empathy towards rape survivors. This article was significant with its focus on counseling practitioners and counseling students, as there is an abundance of literature assessing psychology students. This work, although older, provides some background for the current research. It is important to note that the Hill et al. study (1977) also did not operationalize “feared rape”, leaving unclear whether feared rape meant fear of rape or a victim fearing that they may have been raped.

Furthermore, many studies are outdated. Several works are a decade old, if not much older (Barnett et al., 1992; Chng & Burke, 1999; Dietz et al., 1982; Dye & Roth, 1990; Ford et al., 1998; Hill et al., 1977). While their contribution is notable, newer research was needed to obtain a more accurate reflection of the current mental health field.

Other issues were found within the literature as well. Some research was not geared specifically towards rape but rather had a more general focus. For example, Hunt (2000), while providing much needed background on religion and a just world, does not address counseling or rape. Another work (Campbell, Sefl et al., 1999) utilized self-report in regards to survivor experiences with mental health systems, which may have biased the results. Furthermore, since this study asked participants to reflect on previous experiences, the passage of time may have altered their reports. Still another issue was the neglect of comprehensively investigating demographic variables. For instance, the Dietz et al. (1982) study creating the RES, while groundbreaking in its own right, was a heterosexually biased work based on female survivors and male perpetrators only. Furthermore, the study utilized only one race as a variable in the study instead of having a combination of races or being neutral which may have influenced the findings.

It is important to note the limited nature of the research on rape in regards to participant sexual orientation. For example, Wakelin and Long (2003) focus on the sexual orientation of the victim, while Kassing et al. (2005) and Melanson (1999) investigated the influence of homophobic or negative attitudes in regards to gay individuals. Only one recent study (Davies & McCartney, 2003) could be found that takes into account the

sexual orientation of those comprising the sample. This was important in relation to the current study, as participant sexual orientation was under examination.

Finally, Smith (1997) contributed to the literature connecting rape empathy and RMA. However, this work is conceptual in nature. Other studies (Jiminez & Abreu, 2003; Sakalli-Ugurlu et al., 2007) have statistically analyzed this relationship. However, the Jiminez and Abreu (2003) study changed the scales used in the research to focus more on race, a change that will not be made in this study, although race/ethnicity is a variable under examination. The Sakalli-Ugurlu et al. (2007) study utilized the RES (Dietz et al., 1982), as will this study. However, the authors only included six items from the RES and achieved a Cronbach's alpha of .67 with the altered version. The current study attempts to statistically investigate any potential relationship between rape empathy and RMA.

### **Summary of Relevant Literature**

Overall, the current research has a significant gap regarding the counseling field and levels of RMA and empathy towards rape survivors. This gap is especially noticeable in relation to rape empathy and the counseling field. This study sought to add to the existing body of literature by examining RMA and rape empathy among counseling professionals and trainees. This work was especially warranted due to the harmful effects of RMA, survivor blaming, and low empathy levels towards rape survivors (Burt, 1980; Campbell, 2008; Dietz et al., 1982). Furthermore, while there is some information related to the relationship between RMA and rape empathy (Dietz et al., 1982; Jiminez & Abreu, 2003; Sakalli-Ugurlu et al., 2007; Smith, 1997), this work sought to substantiate the research on this topic particularly in the counseling field.

While many studies have been conducted regarding demographic variables and the constructs under study, a deficit still exists in the literature in regards to the counseling field. Indeed, it was important to examine if gender, age, sexual orientation, religious/spiritual orientation, exposure (whether the participant knows a survivor or is a survivor), race/ethnicity, and counselor level (education/training experience) were predictive of RMA towards rape survivors among professionals and trainees. Rape empathy was also examined to determine if it is predictive of RMA as well. To further expand upon Burt's (1980) seminal work and increase the body of knowledge concerning demographics, the current research utilized more gender neutral terminology than was utilized in the RMA, changing the more "traditional" female survivor, male perpetrator dyad to "survivor" and "perpetrator" so that interpretation remained open with the intention of decreasing heteronormativity (i.e., hetero relationships as normative, potential assumption that rape only occurs in hetero relationships). These alterations on the scale created the MARS, which was renamed at the author's (Burt, 1980) request.

The findings of this work could have implications for counseling program curriculums and for practitioner trainings, especially in regards to continuing education units. For example, as the literature is in solid agreement that males in general exhibit less empathy and increased RMA (Dye & Roth, 1990; Jiminez & Abreu, 2003; Kassing & Prieto, 2003; Sakalli-Ugurlu et al., 2007), training could be tailored for this population to decrease any potential harm to clients. Generally, this study sought to create a comprehensive look at multiple demographic variables, rape empathy, and RMA.



## **CHAPTER THREE**

### **METHODOLOGY**

This chapter outlines the methodology that was used in researching the degree of RMA and rape empathy towards male and female survivors of rape espoused by master's and doctoral counseling trainees and counseling professionals. The demographic variables of gender, age, sexual orientation, religious/spiritual orientation, exposure (whether the participant knows a survivor or is a survivor), race/ethnicity, and counselor level (education/training experience) were also examined. The rationale for this study will be discussed, along with the research questions, participants, instrumentation, and specific data collection methods. Potential limitations of the research design and contributions will also be examined.

#### **Study Rationale**

RMA, or the belief in stereotypical notions regarding rape, the survivor, or the perpetrator (Burt, 1980), can lead to survivor blaming and to detrimental consequences for the rape survivor (Campbell, 2008; Campbell & Raja, 2005). Examples of rape myths include a male being able to fight off any attacker (Melanson, 1999) or the belief that if a survivor is drunk then they are "fair game" to be raped (Burt, 1980). Survivor blaming is associated with RMA and the belief in a just world is associated with survivor blaming (Burt, 1980). The belief in a just world is the idea that in a fair world individuals get what they deserve (e.g., a belief that if a person is raped, then he or she did something to precipitate the attack; Burt, 1980).

While literature exists examining undergraduate students' and some helping professionals' (e.g., social workers or psychologists) acceptance of rape myths, literature

looking specifically at the counseling field is scarce. What has been found, however, is that students and professionals are indeed accepting of rape myths (Dye & Roth, 1990; Ford et al., 1998; Idisis et al., 2007; Kassing & Prieto, 2003). Furthermore, Morry and Winkler (2001) found that some students believed that force against a woman to obtain sexual activity was acceptable at times.

The relationship between RMA and empathy towards rape survivors has been addressed in the literature, although some of it is conceptual, older, and not focused on counselors. Smith (1997) asserted that empathizing involves an individual cognitively perceiving and interpreting another's point of view and also matching that individual's affect. If the observing individual bases their perceptions and interpretations off of biased ideas, such as rape myths, this may inhibit their ability to empathize with that person. Not only do these miscalculations occur in situations that require a more generalized empathy, but they also occur when a rape survivors' external behaviors are misinterpreted, thus decreasing rape empathy towards the survivor (Smith, 1997).

Statistical studies examining the relationship between rape empathy and RMA exist as well. For example, higher empathy levels are associated with decreased attribution of blame for the rape, decreased RMA levels, and more positive attitudes (Dietz et al., 1982; Jiminez & Abreu, 2003; Sakalli-Ugurlu et al., 2007). Rape empathy was also found to be a statistically significant predictor of social perceptions of rape and rape survivors (Dietz et al., 1982).

Rape empathy levels among practitioners are understudied, though there is more literature in regards to empathy levels among students towards rape survivors. Counselors were found to be more empathic towards clients with existential anxiety than towards a

client presenting with “feared rape” (Hill et al., 1977). Furthermore, male counselors were found to be less empathic towards rape survivors than female counselors (Hill et al., 1977), a trend also seen among students (Sakalli-Ugurlu et al., 2007).

Demographic variables, such as gender, age, sexual orientation, religious/spiritual orientation, exposure (whether the participant knows a survivor or is a survivor themselves), race/ethnicity, and counselor level (education/training experience), were also examined in this study. Gender and its impact on rape myth acceptance has been previously studied, though not much literature exists in regards to this in the counseling field. Results showed that males have the tendency to blame rape survivors, male or female, and accept rape myths more so than females (Chng & Burke, 1999; Jiminez & Abreu, 2003; Kassing et al., 2005; Kassing & Prieto, 2003; Nagel et al., 2005). Sexual orientation was found to influence RMA as well, with gay males exhibiting lower levels of survivor blaming than heterosexual males and females (Davies & McCartney, 2003). Gay males and heterosexual women received the most blame for their attacks, however (Wakelin & Long, 2003). Overall, religion/spiritual orientation has not been directly shown to impact RMA (Carr, 2006; Hunt, 2000). However, one study did find that religious intolerance was related to increased RMA (Aosved & Long, 2006), while Carr (2006) found that belief in traditional gender roles, which was associated with higher degrees of belief in Christian fundamentalism, increased RMA.

Concerning exposure to rape themselves or to survivors, persons who knew survivors or who had been a survivor of rape had higher levels of empathy and more intolerant attitudes towards rape compared to those who did not know a survivor or had not been raped (Chng & Burke, 1999). Furthermore, those who had been raped exhibited

higher levels of empathy than those who only knew a survivor (Chng & Burke, 1999). Regarding age, Dye and Roth (1990) indicated that older individuals had higher levels of RMA, while another study found that younger participants believed that rape survivors should not be out late at night (Kassing & Prieto, 2003). The variable of counselor level shows that those with more training exhibited lowered RMA (Chng & Burke, 1999; Kassing & Prieto, 2003). Burt (1980) further found that those with more education were less prone to accept rape myths as well.

Regarding race/ethnicity, one study (Jiminez & Abreu, 2003) concluded that European American females were more positive towards survivors and less accepting of rape myths than were Latinas. In addition, European American females were more sympathetic towards European American survivors than they were towards Latina survivors. Furthermore, Donovan (2007) indicated that European American students believed that, when the perpetrator was European American, African-American survivors were more promiscuous than European American survivors. There were no differences in viewed promiscuity between African-American and European American survivors when the perpetrator was African-American, however. Another study by Lefley et al. (1994) found that Hispanics exhibited the most survivor blaming attitudes, while African-Americans espoused less than Hispanics. European Americans were found to have the least survivor blaming attitudes among the three racial/ethnic groups (Lefley et al., 1994). Conversely, however, Bell et al. (1994) indicated that there were no variations among the racial groups of African-Americans, Asians, and European Americans in how much they blamed a survivor.

Although many quantitative studies exist examining the constructs under study, these studies do not highlight RMA and empathy levels in the counseling field in particular, with attention to several demographic variables. As the previous literature suggested, exposure to rape survivors through training and counseling experience can help to decrease levels of RMA (Kassing & Prieto, 2003) and increase empathy (Chng & Burke, 1999). With the new CACREP (2009) guidelines demanding the integration of trauma related material into master's and doctoral counseling program curriculum, it is hoped that rape will be part of the new educative material, thus reducing the acceptance of rape myths. It is also hoped that practitioners obtain some of their CEUs by attending trainings on rape and trauma. By studying trainees in master's and doctoral counseling programs and professionals already out in the field, levels of RMA and rape empathy were investigated to obtain a sampling of what survivors may be experiencing when they seek services from counselors. The results could have implications for how counseling students are educated regarding rape to better serve clients who present with rape experiences and also on how counseling practitioners choose to continue their education.

Furthermore, by examining gender, age, counselor level, and exposure, it was hoped to see if similarly to previous work if males exhibited higher RMA and less empathy (Idisis et al., 2007; Jiminez and Abreu, 2003; Kassing & Prieto, 2003) and if age or experience had an impact on RMA and empathy (Burt, 1980; Dye & Roth, 1990; Kassing & Prieto, 2003). By addressing religious/spiritual orientation, race/ethnicity, and sexual orientation, this work may further address gaps in the literature, especially in regards to the counseling field.

### **Research Design**

The research design of this study was non-experimental survey research. Survey research does not manipulate any variables but rather investigates phenomena as they naturally occur (Wiersma & Jurs, 2009). Often utilizing interviews or as the name implies, questionnaires, survey research examines “incidence, distribution, and relationships of educational, psychological, and sociological variables” (Wiersma & Jurs, 2009, p. 16). Some surveys simply describe the current, consistent conditions (Marczyk et al., 2005) and other surveys seek to investigate relationships that may occur among the variables of study (Wiersma & Jurs, 2009). A benefit of survey research is its ability to give researchers access to large amounts of data from large samples. Survey research is also a relatively inexpensive way to investigate a research question (Marczyk et al., 2005). The steps involved in survey research include the following: (a) defining the research problem and developing the design; (b) reviewing the literature and constructing operational definitions; (c) developing a plan for obtaining a sample; (d) preparing for data collection, including obtaining instruments or developing surveys; (e) planning how data will be compiled and analyzed; (f) collecting data ; and (g) analyzing data (Wiersma & Jurs, 2009).

This study utilized a parallel-samples design, which is similar to cross-sectional designs (Wiersma & Jurs, 2009). A cross-sectional design is defined as “the collection of data at one point in time from a random sample representing some given population at that time” (p. 196). What distinguishes a parallel-samples design from a cross-sectional design is that two or more populations are under study at the same time, as opposed to just one population being examined in a cross-sectional design (Wiersma & Jurs, 2009). In this study the two populations examined were counseling practitioners and counseling

trainees, and these two populations were assessed once utilizing the demographic sheet (Appendix E), the Rape Empathy Scale (RES; Appendix B), the Male Rape Myth Scale (MRMS; Appendix D), and the Myths and Attitudes about Rape Scale (MARS; Appendix C), which was adapted from Burt's (1980) RMAS. These assessments were administered through SurveyMonkey.

### **Purpose Statement**

The purpose of this quantitative research was to study master's and doctoral counseling students' and counseling practitioners' levels of RMA and rape empathy and further assess the relationship between rape empathy and RMA. Also assessed were if rape empathy and demographic variables (gender, age, counselor level, exposure, sexual orientation, race/ethnicity, and religious/spiritual orientation) are predictive of RMA.

### **Research Questions**

*Research Question 1:* What is the degree of rape myth acceptance and rape empathy in master's and doctoral counseling students and counseling professionals towards male and female rape survivors?

H<sub>1</sub>: There will be a significant difference in RMA and rape empathy levels between master's and doctoral counseling students and counseling professionals towards male and female survivors.

*Research Question 2:* To what degree are demographic variables and rape empathy predictive of RMA towards females?

H<sub>2</sub>: Gender, age, sexual orientation, religious/spiritual orientation, exposure (whether the participant knows a survivor or is a survivor), rape empathy, race/ethnicity, and counselor level (education/training experience) are

significantly predictive of RMA towards female rape survivors by master's and doctoral counseling students and counseling professionals.

*Research Question 3:* To what degree are demographic variables and rape empathy predictive of RMA towards males?

H<sub>3</sub>: Gender, age, sexual orientation, religious/spiritual orientation, exposure (whether the participant knows a survivor or is a survivor), rape empathy, race/ethnicity, and counselor level (education/training experience) are significantly predictive of RMA towards male rape survivors by master's and doctoral counseling students and counseling professionals.

*Research Question 4:* Is there a significant relationship between rape myth acceptance and rape empathy?

H<sub>4</sub>: There will be a significant relationship between RMA towards females and RMA towards males and levels of rape empathy displayed by master's and doctoral counseling students and counseling professionals. The researcher assumes that there will be a relationship between low levels of RMA and high levels of empathy towards rape survivors and between high RMA and low rape empathy.

### **Participants**

This study utilized two randomly selected groups of participants: (1) counselor trainees and (2) counseling professionals (i.e., counselors or counselor educators). Participants noted on the demographic sheet whether they are a trainee or professional. Trainees were master's or doctoral students in counseling program, and the practitioners were practicing counseling professionals or counselor educators. These clinicians were



required to identify as counselors or counselor educators as opposed to identifying with other helping fields such as social work or psychology. 107 (54 per group) participants were needed for the hypotheses to be tested at the .05 level.

### **Instrumentation**

This study utilized the MARS (adapted from Burt's [1980] RAMS), the MRMS, the RES, and a demographic collection sheet. Notes on the permissions for use of each instrument are included in Appendices B, C, and D. Each of these assessments was given through SurveyMonkey, an online website that is able to distribute instruments. Each online assessment packet was presented to each participant in a random order via different links to the packet. The randomization of instruments was used to decrease the incidence of ordering bias in this study, thus helping to preserve the integrity of the collected data.

### **Demographic Information**

Demographics were collected for each participant in this study (Appendix E). Information collected included gender, age, sexual orientation, religious/spiritual orientation, exposure (whether the participant knows a survivor or is a survivor), race/ethnicity, and counselor level (education/training experience). Furthermore, information regarding the participant's education was gathered, including background information on their master's and doctoral counseling program (accreditation status, credit hours completed in the program), any degrees held, information regarding any training received regarding rape, and the number of clients seen presenting with a rape experience.

### **Myths and Attitudes about Rape Survey**

This study utilized the Myths and Attitudes about Rape Scale (MARS), which is an alteration of Burt's (1980) RMAS. The name of the scale was changed at the request of the RMAS's author. A discussion of the altered instrument is presented later in this section. The original assessment is a 19-item self-report measure of attitudes towards rape (Jiminez & Abreu, 2003). The scale utilizes a 7-point Likert scale varying from (1) *strongly agree* to (7) *strongly disagree* with higher scores showing "more accurate perceptions of rape" (Jiminez & Abreu, 2003, p. 254). In other words, higher scores show lower acceptance of rape myths, and lower scores demonstrate higher acceptance of rape myths. Furthermore, two questions ask participants to answer in terms of how often they believe a rape story was fabricated by a survivor with possible answers being *almost all*, *about 3/4*, *about half*, *about 1/4*, or *about none*. One other question ask participants to disclose how likely they would believe an individual's story based on demographic variables, with possible answers being *always*, *frequently*, *sometimes*, *rarely*, or *never*. It is also important to note that one item is reverse scored on this instrument. This instrument assesses levels of belief in such statements as "A woman who goes to the home or apartment of a man on their first date implies that she is willing to have sex" and "Many women have an unconscious wish to be raped, and may then unconsciously set up a situation in which they are likely to be attacked" (Burt, 1980).

Three concepts, derived from feminist theory and social psychology, guided the development of this assessment, which were (1) *sexual conservatism*, defined as restrictiveness of sexual partners or acts and circumstances needed for sex to occur, (2) *adversarial sexual beliefs*, or the expectation that sexual relationships are by nature devious, manipulative, and dishonest, and (3) *acceptance of interpersonal violence*,

defined as the view that “force and coercion are legitimate ways to gain compliance and specifically that they are legitimate in intimate and sexual relationships” (Burt, 1980, p. 218). It is important to note that *sexual conservatism* was conceptualized with the “just world hypothesis” in mind, thus indicating that participants who held conservative beliefs regarding sex may view the survivor’s participation in the forced sexual act, which may not have conformed to perceived acceptable, traditional sexual practices, as so menacing that they are willing to “overlook the coercion and force involved and condemn the survivor for participating” (Burt, 2003, p. 218).

Validity is shown by the item-to-total correlation of scores with the three concepts: *sexual conservatism* ( $r = .39$ ), *adversarial sexual beliefs* ( $r = .40$ ), and *acceptance of interpersonal violence* ( $r = .50$ ) (Burt, 1980). Burt (1980) reported the scale’s Cronbach’s alpha at .88 using a sample of 598 Minnesota adults ages 18 and over. For this sample the mean age was 42 with 60% of the sample being female. Other studies that have administered the RMAS include Jiminez and Abreu (2003) with a reported alpha of .88 when using a sample of Latina/o and European American males and females ( $n = 336$ ), Schechory and Idisis (2006) who reported an alpha of 0.75 when given to female students in social science courses ( $n = 125$ ) and female therapists ( $n = 51$ ), and Bohner et al. (2005) with an alpha of 0.83, who utilized male undergraduates and male employees in a specific area of the United Kingdom ( $n = 114$ ). Dye and Roth (1990) also utilized the RMAS with practicing psychiatrists, social workers, and psychologists ( $n = 257$ ) but did not report an alpha pertaining to their study other than the one obtained by Burt.

Burt's (1980) RMA was selected for use in this study for its ability to measure RMA with adequate reliability and validity. Indeed this classic scale has been used the most frequently in studies of rape myths (Foubert & McEwen, 1998). A potential weakness of this scale is the effect of repeated testing on post-test scores, which have been found to be lowered in previous studies (Foubert & McEwen, 1998). However, this limitation should not have any effect on this study, as no pre-test and post-test methodologies are expected.

An additional limitation is the apparent viewpoint that hetero relationships are normative, leading to the potential assumption that rape only occurs in hetero relationships. To address this, four items were revised to enable for a more open interpretation of who a perpetrator may be. Specifically, the following were altered for this study: (1) A woman who goes to the home or apartment of a *person* (previously "man") on their first date implies that she is willing to have sex; (2) A woman who is stuck-up and thinks she is too good to talk to *potential partners* (previously "guys") on the street deserves to be taught a lesson; (3) If a woman gets drunk at a party and has intercourse with an *individual* (previously "man") she's just met there, she should be considered "fair game" to *others* (previously "males") at the party who want to have sex with her too, whether she wants to or not; (4) What percentage of women who report a rape would you say are lying because they are angry and want to get back at the *person* (previously "man") they accuse? With the changes to the assessment, the Cronbach's alpha for this study was .80.

### **Male Rape Myth Scale**

The Male Rape Myth Scale (MRMS; Melanson, 1999) is a 22-item self-report measure of attitudes about rape perpetrated against males, particularly focusing on acceptance of rape myths and stereotypes regarding male rape (Kassing et al., 2005). The MRMS is a 6-point Likert scale (1= *strongly disagree* to 6= *strongly agree*) with scores falling on a continuum between 22 to 132, with the higher scores indicating more belief in rape myths (Kassing et al., 2005). Example items include “Many men claim rape if they have consented to homosexual relations but have changed their mind afterwards” and “I would have a hard time believing a man who told me he was raped by a woman”. This instrument was selected for this research study due to its sole focus on males as survivors of rape, with both females and males as potential perpetrators.

Melanson (1999) reported strong reliability for the MRMS. Utilizing a sample of undergraduate students ( $n = 303$ ), Melanson (1999) found that the Cronbach’s alpha was .90 with a 4-week test-retest reliability of  $r(291) = .89, p < .0001$ . Furthermore, strong validity was reported as well in two ways (Melanson, 1999). First, convergent validity strongly correlated with criterion measure scores on rape scenarios,  $r(301) = .71, p < .0001$ , and second, the MRMS showcased the expected differences in relation to gender, specifically males demonstrating higher levels of RMA than females. An additional study that has utilized the MRMS was Kassing et al. (2005) who reported a Cronbach’s alpha of .91 utilizing a sample of Midwestern adult males ( $N = 210$ ).

### **Rape Empathy Scale**

The Rape Empathy Scale (RES) created by Deitz et al. (1982) is a 19-item measure of empathy towards and responsibility ascribed to rape survivors (Jiminez & Abreu, 2003). The 7-point Likert scale ranges from (1) *strongly disagree*, indicating

strong empathy for the rapist to (7) *strongly agree*, indicating strong empathy for the survivor (Dietz et al., 1982). Higher scores on the RES signify high levels of empathy towards rape survivors and lower levels of attributing responsibility to the survivor for the attack (Jiminez & Abreu, 2003).

Items on this scale include pairs of statements that indicate more empathy either for the rape survivor or for the rapist. Examples include statements such as, “I feel that the situation in which a man compels a woman to submit to sexual intercourse against her will is not a justifiable act under any circumstances” and “I feel that the situation in which a man compels a woman to submit to sexual intercourse against her will is a justifiable act under certain circumstances.” (Dietz et al., 1982). Another item is “In general, I feel that rape is an act that is not provoked by the rape victim” and “In general, I feel that rape is an act that is provoked by the rape victim.” (Dietz et al., 1982). The original instructions stated “to choose the statement from each item that they preferred and to indicate their degree of preference for one statement over the other (ranging from strong preference for a statement to no preference for one statement or the other)” (Dietz et al., 1982, p. 374). Due to potential confusion among participants about how to complete the survey, the RES was altered in SurveyMonkey to contain only the most empathic statements on the RES. For example, utilizing the two sample questions just given, the statements that appeared on the assessment were “I feel that the situation in which a man compels a woman to submit to sexual intercourse against her will is not a justifiable act under any circumstances” and “In general, I feel that rape is an act that is not provoked by the rape victim” (Dietz et al., 1982). Participants were still instructed to

score their agreement with the statements on a 7-point Likert scale. Following the alteration, the Cronbach's alpha was .78.

Utilizing a sample of psychology undergraduates ( $n = 639$ ) and randomly selected individuals from lists of jurors ( $n = 170$ ), Dietz et al. (1982) reported an alpha coefficient for this scale of .84. Other studies have detailed similar alphas, including .82 when using a sample of 336 Latina/o and European American male and female undergraduates (Jiminez & Abreu, 2003) and .80 when administered to an another set of college students ( $n = 387$ ; Chng & Burke, 1999). Sakalli-Ugurlu et al. (2007) reported a Cronbach's alpha of .67 when they utilized only six items from the assessment with male and female Turkish college students ( $n = 425$ ). Information is somewhat lacking concerning the validity of the RES, however, some previous research utilizing the RES report the instrument as being valid (Chng & Burke, 1999; Dietz et al., 1982). Convergent validity was determined by examining the relationship between scores on the RES and the Attitudes towards Women Scale (AWS) for the first group of participants utilized in creating the instrument, with a significant correlation of  $r = .33, p < .05$  (Dietz et al., 1982). The second group utilizing students showcased validity of  $r = .45, p < .001$ . Indications of discriminant validity were shown by the deficit of a significant relationship between the Marlowe-Crowne Social Desirability Scale and the RES,  $r = .05, ns$  (Dietz et al., 1982). This instrument was chosen due to its measurement of empathy towards rape survivors, since empathy is a quality necessary in all counselors and counselors-in-training.

## Method

### Compliance

Data were collected in accordance with Federal codes (*Code of Federal Regulations Title 45 Part 46, [45CFR46]*), the state of Virginia regulations (*Virginia Code 32.1-162.16 et seq.*), and with the Human Subjects Review Board at Old Dominion University. The ODU board analyzed and subsequently approved any and all research methods prior to data collection. The IRB number for this research was 200902083. The researcher was furthermore in compliance with the American Counseling Association *Code of Ethics* (ACA, 2005).

### **Data Collection**

Participants were counseling trainees and counseling practitioners. To obtain this sample, a randomized list of 2,000 individuals from ACA was purchased with equal numbers of professionals and trainees. This list was chosen as the sampling method for this study because it had up to date information on ACA members since membership must be renewed annually. Furthermore, members of ACA were likely to self-identify as counseling professionals or students, a criterion for participation in this research, and the low cost for several contacts and ease of use of the ACA randomized member list helped to potentially ensure greater returns and also allowed for an equal distribution of trainees and practitioners.

Of the 2,000 solicited (1,000 for each group), 107 (54 per group) were needed at the .05 level to reach statistical power (Cronbach, 1992). All 2,000 individuals were then sent an email (Appendix G) inviting them to participate in the current research. This email also supplied the link to the measures that were used: the MARS, the MRMS, the RES, and the demographic information collection sheet. The participants were then asked to complete the measures by the chosen deadline for inclusion in the study. To increase



response rate, two weeks after the initial contact a follow-up solicitation email was sent to participants reminding them of the study.

The instruments were uploaded onto Survey Monkey following receipt of permission for use (Appendices B, C, and D). To control for ordering bias, participants were divided into three groups via stratified random sampling and assigned one of three links leading to a randomly ordered assessment packet. Upon receipt of an adequate number of returns for this study, the participant answers were uploaded from Survey Monkey to SPSS where the statistical procedures were run and analyzed. Descriptive statistics were utilized to indicate the sample's demographic makeup, including age, gender, educational and training background, religious/spiritual orientation, sexual orientation, race/ethnicity, and exposure to rape, as well as to assess the degrees of RMA and rape empathy among the sample. An independent *t*-test was used to assess significant differences, if any, between the two groups' levels of RMA and rape empathy. A stepwise regression was utilized to determine if rape empathy and demographic variables are predictive of RMA, while a Pearson product moment correlation was used to determine if a relationship existed between RMA and rape empathy.

### **Data Analysis**

*Research Question 1:* What is the degree of rape myth acceptance and rape empathy in master's and doctoral counseling students and counseling practitioners towards male and female rape survivors?

H<sub>1</sub>: There will be a significant difference in rape myth acceptance and rape empathy levels between master's and doctoral counseling students and counseling practitioners towards male and female survivors.

H<sub>1</sub> will be analyzed using descriptive statistics and an independent *t*-test.

*Research Question 2:* To what degree are demographic variables and rape empathy predictive of RMA towards females?

H<sub>2</sub>: Gender, age, sexual orientation, religious/spiritual orientation, exposure (whether the participant knows a survivor or is a survivor), rape empathy, race/ethnicity, and counselor level (education/training experience) are significantly predictive of RMA towards female rape survivors by master's and doctoral counseling students and counseling professionals.

H<sub>2</sub> will be analyzed using the Stepwise Regression statistical test. The stepwise method of regression, rather than entering all variables at once, inputs variables one at a time into the model (Meyers, Gamst, & Guarino, 2006). A predictor variable will be extricated from the model if it does not contribute significantly to the results at the .05 level (Meyers et al., 2006). Stepwise regression models are beneficial to research procedures due to their ability to create a "lean and mean" model, through which "each independent variable in it has earned the right to remain in the equation" by "excluding variables that add nothing of merit to the prediction" (Meyers et al., 2006, p. 175). Also, stepwise procedures are useful for research that is exploratory, as the current study is (Field, 2009). The predictor variables will be RES scores and the various demographic variables. The outcome variable will be scores on the MARS.

*Research Question 3:* To what degree are demographic variables and rape empathy predictive of RMA towards males?

H<sub>3</sub>: Gender, age, sexual orientation, religious/spiritual orientation, exposure (whether the participant knows a survivor or is a survivor), rape empathy,

race/ethnicity and counselor level (education/training experience) are significantly predictive of RMA towards male rape survivors by master's and doctoral counseling students and counseling professionals.

H<sub>3</sub> will be analyzed using the stepwise regression statistical test. The predictor variables will be RES scores and the various demographic variables. The outcome variable will be scores on the MRMS.

*Research Question 4: Is there a significant relationship between RMA and rape empathy?*

H<sub>4</sub>: There will be a significant relationship between RMA towards females and RMA towards males and levels of rape empathy displayed by master's and doctoral counseling students and counseling practitioners towards both male and female rape survivors. The researcher assumes that there will be a relationship between low levels of RMA and high levels of empathy towards rape survivors and between high RMA and low rape empathy.

H<sub>4</sub> will be examined utilizing the Pearson Product Moment Correlation analysis.

### **Limitations**

Researchers for any study must acknowledge both the internal and external threats to the validity of the research. Internal validity is the extent to which researchers can assert that indeed the independent variable had an effect on the dependent variable instead of outside, alternative factors causing the effect (Wiersma & Jurs, 2009). External validity is defined as the extent that the results of a study can be generalized to the population without making inaccurate surmises regarding the sample used (Wiersma & Jurs, 2009).

The internal validity threat of history, or the possibility of events occurring during research that may alter the variables being measured, applies to this study (Wiersma & Jurs, 2009). For example, a rape may have occurred on campus or in a participant's personal life that may affect how they view rape. Furthermore, there will be no way of knowing if any program has included rape-specific trauma training at the point data was collected, which could have had an impact on the data.

Additionally, participants who self-selected to take the assessments may have already developed certain ideas regarding rape that may have made them more prone to participating in a study on this topic (Wiersma & Jurs, 2009). This selection bias may also be seen inherently in the sample's composition, as all were ACA members. A similar limitation is that participants may have answered in a socially desirable manner since rape is an emotionally charged subject (Marczyk et al., 2005). This may have skewed the results, and as this was self-report survey research, no safeguards were in place to control for this limitation. Maturation may also have been an issue due to participant fatigue because of the total number of measures used (3) plus the need to collect demographic data (Wiersma & Jurs, 2009). Ordering bias may present as an issue in this study as participants may have been influenced or "tipped off" to the nature of the research by the assessment packet. To control for this, the researcher utilized multiple links, which had the assessments randomly ordered.

An external validity threat to this study was that of interaction effects of selection biases and the experimental treatment (Wiersma & Jurs, 2009). It may be that students and practitioners who were more educated regarding the counseling field, including about RMA and empathy as a necessary component for a successful counselor, for example,

may have self-selected themselves into the ACA organization. This may have impacted the results of this study. Another example would be participants who reported being Christian may have been influenced by their religious upbringing regarding rape. Since this study focused solely on counseling programs, generalizability to the population in general outside of the field could be an issue. However, Wiersma & Jurs (2009) stated, “It should not be inferred that to have external validity, results must generalize to many and varied populations and conditions” (p. 9). Therefore, the generalizability of these results to the counseling field at large should hopefully prove sufficient.

A few limitations existed due to the design of this research, which was non-experimental survey research with a parallel-samples design. Not all of the participants who were invited to take the assessments responded and the individuals that did not respond to the inventories may have created bias in the findings (Wiersma & Jurs, 2009). Also, this research was self-report and did not involve direct observation of practitioner or trainee work with rape survivors. Participants may also have found it difficult to remember how many clients they have seen in the previous year who had presented with rape issues. Furthermore, items were revised on the RMAS. Although new psychometrics were computed for this study, these changes did alter the original psychometrics for the scale Burt (1980) created.

Stepwise regression procedures are not without its limitations. For example, a researcher’s control over which variables are included in the model may be lessened because a computer, in this study SPSS, is making that decision (Field, 2009; Meyers et al., 2006). Stepwise models may either over-fit a model by inputting too many variables that do not contribute much to the outcome of the study or may under-fit a model by

utilizing too few variables that are indeed important predictors (Field, 2009).

Furthermore, how much a predictor impacts the outcome variable is unknown (Meyers et al., 2006).

### **Potential Contributions**

This study sought to add to the body of literature surrounding rape. While many studies have been done on RMA and on empathy in general, research on this topic that addresses rape empathy and male and female RMA among only counseling practitioners and trainees is virtually nonexistent. By analyzing professionals' and trainees' levels of RMA and rape empathy, the results may inform decisions by counseling programs about how to educate and train their students regarding this pervasive issue and on how practitioners choose to obtain their CEUs. If training is enhanced, this can have an impact on client treatment and potentially reduce client retraumatization. Additionally, by studying gender, age, exposure to rape, counselor level, sexual orientation, race/ethnicity, and religious/spiritual orientation, further understanding may be reached regarding the attitudes of students in counseling programs and practitioners in the field which may allow for further tailoring of educative practices regarding rape. This aspect of the study will also add to the literature as the majority of the existing research concerning these variables has not been counseling program specific. Finally, most sexual orientation research focuses on the victim, as opposed to the participant. This research will examine the influence of the participant sexual orientation on RMA.

## **CHAPTER FOUR**

### **RESULTS**

The purpose of this research was to study master's and doctoral counseling students' and counseling professionals' levels of RMA and rape empathy and further assess the relationship between rape empathy and RMA. Rape empathy and demographic variables were also examined to determine if they were predictive of RMA. Demographic variables under study included gender, age, counselor level (training/education experience), exposure (whether the participant knows a survivor or is a survivor themselves), sexual orientation, race/ethnicity, and religious/spiritual orientation. Quantitative methods were utilized since research is limited that statistically examines the concepts under study within the counseling field specifically. This chapter will discuss the demographics of the sample utilized and will also present the results of this research.

#### **Demographics**

This study utilized two randomly selected groups of participants: (1) counselor trainees, who were either master's or doctoral students, and (2) professionals, who were counselors or counselor educators. Participants were asked to identify themselves as professionals and/or students. Since individuals could choose more than one role on the demographic sheet, such as being a doctoral student and a counselor, they were also invited to identify their primary role. The sample was obtained through ACA, who provided a randomized list of 1,000 students and 1,000 professionals. This list was then divided via stratified sampling to one of three links which directed them to the

assessment packet on SurveyMonkey. The assessments were placed in a random order so as to control for ordering bias in the results.

The first solicitation to participate was sent out on June 22, 2010. Two weeks later, the researcher sent out a reminder email on July 7, 2010. After the second email, the required number of participants was met (107 at the .05 level). Out of the 2,000 obtained email addresses, 58 emails were returned to the researcher as undeliverable leaving 1,942 potential participants. The total rate of return for this study was 213 out of 1,942 potential participants, or 10.9%. Some individuals began but did not complete the assessment packet. These individuals, which were 19 in number, were deleted from the overall results. After the deletion of these participants, 194 (10.0%) surveys were counted as fully completed by the researcher. Overall, 108 (55.7%) individuals identified themselves as professionals, and 85 (43.8%) identified themselves as trainees. One (0.5%) did not answer the question. Although 194 cases were counted as complete, some questions were unanswered on the demographic sheet, the MARS, the RES, and the MRMS. The number of items with missing responses was 43. No more than three responses were missed in any participant packet.

On the demographic sheet, the participants indicated their age. One person did not answer this question. Individuals were given several age ranges in which to place themselves. Participants fell into all age ranges with the exception of 76+. Table 2 illustrates the distribution of participants per age category. Furthermore, Table 3 shows the age composition as dispersed among the two groups: professionals and trainees.



Table 2  
*Age of Participants*

	Frequency	Percent
18-24	20	10.3
25-30	46	23.7
31-35	28	14.4
36-40	19	9.8
41-45	14	7.2
46-50	20	10.3
51-55	19	9.8
56-60	12	6.2
61-65	10	5.2
66-70	4	2.1
71-75	1	.5

Table 3  
*Participant Ages By Category*

	Professionals		Trainees	
	Frequency	Percentage	Frequency	Percentage
18-24	3	2.8	17	20.0
25-30	23	21.3	23	27.1
31-35	19	17.6	9	10.6

36-40	11	10.2	8	9.4
41-45	8	7.4	6	7.1
46-50	12	11.1	8	9.4
51-55	12	11.1	6	7.1
56-60	10	9.3	2	2.4
61-65	6	5.6	4	4.7
66-70	3	2.8	1	1.2
71-75	1	0.9	0	0.0

---

Participants were also asked to identify their gender on the demographics sheet. Participants were able to mark that they were male, female, or transgendered. Of the 194 participants, all answered this question. The sample was composed of 156 females (80.4%) and 38 males (19.6%). No individuals identified as transgendered.

Individuals also noted their race/ethnicity. Participants could identify as African American, Asian American, Hispanic, Native American, White, Other, or a combination of the above. Race/ethnicities listed in the “other” category included Pacific Islander and Arabic. There were no missing responses. Also, none of the participants in this research identified as a combination of any race/ethnicity. Table 4 outlines the race/ethnicity distribution for this sample. Table 5 shows the race/ethnicity dispersion by professional or student category.

Table 4  
*Race/Ethnicity of Participants*

	Frequency	Percent
African American	19	9.7
Asian American	1	.5
Hispanic	8	4.1
Native American	4	2.1
White	160	82.1
Other	3	1.5

Table 5  
*Participant Race/Ethnicity By Category*

	Professionals		Trainees	
	Frequency	Percentage	Frequency	Percentage
African-American	9	8.3	10	11.6
Asian-American	0	0.0	1	1.2
Hispanic	2	1.9	6	7.0
Native American	2	1.9	2	2.3
White	93	86.1	66	76.7
Other	2	1.9	1	1.2

Participants were asked to note their sexual orientation. No missing responses were given for the 194 valid cases. Overall, there were 3 (1.5%) individuals who reported they were gay, and 6 (3.1%) participants who identified as lesbians. Furthermore, 15 (7.7%) members of the sample noted that they were bisexual, and one (0.5%) identified as questioning. The majority, 169 (87.1%) individuals in total, cited that they were heterosexuals.

Participants also reported their religious/spiritual orientation. The majority of the sample, 126 (64.9%), indicated they were Christian. Four (2.1%) were Jewish, 9 (4.6%) Buddhist, 21 (10.8%) Agnostic, and 17 (8.8%) marked “none” as their orientation. Fourteen (7.2%) persons noted “other” as their religious/spiritual orientation, citing Quaker, Religious Science, Interfaith, Baha’i, and Native American traditionalist as their religion or spiritual preference. Furthermore, 3 (1.5%) participants chose not to answer the question. When asked if they were practicing, somewhat practicing, or not practicing their religious or spiritual orientation, 99 (51.0%) stated they were practicing, 54 (27.8%) cited they were somewhat practicing, and 39 (20.1%) were not practicing. Two (1.0%) individuals did not respond to this question.

Study participants reported whether they themselves had experienced a rape. They also could identify if they knew a survivor. Concerning personally experiencing a rape, all individuals answered the question. Of the 194 responses, 80 (41.2%) reported that they had experienced a rape, while 114 (58.8%) stated they had not. A majority of individuals cited that they did know a survivor of a rape. 167 (86.1%) knew an individual who has experienced a rape, and 26 (13.4%) did not. One (0.5%) participant did not respond to the question.

Participants communicated their professional roles. They could choose between counseling practitioner, counselor educator, master's student, doctoral student, or a combination of the roles. Two (1.0%) participants did not respond. Table 6 highlights the makeup of their professional roles.

Table 6  
*Professional Roles*

	Frequency	Percent
Counseling Practitioner	103	46.6
Counselor Educator	16	7.2
Master's Student	80	36.2
Doctoral Student	22	10.0

Participants also noted their primary role out of counseling practitioner, counselor educator, master's student, or doctoral student. One (0.5%) did not respond. Table 7 indicates the participants' identified primary roles.

Table 7  
*Primary Roles*

	Frequency	Percent
Counseling Practitioner	97	50.0
Counselor Educator	11	5.7
Master's Student	75	38.7

Furthermore, participants identified their highest degree completed. One (0.5%) identified an Associate's degree as their highest education. 58 (29.9%) reported that they had obtained a Bachelor's degree, while 11 (5.7%) participants reported having received a Ph.D. Both EdD and EdS degrees had 3 (1.5%) each. The majority of the sample (118, 60.8%) noted that they had earned a 118 Master's degree. All participants answered this question; there were no missing cases.

Participants were asked whether they had graduated from or were currently enrolled in a CACREP counseling program. They were also asked if they taught in a CACREP accredited program and if they included any teaching instruction on rape in their curriculums. Overall, 149 (76.8%) stated that they had graduated from or were currently enrolled in a CACREP program. 36 (18.6%) stated that they were not, while 8 (4.1%) cited that they were unsure. One (0.5%) participant did not respond. Regarding teaching in a CACREP program, 11 (5.7%) participants stated they did teach in an accredited program, while 83 (42.8%) stated no. Three (1.5%) were unsure, and 97 (50%) reported that this was not applicable (N/A) to them. All participants responded to this question. Concerning including rape related instruction material, 13 (6.7%) stated they did include it. Three (1.5%) did not, while 178 (91.8%) stated this question was not applicable to them. No responses were missing.

Individuals noted the frequency with which they saw clients who presented with rape related concerns within the last year. Several options were provided for participants

to choose from. Overall, ten (5.2%) did not respond. Table 8 provides the descriptive statistics regarding the answers to this question.

Table 8  
*Number of Clients with Rape Related Concerns in the Past Year*

	Frequency	Percent
0-1	70	36.1
2-5	45	23.2
6-10	21	10.8
11-15	14	7.2
16-20	12	6.2
21-25	6	3.1
26-30	4	2.1
31-35	1	.5
36-40	2	1.0
41+	9	4.6

Participants were asked to identify their years working in the field as counselor educators. If they did not work in counselor education, participants could respond “N/A”. There were no missing responses. Table 9 provides the descriptive statistics for this question.

Table 9  
*Years Working as Counselor Educators*

	Frequency	Percent
0-2 Years	7	3.6
3-5 Years	8	4.1
6-10 Years	2	1.0
11-15 Years	2	1.0
16-20 Years	1	.5
21-25 Years	1	.5
N/A	173	89.2

Participants were also asked to report how long they had been working as counseling practitioners if applicable. If they do not work as a counselor, participants could respond “N/A”. All 194 participants responded to this question. Table 10 identifies the number of years worked as a practitioner for this sample.

Table 10  
*Years Working as Counselors*

	Frequency	Percent
0-2 Years	39	20.1
3-5 Years	27	13.9
6-10 Years	18	9.3
11-15 Years	12	6.2



16-20 Years	4	2.1
21-25 Years	3	1.5
26-30 Years	3	1.5
31-35 Years	1	.5
36-40 Years	1	.5
N/A	86	44.3

---

Participants who were currently students were asked to report the number of credit hours they had completed in their counseling programs. Participants who identified themselves as doctoral students were asked to combine the hours they had completed in their master's program with their completed hours in their doctoral program. If they are not currently a student, participants could respond "N/A". No responses were missing. Table 11 highlights the descriptive statistics for this question.

Table 11  
*Number of Completed Credit Hours*

	Frequency	Percent
0-9	7	3.6
10-20	6	3.1
21-30	10	5.2
31-40	10	5.2
41-50	27	13.9

51-60	16	8.2
61-70	11	5.7
71-80	4	2.1
81-90	4	2.1
91-100	5	2.6
100+	9	4.6
N/A	85	43.8

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Participants were also asked to report any licensures or certifications that they currently are in possession of. Several options were provided that the sample could choose from. The options included Licensed Professional Counselor (LPC), Nationally Certified Counselor (NCC), Licensed Marriage and Family Therapists (LMFT), Certified Substance Abuse Counselors (CSAC), Certified Rehabilitation Counselors (CRC), none, and other. Participants could also report if they held a combination of licenses or certifications. Overall, four (2.1%) individuals did not respond to this question. Other licenses or certifications reported by participants outside of the provided choices included Licensed Clinical Professional Counselor (LCPC), Licensed Graduate Professional Counselor (LGPC), Licensed Mental Health Counselor (LMHC), Licensed Clinical Addictions Specialist (LCAS), Certified Addictions Counselor (CAC), and Licensed School Counselor (LSC). See Table 12 for further specifications regarding frequency of participants per category.

Table 12  
*Participants' Held Licenses/Certifications*

	Frequency	Percent
LPC	53	22.6
NCC	38	16.2
LMFT	6	2.6
CSAC	6	2.6
CRC	4	1.7
None	95	40.6
Other	32	13.7

Participants reported the number of hours they had received in training on sexual assault issues. Examples of such training opportunities include job site trainings, workshops, self-study, or CEU experiences. 66 (34.0%) reported they had spent 1-5 hours in training, while 34 (17.5%) noted 6-10 hours. Eight (4.1%) received 11-15 hours, 15 (7.7%) 16-20 hours, and 5 (2.6%) individuals spent 21-25 hours in training. Three (1.5%) reported between 26-30 hours of training on rape, while 19 (9.8%) communicated that they had spent 31+ hours on the topic. 44 (22.7%) stated that they had received no training at all on rape related issues.

### **Summary of Participant Demographics**

The most frequently represented age category was that of the 25-30 year old age bracket. The majority were White females. Most individuals were heterosexual,

Christian, and practicing their religious/spiritual orientation. Most participants had not reported experiencing rape. However, most knew an individual who had been raped.

The most frequently represented primary role were those who reported they were counselors. However, master's students were the second most frequently reported role. Most held a master's degree and had graduated from or were currently enrolled in a CACREP accredited program. Concerning working as a counselor educator, the most frequently cited amount of time in the field was between 3-5 years. Practitioners most frequently reported working in the field 0-2 years. The most frequently reported amount of completed credit hours taken by the students in the sample was the 41-50 credit hour category.

Participants reported holding no license or certification more frequently than the other licensure and certification options. However, among those who did hold a credential, LPCs were most frequently reported, followed closely by those who were NCCs. Furthermore, in the last year, the most frequently reported category of how many clients had been seen that had presented with rape related material was 0-1. The second most frequently reported group had treated between 2-5 clients. Concerning hours spent in training on rape related material, 1-5 hours was the most frequently reported.

### **Scoring Responses on the Instruments**

The scoring of the RES, MARS, and the MRMS was completed in SPSS, 16.0 for use with Microsoft Windows (SPSS, 2007). The outcome variable, RMA, was investigated using the MRMS (Melanson, 1999) and the MARS, which was based on Burt's (1980) RMAS. The RES, which measured rape empathy, was a predictor variable, in addition to information garnered from the demographics sheet.

The MRMS contains 22 items, with items 1, 6, and 19 being reverse scored. Utilizing a 6-point Likert scale (1= *strongly disagree* to 6= *strongly agree*), MRMS scores fall on a continuum between 22 to 132, with the higher scores indicating higher levels of acceptance of rape myths (Kassing et al., 2005). The maximum range on the MRMS is 110. Overall, 194 participants in the study completed the MRMS. The mean score for the MRMS was 46.25. The standard deviation was 11.72. The range of scores for this particular sample was 27 - 118. The MRMS scores were leptokurtic (7.143), and were positively skewed (1.934). The Cronbach's alpha for the MRMS in this study was .83.

The RMAS (Burt, 1980), which the altered MARS was created from, contains 19 items. It is important to note that item 2 on the scale is reverse scored. The scale utilizes a 7-point Likert scale with answers ranging from (1) *strongly agree* to (7) *strongly disagree*. Two questions ask participants to answer in terms of how often they believe a rape story was fabricated by a survivor with possible answers being *almost all*, *about 3/4*, *about half*, *about 1/4*, or *about none*. One other question ask participants to disclose how likely they would believe an individual's story based on demographic variables, with possible answers being *always*, *frequently*, *sometimes*, *rarely*, or *never*. Higher scores on the MARS indicate "more accurate perceptions of rape" (Jiminez & Abreu, 2003, p. 254). To specify further, higher scores show lower acceptance of rape myths, and lower scores demonstrate higher acceptance of rape myths. The range of scores on the MARS is from 19 to 133 ,with a maximum range of 114.

In total 194 participants completed the MARS. The mean score for the MARS was 83.27, with the standard deviation being 10.16. The range of scores for this particular

sample was from 37 to 99. The MARS scores were leptokurtic (8.855), and were negatively skewed (-2.761). The Cronbach's alpha coefficient for this study was .80.

The RES is a 19-item assessment of empathy towards and responsibility ascribed to rape survivors (Jiminez & Abreu, 2003). The assessment allows participants to answer on a 7-point Likert scale ranges from (1) *strongly agree* to (7) *strongly disagree* (Dietz et al., 1982). Higher scores indicate higher levels of empathy towards rape survivors and lower levels of attributing responsibility to the survivor for the attack (Jiminez & Abreu, 2003). Scores can range from 19 to 133, with a maximum available range of 114. The mean for the RES was 112.18, and the standard deviation was 12.63. The range of scores for this sample was 44 to 133. The RES scores were leptokurtic (3.741), and were negatively skewed (-1.270). Reliability analysis for the RES for use in this study yielded a Cronbach's alpha coefficient of .78.

## **Findings**

This research examined the influence of rape empathy and demographic variables on RMA. This study sought to provide further information on these concepts through four research questions. The following section provides the results of the statistical procedures used in this research.

### **Research Question 1**

The first research question asked, "What is the degree of rape myth acceptance and rape empathy in master's and doctoral counseling students and counseling professionals towards male and female rape survivors?" This question was designed to illuminate any significant differences of RMA and rape empathy levels among

professionals and students through an independent  $t$ -test. Baseline means were also obtained via descriptive statistics.

### **Test of Hypothesis 1**

Hypothesis 1 stated that there would be a significant difference in RMA and rape empathy levels between trainees (master's and doctoral counseling students) and counseling professionals (practitioners and educators). Baseline levels for the sample were obtained using descriptive statistics. Data analysis also included the use of the non-parametric Mann-Whitney test instead of the originally intended independent  $t$ -test. The Mann-Whitney is similar to the independent  $t$ -test but has less assumptions, making it a good choice for data that violates assumptions (Field, 2009).

This particular sample did indeed violate the assumption of normality (i.e., most of the scores were not around the distribution's center) as calculated by the Kolmogorov-Smirnov test (Field, 2009). The Kolmogorov-Smirnov test "compares the scores in the sample to a normally distributed set of scores with the same mean and standard deviation" (Field, 2009, p. 144). Significant results ( $p < .05$ ) demonstrate that the distribution is not normal. The distribution of scores on the MRMS,  $D(194) = 0.15$ ,  $p < .001$ , the MARS  $D(194) = 0.21$ ,  $p < .001$ , and the RES  $D(194) = 0.08$ ,  $p < .01$  were all significantly non-normal.

Results on the Mann-Whitney indicated that female RMA levels as measured by the MARS among trainees ( $Mdn = 86.00$ ) did not differ significantly from female RMA levels among professionals ( $Mdn = 86.00$ ),  $U = 4240.50$ ,  $z = -.910$ ,  $p > .05$ . Male RMA levels among trainees ( $Mdn = 43.00$ ) computed from scores on the MRMS also did not differ significantly from professionals' male RMA levels ( $Mdn = 43.50$ ),  $U = 4577.50$ ,  $z$

= -.032,  $p > .05$ . Rape empathy levels as measured by the RES among trainees ( $Mdn = 114.00$ ) did not differ significantly from rape empathy levels among professionals in the sample ( $Mdn = 114.00$ ),  $U = 4327.00$ ,  $z = -.683$ ,  $p > .05$ . Hypothesis 1 was not supported.

The descriptive statistics computation yielded the following means: On the MRMS, which measures male RMA, the sample mean was  $\bar{x} = 46.06$  ( $SD = 11.72$ ). The sample mean on the MARS, measuring female RMA was 83.27 ( $SD = 10.17$ ). Finally, on the RES which assesses rape empathy, the mean was 112.18 ( $SD = 12.63$ ).

Not only were descriptive statistics computed for the sample as a whole, but they were also run for the two overarching groups of professionals and trainees as well. Table 13 provides the means and standard deviations for the professionals' and trainees' scores on the RES, MRMS, and MARS.

Table 13  
*RMA and Empathy Levels By Group*

	Professionals		Trainees	
	Mean	SD	Mean	SD
MRMS	46.06	10.94	46.56	12.75
MARS	82.32	11.21	84.41	8.64
RES	111.38	13.29	112.96	11.65

Means and standard deviations were also computed to obtain a baseline of RMA and rape empathy levels among the four groups of counselors, counselor educators,



master's students, and doctoral students. Table 14, 15, and 16 demonstrate these levels by group.

Table 14

*Male RMA By Group*

	Mean	Standard Deviation
Counseling Practitioners	45.90	10.38
Counselor Educators	47.45	15.59
Master's Students	46.93	13.13
Doctoral Students	43.8	9.41

Table 15

*Female RMA By Group*

	Mean	Standard Deviation
Counseling Practitioners	81.92	11.63
Counselor Educators	85.81	5.3
Master's Students	84.76	7.44
Doctoral Students	81.8	15.25

Table 16

*Rape Empathy Level By Group*

	Mean	Standard Deviation
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Counseling Practitioners	110.96	13.56
Counselor Educators	115.09	10.39
Master's Students	112.85	12.18
Doctoral Students	113.8	6.89

### **Research Question 2**

Research question 2 asked, "To what degree are demographic variables and rape empathy predictive of RMA towards females?"

### **Test of Hypothesis 2**

Hypothesis 2 stated that gender, age, sexual orientation, religious/spiritual orientation, exposure (whether the participant knows a survivor or is a survivor), rape empathy, race/ethnicity, and counselor level (education/training experience) would be significantly predictive of RMA towards female rape survivors among master's and doctoral counseling students and counseling professionals.

Hypothesis 2 was examined utilizing a Stepwise Regression analysis. The order in which the variables were entered are as follows: (1) scores from the RES, (2) Gender, (3) Experience Rape, (4) Knowing a Rape Victim, (5) Hours Spent Training on the Subject of Rape, (6) Highest Completed Degree, (7) Age, (8) Race/Ethnicity, (9) Sexual Orientation, (10) Religious/Spiritual Orientation, and (11) reported level of Practicing their religious/spiritual orientation.

Utilizing the scores from the MARS, which measures acceptance of rape myths concerning females, the results indicated that the only significant predictor of female

RMA was sexual orientation,  $R^2 = 0.37$ ,  $F(1, 182) = 7.2$ ,  $p < .01$ . Table 17 indicates the results of the multiple regression. Despite one significant predictor, overall these findings do not support Hypothesis 2.

Table 17

*Summary of Stepwise Regression Predicting Female RMA*

Model	<i>R</i>	$R^2$	Adjusted $R^2$	Std. Error of the Estimate
1	.19 <sup>a</sup>	.037	.032	10.07

a. Predictors: (Constant), Sexual Orientation

*ANOVA<sup>b</sup>*

Model		Sum of Squares	<i>Df</i>	Mean Square	<i>F</i>	<i>Sig.</i>
1	Regression	731.22	1	731.22	7.2	.01 <sup>a</sup>
	Residual	19195.17	189	101.56		
	Total	19926.39	190			

a. Predictors: (Constant), Sexual Orientation

b. Dependent Variable: Female RMA

*Coefficients*

Variable	Unstandardized Coefficients		Standardized Coefficients	<i>t</i>	<i>Sig.</i>
	<i>B</i>	<i>Std. Error</i>	<i>Beta</i>		
1 (Constant)	69.61	5.132		13.56	.00
Sexual Orientation	4.51	1.68	.192	2.68	.01

a. Dependent Variable: Female RMA

### **Research Question 3**

The third research question asked, “To what degree are demographic variable and rape empathy predictive of RMA towards males?”

### **Test of Hypothesis 3**

Hypothesis 3 asserted that gender, age, sexual orientation, religious/spiritual orientation, exposure (whether the participant knows a survivor or is a survivor), rape empathy, race/ethnicity and counselor level (education/training experience) would be significantly predictive of RMA towards male rape survivors among master’s and doctoral counseling students and counseling professionals.

Hypothesis 3 was examined utilizing a Stepwise Regression analysis. The order in which the variables were entered are as follows: (1) scores from the RES, (2) Gender, (3) Experience Rape, (4) Knowing a Rape Victim, (5) Hours Spent Training on the Subject of Rape, (6) Highest Completed Degree, (7) Age, (8) Race/Ethnicity, (9) Sexual Orientation, (10) Religious/Spiritual Orientation, and (11) reported level of Practicing their religious/spiritual orientation.

The scores from the MRMS were used for this analysis, which measures male RMA. The results from the Stepwise Regression procedure indicated that no predictor variables had a statistically significant effect on the outcome variable. These findings do not support Hypothesis 3.

### **Research Question 4**

Research question 4 asked, “Is there a significant relationship between rape myth acceptance and rape empathy?”

### **Test of Hypothesis 4**

Hypothesis 4 stated that there will be a significant relationship between RMA and levels of rape empathy displayed by master's and doctoral counseling students and counseling practitioners towards both male and female rape survivors. The researcher assumed that there would be a significant relationship between low levels of RMA and high levels of empathy towards rape survivors and between high RMA and low rape empathy.

Hypothesis 4 was examined utilizing the Spearman Rho Correlation Coefficient. This analysis was used instead of the originally intended Pearson Product Moment Correlation analysis due to data violating the assumption of normality on the Kolmogorov-Smirnov test. The Kolmogorov-Smirnov yielded the following results: The distribution of scores on the MRMS,  $D(194) = 0.15, p < .001$ , the MARS  $D(194) = 0.21, p < .001$ , and the RES  $D(194) = 0.08, p < .01$  were all significantly non-normal.

The correlation between the RES and MARS was statistically significant,  $r_s = .18, p \leq .05$ , indicating that increased rape empathy levels were associated with more accurate perceptions of female rape (i.e., higher MARS scores). The correlation between RES and MRMS was not statistically significant,  $r_s = -.05, p > .05$  thus indicating that there is no statistically significant relationship between male RMA and rape empathy. A statistically significant relationship was found between MARS and MRMS,  $r_s = -.48, p < .001$ , however. This result indicates that higher male RMA was related to higher female RMA (i.e., higher MRMS scores associated with lower MARS scores). Hypothesis 4 was partially supported.

### Summary

This study concluded with three overall findings. First, there was no statistically significant difference between professionals' and students' levels of rape empathy, male RMA, and female RMA. Second, sexual orientation was found to be a statistically significant predictor of female RMA as measured by the MARS. However, no other variables significantly predicted levels of female RMA. There were no significant predictor variables for male RMA as measured by the MRMS. Finally, a statistically significant positive relationship was found between rape empathy and female RMA, indicating that the higher the levels of rape empathy, the less a person accepts female rape myths. No such relationship existed between male RMA and rape empathy. Male and female RMA were significantly related, however, with the results indicating that as belief in male rape myths increases, so does female RMA.

## CHAPTER FIVE

### DISCUSSION

The purpose of this study was to investigate master's and doctoral counseling students' (trainees) and counseling professionals' (counselors and counselor educators) levels of RMA and rape empathy towards both male and female survivors of rape. The relationship between RMA and rape empathy was analyzed, as well as the predictive nature of demographic variables and rape empathy on RMA levels. Random sampling of ACA members was used. Participants were able to access the survey packets consisting of the MRMS, RES, and MARS on surveymonkey.com. Three different links were randomly assigned via stratified sampling to the professionals and trainees, and of the 2,000 individuals contacted for this study, 194 completed the survey packet, yielding a 10% response rate. Participation was strictly voluntary, as they could stop taking the surveys at any time.

Overall, 108 (55.7%) individuals identified themselves as professionals, and 85 (43.8%) identified themselves as trainees. The most frequently reported age category that participants belonged to was the 25-30 year old age bracket. There were 80 (36.2%) master's students and 22 (10%) doctoral students. Furthermore, 103 (46.6%) identified as counselors, while 16 (7.2%) identified as counselor educators. One (0.5%) did not answer the question. Primarily, individuals were White (82.1%) and female (80.4%). Christians (64.9%), those practicing their religious/spiritual orientation (51.0%), and heterosexuals (87.1%) also comprised the majority of the sample. Most participants (58.8%) had not been raped, although the majority (86.1%) knew someone who had been. The sample contained a majority with master's degrees (60.8%), and participants

documented most frequently that they held no licensure or certification (40.6%), although those holding a LPC were the second most commonly appearing category (22.6%). The sample most frequently reported that if they were a counselor they had worked in the field 0-2 years (20.1%) and if they were a counselor educator, they had worked in the field for 3-5 years (4.1%).

It is important to note that although a high number of participants knew a survivor and nearly 40% of the sample had been raped themselves, clinical experience with rape survivors was limited. Indeed, the sample most frequently reported spending between 1-5 hours training on rape related material (34.0%). The second most frequently reported training category (22.7%) was that they had received no training. Furthermore, over a third had only seen 0-1 clients who presented with rape related issues (36.1%).

The first research question sought to answer if there were differences between the sample groups regarding levels of RMA and rape empathy. Through a Mann-Whitney analysis, it was demonstrated that there was no statistically significant difference between trainees' and professionals' levels of RMA and rape empathy. Descriptive statistics were also used to obtain baseline means for the sample of counseling trainees and professionals.

Research Question 2 examined whether rape empathy and demographic variables were predictive of female RMA. The demographic variables included gender, age, counselor level (training/education experience), exposure (whether the participant knows a survivor or is a survivor themselves), sexual orientation, race/ethnicity, and religious/spiritual orientation. A Stepwise Regression was used to analyze this question.



The results demonstrated that of all the predictor variables, only sexual orientation was a statistically significant predictor of levels of female RMA.

Research Question 3 examined rape empathy and demographic variables and their influence on levels of male RMA. A Stepwise Regression procedure was utilized to investigate this question. The demographic variables under study were the same as in Question 2. The results from the regression analysis indicated that none of the predictor variables had any statistically significant impact on male RMA.

Research Question 4 studied the relationship between rape empathy and RMA. A Spearman Rho Correlation procedure was used to analyze this question, as a Pearson Product Moment Correlation could not be used as originally intended due to the data violating the assumption of normality. The findings demonstrated a positive relationship between rape empathy and female RMA, meaning that as levels of rape empathy increase so do more accurate ideas regarding female rape myths. There was no statistically significant relationship between rape empathy and male RMA. However, a statistically significant negative relationship was found between male and female RMA, indicating that as male RMA increases, so does female RMA. This interpretation is due to the opposite way the assessments were scored (i.e., higher MRMS scores associated with lower MARS scores).

### **Relationship to Findings in Prior Studies**

The literature review in Chapter 2 provides research that discussed professionals' and students' levels of RMA and rape empathy (Chng & Burke, 1999; Dye & Roth, 1990; Idisis et al., 2007; Kassing, Beesley, & Frey, 2005; Kassing & Prieto, 2003). The relationship of demographic variables to RMA and rape empathy was also examined.

This study sought to obtain a baseline of RMA and rape empathy among professionals and students in the counseling field in particular.

Concerning the MRMS which measures male rape myths, higher scores indicate higher levels of RMA. The current sample's mean ( $M = 46.25$ ) was lower than Melanson's (1999) original sample ( $M = 54.14$ ) which was used to create the instrument. Kassing, Beesley, and Frey (2005) reported a mean ( $M = 67.1$ ) higher than the current sample's mean as well. This may indicate that counselors are less accepting of male RMA, although further research is needed.

The MARS, an alteration of Burt's (1980) RMAS, measures levels of female RMA, with higher scores indicating lower levels of RMA. The current sample ( $M = 83.27$ ) had a higher mean than the sample in Burt's (1980) study ( $M = 49.4$ ), potentially indicating that counselors accept less female rape myths than the original participants. This discrepancy between the means may be due to sample differences, as Burt (1980) did not use an all-counselor sample.

On the RES which assesses rape empathy, three groups each of males and females, for a total of six separate scores, were used to create the instrument. Higher scores indicate higher levels of empathy towards rape survivors. The male means were 98.25, 100.15, and 101.91. The female means were 108.86, 111.71, and 112.60. Calculating the total mean for these two groups computes to  $M = 105.58$ . The current study sample ( $M = 112.18$ ) had a higher mean. This could possibly indicate that counselors are more empathic towards rape survivors than the individuals used in the original sample.

In regards to group differences of held levels of RMA, Idisis et al. (2007) found that while there were no significant differences between professionals' and students' attribution of blame towards survivors, the therapists in their sample were more likely to view a rape as more severe than a graduate counseling student in the sample. On the other hand, Schechory and Idisis (2006) concluded that therapists held less stereotypical viewpoints regarding survivors and accepted less rape myths than students as well. The results from this study indicated that there was no statistically significant difference between professionals' and trainees' levels of RMA and rape empathy. Idisis et al. (2007) offered the explanation that the sample being highly educated may account for a lack of group differences. Since the current sample may all be considered highly educated (i.e., master's student or above), the sample was homogenous and group differences may have been harder to detect. An additional reason for a discrepancy in the results may be that the previous studies used undergraduate students, as opposed to graduate students, as well as professionals who were not counselors.

The current study did not find a predictive relationship between rape empathy and male RMA. Nevertheless, the correlational analysis revealed a statistically significant correlation between female RMA and rape empathy, indicating that as rape empathy increases, female RMA decreases. No statistically significant relationship was found between rape empathy and male RMA, however.

Previous literature has provided some insight into the relationship between rape empathy and RMA. For example, higher levels of rape empathy were found to be associated with lower levels of female RMA (Jiminez & Abreu, 2003). A study demonstrating the relationship between rape empathy and male RMA could not be found

nor was a significant correlation found between rape empathy and male RMA. This may be because rapes of females occur more frequently than do male rapes (NVAWS, 2000), so participants have more experience with (seeing clients, training, education, etc.) and exposure to (including knowing a survivor) female rapes, thus increasing empathy (Burt, 1980; Chng & Burke, 1999).

Sakalli-Ugurlu et al. (2007) asserted that males were less empathic and espoused more negative beliefs towards survivors. The authors (2007) also concluded that rape empathy was predictive of positive attitudes. Although the current study did not find such a predictive relationship, it may be due to differences in the method and sample. For example, the Sakalli-Ugurlu et al. (2007) study used the ARV (Ward, 1988) to measure beliefs regarding rape, whereas this research used the MARS and MRMS. To assess the empathy component, Sakalli-Ugurlu et al. (2007) utilized a shortened 6-item version of the RES with a Cronbach's alpha of .67. This research used the whole RES. Finally, Sakalli-Ugurlu et al. (2007) conducted their research in Turkey, a primarily Islamic country, whereas this sample was primarily Christian. Differences in religious background, although not found to be a statistically significant predictor of RMA in this study, may have played a role in their study.

Regarding the demographic variables, much of the current research is correlational in nature as opposed to trying to predict the impact of variables on RMA. This difference in analysis may explain some of the non-significant findings contained within this study, which sought to take the literature further by examining various variables' predictive influences on RMA.

The current literature clearly demonstrated that males (Dye & Roth, 1990; Jiminez & Abreu, 2003; Kassing & Prieto, 2003), particularly those who stated that they are heterosexual (Davies & McCartney, 2003), exhibited less empathy and higher RMA towards rape survivors. Furthermore in regards to sexual orientation, gay males and heterosexual females were found to be the least accepting of rape myths when compared to heterosexual males when presented with materials measuring acceptance of male rape myths (Davies & McCartney, 2003).

Sexual orientation was found to be a statistically significant predictor of female RMA only. The lack of a significant finding regarding male RMA may be because more blame for a rape was attributed to those who were “primarily... perceived to be sex objects of the perpetrator” (Ford, Liwag-McLamb, & Foley, 1998, p. 261). To clarify further, the sample was primarily heterosexual, and participants may have consciously or subconsciously imagined that the survivor, or the “sex object”, was a female due to their own innate sexuality. This may have occurred even though wording was changed on the MARS to be more gender neutral. The significant predictive influence of sexual orientation supplements the sparse literature in regards to study participant, as opposed to victim, sexual orientation.

However, gender was not found to be predictive of either male or female RMA. A significant predictive relationship may not have been found due to the majority of the previous studies (Dye & Roth; 1990; Jiminez & Abreu, 2003; Wakelin & Long, 2003) not using counselors as their sample. Even though one study (Kassing & Prieto, 2003) did use counselor trainees and found the expected gender differences, the proportion of males

(39.9%) in their sample ( $n = 183$ ) to males (19.6%) in the current study ( $n = 194$ ) may be have influenced the results.

Regarding age, older individuals were found to have higher RMA (Dye & Roth, 1990; Nagel et al., 2005). In this study, age was not found to predict RMA levels. Although this result differs from the Dye and Roth (1990) study, this may be due to their sample being older ( $M = 43.12$ ) than the current sample, who reported most frequently belonging to the 25-30 year old age bracket. Similarly, the Nagel et al. (2005) sample was also older with the most frequently reported age category being 41-50 years old ( $n = 56$ , 25.5%). Furthermore, neither of these samples utilized individuals in the counseling field.

Burt (1980), Kassing et al. (2005), and Kassing and Prieto (2003) concluded that as training experience and education increases, RMA decreases. The current research concluded that neither training nor education level predicted acceptance of rape myths. Since this sample ( $n = 66$ , 34.0%) reported most often that they had only received 1-5 hours of training on rape related material or reporting second most frequently that they had received no training ( $n = 44$ , 22.7%), this may explain the lack of a significant statistical finding in the current study. It is also important to note that Burt (1980) and Kassing et al. (2005) did not utilize counselors as their sample, and although Kassing and Prieto (2003) did, the discrepancy in the results may be attributable to using a different assessment and case studies to measure RMA. Furthermore, this sample was homogenous since all participants were highly educated (i.e., currently enrolled in or graduated from graduate school), and many had similar levels of training.

Exposure to rape, either through knowing a survivor or being a survivor, has been previously demonstrated to increase empathy and lower negative attitudes about rape

(Barnett et al., 1992; Chng & Burke, 1999; Dietz et al., 1982; Smith & Frieze, 2003).

Exposure was not predictive of RMA levels in the current study, although most participants knew a rape survivor. Most had not been raped themselves, however. This non-significant finding may be due to differences in the assessments utilized and the sample composition, which in previous works were not counselors. Homogeneity of variance may also explain a lack of a significant finding with the exposure variable, as so many participants had similar experiences.

Race/ethnicity was not found to be a significant predictor of RMA levels in this study. Some previous research suggests that Whites espouse less blaming attitudes than do Hispanics, Latinas, African-Americans, and Asians (Jiminez & Abreu, 2003; Lee et al., 2005; Lefley et al., 1994). The samples in these studies, in contrast with the current one, were able to obtain more diverse individuals in their sample. For example, Jiminez and Abreu (2003) had a sample comprised of 165 Latino/as and 171 White/European Americans. Lee et al. (2005) utilized a sample ( $n = 169$ ) with 57% reporting as White and 43% reporting as Asian. The current research was composed of 82.1% ( $n = 160$ ) Whites, with the remaining individuals identifying as persons of color ( $n = 35$ , 17.9%).

It is important to note that one study ( $n = 313$ ) found no significant differences in levels of blaming survivors among African-Americans, Asians, and European Americans (Bell et al., 1994). The composition of the sample in the Bell et al. (1994) study is somewhat closer to the one found in the current research. Their sample was composed of 77% participants reporting that they were White and 21% reporting that they were a person of color. These numbers are more closely aligned than the other studies (Jiminez

& Abreu, 2003; Lee et al., 2005) with the racial/ethnic demographic information found in this study.

Finally, religious/spiritual orientation and its influence on RMA have not been clearly demonstrated in the literature. Previous research has indicated, however, that the belief in traditional sex roles, homophobia, religious intolerance, and authoritarianism were associated with more negative attitudes towards rape survivors (Aosved & Long, 2006; Carr, 2006). This study did not find that religious/spiritual orientation or the amount one practiced their orientation were predictive of RMA levels. In relation to the previous findings, this may demonstrate that the current sample potentially ascribes less to the concepts reported to impact RMA (Aosved & Long, 2006; Carr, 2006). However, more research is clearly needed to examine the impact of religious/spiritual orientation on RMA.

### **Limitations of the Study**

Internal and external threats to the validity exist for this research. Internal validity is the extent to which researchers can assert that indeed the independent variable had an effect on the dependent variable instead of outside, alternative factors causing the effect (Wiersma & Jurs, 2009). External validity is defined as the extent that the results of a study can be generalized to the population without making inaccurate surmises regarding the sample used (Wiersma & Jurs, 2009). Limitations to this study exist due to these two factors, as well as in the regression analysis used.

**Internal validity.** History, or the existence of an event happening during the research study thus affecting the results, may be a factor (Wiersma & Jurs, 2009). A rape may have occurred in the participant's community or in their own life that altered their



point of view regarding rape and rape survivors. Selection bias is another threat to internal validity since all participants were ACA members, and participants who self-selected to participate may have already developed certain viewpoints about rape that may have made them more prone to participating in a study on this topic. It is also important to note the low response rate (10%) could potentially be due to the topic of the study, which may have caused discomfort and prevented some of the sample from participating.

A similar limitation is that participants may have answered in a socially desirable manner since rape is an emotionally charged subject (Marczyk et al., 2005). Due to participants knowing that their attitudes were being measured by the researcher, they may have chosen to alter their responses to be more empathic or less accepting of rape myths. This change in participant behavior, known as the Hawthorne Effect, indeed may have affected this research as it was self-report in nature and not observational (Marczyk et al., 2005). Finally, Wiersma and Jurs (2009) discuss maturation as a threat. This threat could have occurred due to participants becoming fatigued after reading the informed consent, completing the demographics questionnaire, and completing three assessments.

**External validity.** The main purpose of this study was to investigate RMA among those in the counseling field only. Since the focus was on one specific field, generalizability outside of the field could be an issue. However, as previously stated, Wiersma & Jurs (2009) asserted, "It should not be inferred that to have external validity, results must generalize to many and varied populations and conditions" (p. 9). Therefore, the generalizability of these results to the counseling field at large should hopefully prove sufficient. It is important to note that the response rate (10.0%) was low and from only

one group (ACA members), potentially affecting external validity , as more responses may have yielded different results. Furthermore the sample was homogenous, with very few members identifying as a person of color (approximately 18%) or as non-heterosexual (approximately 13%), for example.

**Method.** The Stepwise Regression method was utilized in this study due to the current research being more exploratory in nature (Field, 2009). However, this method is not without its limitations. Field (2009) and Meyers et al. (2006) warn that because a computer program, in this case SPSS, is making decisions about which variables are selected, a researcher's influence is lessened on what is included in the model. Furthermore, a stepwise regression may either over-fit a model by inputting too many variables that do not contribute much to the outcome of the study or may under-fit a model by utilizing too few variables that are indeed important predictors (Field, 2009). Meyers et al. (2006) further warns that predictors that are indeed beneficial may be excluded due to decreased researcher control and that the amount of influence a predictor has on the outcome variable is unknown.

Items were slightly revised on the RMAS (Burt, 1980). By changing these items, the psychometrics for the original assessment were altered and may have impacted the data. The Cronbach's alpha following the alteration was .80. Additionally, the results from this study indicated skewness levels outside of -1 and 1, thus indicating the data was skewed. This is perhaps because the sample was comprised of individuals who were all involved in the counseling field and therefore were more aware of rape related issues, making them more empathic and less accepting of rape myths.

### **Implications for Practice and Training**

As previous literature has exhibited, high RMA and low rape empathy can be detrimental to rape survivors and clinical outcomes (Bohner et al., 2005; Burt, 1980; Campbell, Ahrens, et al., 2001; Campbell & Raja, 1999; 2005; Dietz et al., 1982; Sakalli-Ugurlu et al., 2007). Furthermore, exposure to rape, either through being attacked personally or knowing a survivor, increases empathy (Chng & Burke, 1999). As both counselors already out in the field and trainees may come into contact with rape survivors clinically, knowing one's own biases against rape and survivors of rape can perhaps help to ensure that the client is not subjected to further victimization through intentional or unintentional negative attitudes and survivor blaming. Increasing exposure to rape through volunteer work at a rape crisis center or by answering a crisis hotline may also prove beneficial. Additionally, due to the potential severity of the fallout following a rape, a counselor's work with the client may benefit from supervision or other self-care measures to help prevent or remediate vicarious trauma, thus improving client care (McCann & Pearlman, 1990).

Training and highest degree completed were not found to significantly predict levels of RMA. The non-significant findings in this study may suggest that counselors' possess the necessary empathy and accurate attitudes about rape to effectively treat survivors. This finding may also suggest that the current training methods and educative curriculums are adequate for treating clients appropriately. If further action is desired, however, counselors may seek continuing education opportunities pertaining to rape. Furthermore, counselor educators may consider including extended information about rape and its consequences in the courses they teach to shape student attitudes "from the ground up" about the issues survivors face. Role playing in counseling labs or actual

training experience with individuals presenting with rape issues could be very helpful to students prior to or in conjunction with their practicum or internship experience.

Sexual orientation was found to significantly predict female RMA, although not male RMA. This may be because more blame for a rape was attributed to those who were “perceived to be sex objects of the perpetrator” (Ford, Liwag-McLamb, & Foley, 1998, p. 261). Since the majority of this sample reported being heterosexual, participants may have answered questions with the male perpetrator-female survivor dynamic in mind, even though wording was changed to be more gender neutral. Therefore, work may be done to broaden the idea of who a perpetrator or a survivor may be.

Higher rape empathy was associated with lower levels of female RMA. Since female rape is more common, participants may conceivably have more experience working with female clients and know more female survivors. These types of experiences lead to higher rape empathy (Chng & Burke, 1999). Due to these circumstances, a relationship between higher rape empathy and lower male RMA may not have been found. Exposing students to male survivors’ stories and clinical cases may aid in furthering the relationship between high rape empathy and low male RMA.

Finally, this study found that male RMA and female RMA increase together. In other words, as belief in rape myths about males increase, so do belief in rape myths about females. This implies that whatever form of training an individual engages in, be it self-study, workshops, or hearing material presented in a counseling course, both male and females rape myths should be combated.

### **Implications for Future Research**

While this study did not find a statistically significant predictive relationship between training, education, and RMA, future research could compare groups of counseling professionals and trainees against individuals who are not in the counseling field to assess differences in rape attitudes. This would lend some support to the current training and educative practices and their potential positive impact on RMA. Qualitative research may also be undertaken to gather information about counselors' ideas and own personal experiences regarding rape. Furthermore, research could be conducted similar to the current study, comparing RMA levels and rape empathy among those who have or have not been exposed to rape (i.e., personally raped or know someone who has been).

Furthermore, additional research is warranted to investigate whether rape empathy is predictive of RMA as this study did not yield such a finding. Perhaps new studies could utilize different assessment tools or regression methods to study this relationship further. Since a statistically significant relationship was found between male and female RMA, future studies could examine which type of RMA may be more prominent and focus trainings accordingly.

Additionally, more research is needed on the male experience following a rape. For example, a qualitative study could focus on the male experience when receiving an evidence collection kit or when undergoing the reporting process. By learning more about what a male survivor goes through after an attack, hopefully more professionals will feel more comfortable and better understand their viewpoint when providing services to them.

Research could also be conducted to find out how much counseling professionals know about treating a survivor. Similar to the Dye and Roth (1990) study, this would provide a broad picture of the techniques and theories counselors are currently using and

what the issues are that they deem most important. It would be beneficial to know how many professionals know about and understand the evidence collection process, as well as the other systems survivors cycle through once they report.

More research is needed on the demographic variables utilized in this study as well. For example, religious/spiritual orientation and its impact on RMA is understudied. A replication of the current study with a larger, more diverse sample may yield different results. Furthermore, additional examination of the concepts asserted by Aosved and Long (2006) and Carr (2006) to be related to RMA is warranted. Additionally, since this study did not find significant results concerning the education and training variables, further study may elucidate more specific information about exact levels of training and education that do impact RMA. Race/ethnicity and sexual orientation should also be investigated since this sample was homogenous.

## CONCLUSIONS

The current research was conducted to assess the influence of rape empathy and demographic variables on counselor RMA, as well as to discover any relationship between rape empathy and RMA. This study found that female RMA and rape empathy are indeed significantly related, while rape empathy and male RMA were not. Female and male RMA also had a statistically significant relationship. As far as the predictive influence of rape empathy and the demographic variables under study on male and female RMA, only sexual orientation was found to predict female RMA levels. No variables predicted levels of male RMA. Furthermore, there was no statistically significant difference between levels of RMA and rape empathy between professionals and trainees.

Although this study did not find many significant predictive relationships between RMA, rape empathy, and demographic variables, this study adds to the literature by providing an exploratory study that gives a baseline of levels of RMA and rape empathy among counseling professionals and trainees. Research focused solely on the counseling field examining RMA, demographic variables, and rape empathy is limited or has not had the same combination of variables. As this study was indeed exploratory, future research is needed to examine these concepts further.

**CHAPTER SIX**  
**MANUSCRIPT FOR PUBLICATION**

The Influence of Rape Empathy and Demographic Variables on Counselor Rape Myth

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### Abstract

Rape myth acceptance (RMA) and low rape empathy among counselors can have negative consequences for survivors. This study investigated levels of RMA and rape empathy among counseling professionals and trainees ( $n = 194$ ) and examined the influence of rape empathy and demographic variables on RMA. No significant differences were found between professionals' and trainees' levels of RMA and rape empathy. A statistically significant correlation was found between rape empathy and female RMA. Male and female RMA were also significantly related. Sexual orientation was found to be a statistically significant predictor of female RMA. Implications for research, training, and practice are provided.

**Keywords:** rape, rape empathy, rape myth acceptance, counselors

## The Influence of Rape Empathy and Demographic Variables on Counselor Rape Myth Acceptance

The National Crime Victimization Survey (NCVS, 2007) reported that there were 248,300 rape survivors in 2007, of which 236,980 were females and 11,300 were males. This translates to a rape approximately every two minutes in the United States (Rape, Abuse and Incest National Network [RAINN], 2010). With so many individuals affected by this crime and 39% of survivors seeking mental health services (Campbell, Wasco, Ahrens, Sefl, & Barnes, 2001), counselors have an obligation to be well-informed of the consequences of rape and self-aware of any biases towards this population. Indeed negative reactions towards a survivor such as blaming them for the rape have been associated with longer healing times, poorer physical health, and exacerbated psychological symptoms (Campbell, Ahrens, Sefl, Wasco, & Barnes, 2001).

The purpose of this research was to study master's and doctoral counseling students' and counseling professionals' levels of rape myth acceptance (RMA) and rape empathy and further assess the relationship between rape empathy and RMA. This study also investigated if rape empathy and demographic variables were predictive of RMA. Rape myths are prejudicial beliefs about rape victims, perpetrators, and the attack itself (Burt, 1980), while rape empathy is the ability of an observer to deeply understand the point of view and the emotions of another specifically in regards to rape situations (Smith, 1997). The demographic variables included gender, age, counselor level (training/education experience), exposure (whether the participant knows a survivor or is a survivor themselves), sexual orientation, race/ethnicity, and religious/spiritual orientation. This article will provide a brief overview of the current body of literature

concerning RMA and rape empathy, most of which does not focus on the counseling field, thus highlighting the importance of this study. The examined demographic variables will also be presented, along with the results from the current research.

### **Rape Myth Acceptance**

Burt (1980) discussed RMA in the seminal article outlining the creation of the Rape Myth Acceptance Scale (RMAS). Rape myths were defined as “prejudicial, stereotyped, or false beliefs about rape, rape victims, and rapists” that help aid “in creating a climate hostile to rape victims” while serving to “deny or reduce perceived injury or to blame the survivors for their own victimization” (p. 217). Examples of rape myths include the belief that a rape survivor is promiscuous (Burt, 1980; Melanson, 1999), women who dress provocatively deserve to be raped (Burt, 1980), that females cannot rape males (Kassing, Beesley, & Frey, 2005), male rape is perpetrated only by those who are gay (Melanson, 1999), males should be able to escape a male or a female rapist (Melanson, 1999), the only true rape is a violent stranger rape (Campbell, 2008) or that alcohol consumption by the survivor makes them sexually available (Burt, 1980). Schechory and Idisis (2006) asserted that acceptance of rape myths protect the one who believes them. For females RMA provides a false sense of security against the idea that they too could be raped, and RMA protects males by allowing them to legitimize forceful sexual behavior.

The literature indicates that RMA is harmful. For instance RMA is a factor in exacerbating survivors’ psychological and physical symptoms (Campbell, Ahrens, et al., 2001) and in contributing to increased levels of survivor blaming (Burt, 1980).

Acceptance of rape myths may also increase a male’s likelihood to rape (Bohner, Jarvis,

Eyssel, & Siebler, 2005). Furthermore, the consequences of RMA, including survivor blaming, being asked what was worn during the rape, and being interrogated regarding previous sexual encounters for example, has been linked to the “second rape” or “secondary victimization” (Campbell & Raja, 1999; 2005). Secondary victimization is defined as the “unresponsive treatment rape victims receive from social systems personnel”, including “victim blaming behaviors and practices engaged in by community services providers, which further the rape event, resulting in additional stress and trauma” (Campbell & Raja, 1999, p. 262).

Burt (1980) asserted that some acceptance of rape myths may stem from a belief in a just world. This theory argues that in a just world only bad things happen to those who in some way were complicit in the action taking place (Burt, 1980). In other words, a survivor may be blamed as the precipitating cause of the attack by his or her own behavior. The just world concept can serve as a protective measure for the individuals who espouse these beliefs, as this viewpoint carries with it the notion that if a person behaves “correctly”, unfortunate events such as rape will not happen to them (Burt, 1980).

The current literature is limited in its examination of RMA among counseling professionals and students. Much of what is available utilized samples of undergraduate students or professionals that were not classified as counselors. One such study of professionals was conducted by Dye and Roth (1990), who examined the attitudes towards rape survivors and the rape treatment knowledge base of psychologists, social workers, and psychiatrists. The results indicated that overall the sample held low levels of RMA, knew common symptomology associated with a rape, and understood the more

prevalent treatment options. However, some participants' attitudes were found to conform to negative stereotypes about survivors, such as placing blame on them for their role in the rape, as well as conflict over how to treat a rape survivor. Concerning how these attitudes played out in treatment, more prejudiced professionals tended to focus on the rape and the survivor's role in the attack during a session more so than those who were less prejudiced (Dye & Roth, 1980).

Two more studies addressed RMA among similar samples. Schechory and Idisis (2006) investigated RMA among a sample of what they termed as "therapists", which included social workers and criminologists, and undergraduate students. The results indicated that the therapists accepted less rape myths than did the students. In regards to female versus male rape myths, both groups were significantly found to accept more rape myths regarding males (Schechory & Idisis, 2006). Additional research (Idisis, Ben-David, & Ben-Nachum, 2007) examining professionals and students concluded that among their sample of undergraduates, psychiatrists, clinical criminologists, psychologists, and social workers, overall attribution of blame for the rape was low. Even though there were no significant differences between professionals' and students' levels of blaming the survivor, the professionals in the sample deemed the rape as a more severe issue and wanted more severe punishments for the rapist than did the students (Idisis et al., 2007).

One study (Kassing and Prieto, 2003) examined male RMA among counselor trainees specifically. Generally, RMA was low. Still, the participants were found to believe that males should be able to fight off their attacker, that rape is more serious if the survivor is married, and that survivors frequently lie about being raped. The only rape

myth categorically rejected by all participants was the myth that rape is not rape if it is perpetrated by an acquaintance (Kassing & Prieto, 2003).

### **Rape Empathy**

Rape empathy is empathy applied specifically to the rape context (Smith, 1997) and is “the relative tendency for subjects to assume the psychological perspective of the rape victim or the rapist” (Dietz, Blackwell, Daley, & Bentley, 1982, p. 374). Empathy, including rape empathy, involves both matching another’s affective state and cognitively processing and interpreting another’s situation (Smith, 1997).

Research on rape empathy is sparse concerning those specifically working and training in the counseling field. Nevertheless, even with limited literature, studies have indicated that higher empathy levels are related to more positive attitudes towards rape survivors and decreased RMA (Jiminez & Abreu, 2003; Sakalli-Ugurlu, Yalcin, & Glick, 2007), while low levels of rape empathy are predictive of a higher desire to rape a woman (Dietz et al., 1982). Those with lower empathy were also found to attribute more responsibility to the survivor for the attack (Dietz et al., 1982; Jiminez & Abreu, 2003). Smith and Frieze (2003) also found this assertion to be true, with their study demonstrating that as empathy levels rise, survivor blaming decreases.

One counselor specific study conducted by Hill, Tanney, Leonard, and Reiss (1977) concluded that the sample, when presented with different issues such as existential crises, rape, or career concerns, were more empathic towards existential crises than they were towards rape, although the sample identified rape as the most severe issue needing the longest treatment. The female counselors in this sample were also found to be more empathic towards survivors and more optimistic towards their treatment outcomes than

the male participants (Hill et al., 1977). Further research by Chng and Burke (1999) utilized undergraduate students to investigate rape empathy. Their results indicated that knowing a survivor or having been attacked themselves increased empathy levels. Males were also demonstrated to have lower empathy levels towards survivors than were females (Chng & Burke, 1999). Much the same results were found in other research further establishing that females were more empathic and that higher empathy was also associated with knowing a survivor or having being attacked themselves (Barnett et al., 1992; Dietz et al., 1982; Sakalli-Ugurlu et al., 2007). Furthermore, Smith and Frieze (2003) demonstrated that females in their study were generally more empathic towards the survivor, whereas the male participants exhibited more empathy towards the perpetrator.

**Rape myth acceptance and rape empathy relationship.** An older but still valuable study by Smith (1997) discussed the relationship between RMA and rape empathy. She asserted that accurately empathizing with another involves two aspects: a cognitive aspect and an affective aspect. To empathize with someone on an emotional level, an observer should be able to understand and match the person's affective state. Furthermore, the observer must be able to interpret and perceive cognitively the individual's situation (Smith, 1997). If these interpretations and perceptions of the survivor are based on engrained stereotypical or biased notions, such as rape myths, this alters the ability to accurately respond with empathy towards survivors (Smith, 1997). When the observer is basing their interpretations off of external cues, such as crying or other behaviors that survivors "should" exhibit, the absence of what is expected in accordance with stereotypes may indeed lower rape empathy (Smith, 1997).

Statistical studies examining the relationship between rape empathy and RMA exist as well. For example, higher empathy levels are associated with decreased attribution of blame for the rape, decreased RMA levels, and more positive attitudes (Dietz et al., 1982; Jiminez & Abreu, 2003; Sakalli-Ugurlu et al., 2007). Rape empathy was also found to be a statistically significant predictor of social perceptions of rape and rape survivors (Dietz et al., 1982). Sakalli-Ugurlu et al. (2007) further concluded that rape empathy predicted more positive attitudes regarding rape.

### **Demographic Variables**

Previous research has been conducted examining the relationship between various demographic variables, empathy, and RMA, although literature specifically examining the counseling field is scarce. Demographic variables included in this study were gender, age, sexual orientation, religious/spiritual orientation, exposure (whether the participant knows a survivor or is a survivor), race/ethnicity, and counselor level (education/training experience).

**Age.** Acceptance of rape myths increases as one's age increases (Dye & Roth, 1990). These results are mirrored in other research asserting that older individuals are more likely to accept rape myths (Kassing, Beesley, & Frey, 2005; Nagel, Matsuo, McIntyre, & Morrison, 2005). Research investigating a younger sample (i.e., counseling graduate students) concluded that these participants were also prone to accepting rape myths (Kassing & Prieto, 2003). For instance, the younger the participant was, the more inclined to believe that a survivor should not have been out late alone.

**Education and training.** Burt (1980) demonstrated that as education increases, RMA levels decrease. Both Nagel et al. (2005) and Kassing et al. (2005) found similar



results in their research that concluded that RMA decreases as education and income increases. An additional study (Kassing & Prieto, 2003) revealed that levels of RMA decreased as experience working with survivors increased. Knowledge concerning rape issues and treatment protocols for survivors increases with the more clients seen per week (Dye & Roth, 1990).

**Exposure.** Exposure for purposes of this study means knowing a survivor or being a survivor of rape. Individuals who know survivors of rape have higher degrees of rape empathy than those who do not know a survivor (Barnett et al., 1992; Dietz et al., 1982). Previous research further indicated that being a survivor of rape is associated with increased levels of rape empathy (Chng & Burke, 1999; Smith & Frieze, 2003). Furthermore, individuals who did not know a survivor or who had not been raped themselves exhibited more tolerant attitudes towards rape when compared to persons who knew survivors or who have been raped (Chng & Burke, 1999). Individuals who were only acquainted with someone who had survived an attack exhibited higher rape tolerant attitudes and lower empathy levels compared to those who had themselves been raped (Chng & Burke, 1999).

**Gender.** Females repeatedly were found to have higher rape empathy levels when compared to male participants (Jiminez & Abreu, 2003). Females also have more overall positive attitudes towards rape survivors (Sakalli-Ugurlu et al., 2007). The current research comprehensively indicates that males more readily accept rape myths than females do and are inclined to be more indulgent in their attitudes towards those who are accused of rape (Dye & Roth, 1990; Jiminez & Abreu, 2003; Kassing & Prieto, 2003). In

other words, males exhibit less rape empathy and are more likely to espouse negative attitudes regarding a survivor (Sakalli-Ugurlu et al., 2007).

**Sexual orientation.** Kassing et al. (2005) indicated that homophobia was related to increased levels of RMA. Melanson (1999) found that negative attitudes towards gay individuals and a belief that males should not express emotions were demonstrated to be predictive of male RMA levels. A study by Wakelin and Long (2003) asserted that heterosexual women and gay males reportedly experience more survivor blaming than do heterosexual males or lesbians. Furthermore, the authors stated that the personality of a gay male is seen more as a component that contributed to the rape when compared against the other groups. For example, a stereotypical idea concerning gay males is that they have high sex drives. Those who believe in this notion may be more ready to blame the survivor for the attack (Wakelin & Long, 2003). Also, when compared to heterosexual males and lesbians, gay males and heterosexual women are more likely to be assumed to have an unconscious desire to be raped (Wakelin & Long, 2003). Generally, the current body of knowledge is limited in regards to participant sexual orientation, as opposed to survivor sexual orientation. The literature indicates that although gay males and heterosexual females are attributed the most responsibility for a rape should it occur, they are the most empathic and least accepting of rape myths when compared to heterosexual males (Davies & McCartney, 2003). Gay males are the most pro-survivor out of the three groups (Davies & McCartney, 2003). Indeed, overall heterosexual males are more prone to blame the survivor and accept more rape myths (Davies & McCartney, 2003).

**Race/ethnicity.** Jiminez and Abreu (2003) asserted that White women had lower levels of RMA and more positive attitudes towards rape survivors when compared to

Latinas. Even though Whites held more positive attitudes towards survivors than did Latinas, European American females were more sympathetic towards a White survivor than they were towards a Latina who had been raped (Jiminez & Abreu, 2003). Furthermore, a study by Donovan (2007) concluded that White undergraduates were more prone to believe that African-American survivors were more promiscuous than White survivors when the race of the perpetrator was White. However, there were no differences in attributed promiscuity when the perpetrator was African American.

Lee, Pomeroy, Yoo, and Rheinboldt (2005) conducted a study comparing rape attitudes among Asian and White college students. The results indicated that the Asian participants were more likely to engage in survivor blaming and believe that the survivor somehow caused the attack. Additionally, Asian participants more often believed that rape is mostly perpetrated by strangers and that sex is the main motivation for rape. Both of these beliefs are rape myths. It is important to note that while previous research did find variations in attitudes towards survivors, another study (Bell, Kuriloff, & Lottes, 1994) found no significant differences in survivor blaming among African-Americans, Asians, and Whites.

**Religious/spiritual orientation.** The literature pertaining to religious or spiritual orientation and its relationship to RMA and rape empathy is limited. What is available suggests that there is no clear relationship between religious/spiritual orientation and RMA (Carr, 2006; Hunt, 2000), although Aosved and Long (2006) did find that religious intolerance was associated with RMA. Additionally, while Carr (2006) found that Christian fundamentalism did not have a direct impact on RMA, participants who espoused more firm beliefs in fundamentalism believed more in traditional gender roles,

which was found to be associated with increased levels of RMA and less sympathetic attitudes towards rape survivors.

## **Method**

### **Participants**

This study utilized two randomly selected groups of participants: (1) counselor trainees (master's or doctoral students) and (2) counseling professionals (counselors or counselor educators). Participants noted on the demographic sheet included in the survey packet whether they were a trainee or professional. The participants were required to identify as counselors or counselor educators as opposed to identifying with other helping fields such as social work or psychology to be eligible for participation in the study. Assuming a moderate effect size at  $P = .80$ , a sample of 107 (54 per group) participants was needed for the hypotheses to be tested at the .05 level (Cohen, 1992). To obtain the desired number of participants, 2,000 individuals (1,000 students, 1,000 professionals) were solicited for inclusion in the study. Overall the return rate was 10.9%, and 213 participants began the survey packet. However, 194 (10.0%) participants fully completed the assessments.

Overall, 108 (55.7%) individuals identified themselves as professionals, and 85 (43.8%) identified themselves as trainees. One (0.5%) did not answer the question. More specifically, the sample ( $n = 194$ ) contained 80 (36.2%) master's students, 22 (10%) doctoral students, 103 (46.6%) practitioners, and 16 (7.2%) counselor educators. Concerning age, individuals were given options that allowed them to place themselves within a range of ages. Participants fell into all age ranges with the exception of 76+. Participants (46, 23.7%) most frequently identified themselves as falling within the 25-30

age range. The second most popular age range was 31-35, with 28 (14.4%) participants falling into this category. Regarding gender, 156 participants identified as female (80.4%) and 38 as males (19.6%). Finally, the racial/ethnic makeup of this sample included 160 Whites (82.1%), 19 (9.7%) African Americans, 8 (4.1%) Hispanics, 1 (0.5%) Asian American, 4 (2.1%) Native Americans, and 3 (1.5%) who identified as other. Overall, 3 (1.5%) individuals reported they were gay, and 6 (3.1%) identified as lesbians. Furthermore, 15 (7.7%) members of the sample noted that they were bisexual, and one (0.5%) identified as questioning. The majority, 169 (87.1%) individuals in total, cited that they were heterosexuals.

Furthermore, Christians (64.9%) and those practicing their religious/spiritual orientation (51.0%), constituted the majority of the sample. Many participants (58.8%) had not been raped, although a large amount (86.1%) knew someone who had been attacked. The sample primarily held master's degrees (60.8%) and had only seen 0-1 clients who presented with rape related issues (36.1%). Most frequently, those involved in this research had not obtained licensure or certification (40.6%), nevertheless those with the LPC credential were the second most frequently reported (22.6%). Overall, the sample had most often spent between 1-5 hours training on rape related material (34.0%). Finally, the participants most frequently reported (20.1%) working 0-2 years as counselors, with 4.1% of educators saying they had been in the field for 3-5 years.

## **Procedure**

After receiving IRB approval, an email list of random members of the American Counseling Association (ACA) was requested and obtained. Half of the list, which contained 2,000 names in total, was comprised of trainees, and the other half was

comprised of professionals. Multiple links guiding the participants to three randomly ordered assessment packets were created to control for ordering bias in the study. The participants were assigned to their survey link via stratified sampling. They then received an email from the researcher informing them of the purpose of the study and directing them to the assessment packet uploaded to SurveyMonkey ([www.surveymonkey.com](http://www.surveymonkey.com)).

The assessment packets contained the informed consent, a demographic collection sheet, the Rape Empathy Scale (RES; Dietz et al., 1982), the Male Rape Myth Scale (MRMS; Melanson, 1999), and a revised version of Burt's (1980) Rape Myth Acceptance Scale (RMAS). The revised version of this scale for purposes of this study was known as the Myths and Attitudes about Rape Survey (MARS). Once the participants followed the link to SurveyMonkey, they could complete the assessment packet at their convenience with no time limit. After waiting two weeks from the first solicitation email, a second email was sent out to remind participants of the survey and to thank those who had already completed the packet. After another two weeks, the surveys were closed.

## **Measures**

**Demographic Sheet.** Demographic information was collected from this sample. The demographic sheet included questions asking for the disclosure of the participants' gender, age, sexual orientation, religious/spiritual orientation, exposure (whether the participant knows a survivor or is a survivor), race/ethnicity, and counselor level (education/training experience).

**Myths and Attitudes about Rape Survey.** This study utilized the Myths and Attitudes about Rape Survey (MARS), which is an alteration of Burt's (1980) Rape Myth Acceptance Scale (RMAS). A different name was created per the request of the original

author of the RMAS. The original assessment is a 19-item self-report measure of attitudes towards rape (Burt, 1980). The scale utilizes a 7-point Likert scale varying from (1) *strongly agree* to (7) *strongly disagree*. Higher scores indicate lower acceptance of rape myths, and lower scores demonstrate higher RMA (Jiminez & Abreu, 2003). Two questions ask participants to answer in terms of how often they believe a rape story was fabricated by a survivor with possible answers being *almost all*, *about ¾*, *about half*, *about ¼*, or *about none*. One other question asks participants to disclose how likely they would believe an individual's story based on demographic variables, with possible answers being *always*, *frequently*, *sometimes*, *rarely*, or *never*. Scores range from 19 to 133.

The RMAS assesses levels of belief in such statements as “A woman who goes to the home or apartment of a man on their first date implies that she is willing to have sex” and “Many women have an unconscious wish to be raped, and may then unconsciously set up a situation in which they are likely to be attacked” (Burt, 1980). Three concepts guided the development of this assessment, which were (1) *sexual conservatism*, defined as restrictiveness of sexual partners or acts and circumstances needed for sex to occur, (2) *adversarial sexual beliefs*, or the expectation that sexual relationships are by nature devious, manipulative, and dishonest, and (3) *acceptance of interpersonal violence*, defined as the view that “force and coercion are legitimate ways to gain compliance and specifically that they are legitimate in intimate and sexual relationships” (Burt, 1980, p. 218). It is important to note that *sexual conservatism* was conceptualized with the “just world hypothesis” in mind, thus indicating that participants who held conservative beliefs regarding sex may view the survivor's participation in the forced sexual act, which may

not have conformed to perceived acceptable, traditional sexual practices, as so menacing that they are willing to “overlook the coercion and force involved and condemn the survivor for participating” (Burt, 1980, p. 218). Validity is shown by the item-to-total correlation of scores with the three concepts: *sexual conservatism* ( $r = .39$ ), *adversarial sexual beliefs* ( $r = .40$ ), and *acceptance of interpersonal violence* ( $r = .50$ ) (Burt, 1980).

Using a sample of Minnesota adults ages 18 and over, Burt (1980) reported the scale’s Cronbach’s alpha at .88. Other studies have yielded similar alphas. For instance, Jiminez and Abreu (2003) reported an alpha of .88 when using a sample of Latina/o and White students. Schechory and Idisis (2006) reported an alpha of 0.75 with a sample of female students in social science courses and female therapists, and Bohner et al. (2005) reported an alpha of 0.83 when utilizing male undergraduates and male employees in the United Kingdom. The Cronbach’s alpha in the current study for the MARS was .80.

A potential limitation of the wording of the original RMAS (Burt, 1980) implies that hetero relationships are normative, leading to the potential assumption that rape only occurs in hetero relationships. Specifically, the survivor in the scale is always a female and the perpetrator is always a male. This prompted a slight change in the RMAS. Four items were revised to enable for a more open interpretation of who a perpetrator may be. Specifically, the following were altered for this study: (1) A woman who goes to the home or apartment of a *person* (previously “man”) on their first date implies that she is willing to have sex; (2) A woman who is stuck-up and thinks she is too good to talk to *potential partners* (previously “guys”) on the street deserves to be taught a lesson; (3) If a woman gets drunk at a party and has intercourse with an *individual* (previously “man”) she’s just met there, she should be considered “fair game” to *others* (previously “males”)



at the party who want to have sex with her too, whether she wants to or not; (4) What percentage of women who report a rape would you say are lying because they are angry and want to get back at the *person* (previously “man”) they accuse?

**Male Rape Myth Scale.** The Male Rape Myth Scale (MRMS; Melanson, 1999), a 22-item self-report measure of levels of male RMA, uses a 6-point Likert scale (1= *strongly disagree* to 6= *strongly agree*) with scores falling on a continuum between 22 to 132. Higher scores indicate more belief in rape myths (Kassing et al., 2005). “Many men claim rape if they have consented to homosexual relations but have changed their mind afterwards” and “I would have a hard time believing a man who told me he was raped by a woman” are examples of items on this scale (Melanson, 1999).

Utilizing a sample of undergraduate students, Melanson (1999) found that the Cronbach’s alpha was .90 with a 4-week test-retest reliability of  $r(291) = .89, p < .0001$ . Furthermore, strong validity was reported as well in two ways (Melanson, 1999). First, convergent validity strongly correlated with criterion measure scores on rape scenarios,  $r(301) = .71, p < .0001$ , and second, the MRMS showcased the expected differences in relation to gender, specifically males demonstrating higher levels of RMA than females. An additional study that has utilized the MRMS was Kassing et al. (2005) who reported a Cronbach’s alpha of .91 utilizing a sample of Midwestern adult males. The Cronbach’s alpha in the current study was .83.

**Rape Empathy Scale.** The Rape Empathy Scale (RES; Deitz et al., 1982) is a 19-item measure of empathy towards and responsibility ascribed to rape survivors. The RES is a 7-point Likert scale, with possible answers ranging from (1) *strongly disagree*, which indicates strong empathy for the rapist to (7) *strongly agree*, which indicates strong

empathy for the survivor (Dietz et al., 1982). The range of scores for the RES is 19 to 133. Higher scores on the RES signify high levels of empathy towards rape survivors and lower levels of attributing responsibility to the survivor for the attack (Jiminez & Abreu, 2003).

Items on this scale include pairs of statements that indicate more empathy either for the rape survivor or for the rapist. Examples include statements such as, “I feel that the situation in which a man compels a woman to submit to sexual intercourse against her will is not a justifiable act under any circumstances” and “I feel that the situation in which a man compels a woman to submit to sexual intercourse against her will is a justifiable act under certain circumstances.” (Dietz et al., 1982). Another item is “In general, I feel that rape is an act that is not provoked by the rape victim” and “In general, I feel that rape is an act that is provoked by the rape victim.” (Dietz et al., 1982). The original instructions stated “to choose the statement from each item that they preferred and to indicate their degree of preference for one statement over the other (ranging from strong preference for a statement to no preference for one statement or the other)” (Dietz et al., 1982, p. 374). Due to potential confusion among participants about how to complete the survey, the RES was altered in SurveyMonkey to contain only the most empathic statements on the RES. For example, utilizing the two sample questions just given, the statements that appeared on the assessment were “I feel that the situation in which a man compels a woman to submit to sexual intercourse against her will is not a justifiable act under any circumstances” and “In general, I feel that rape is an act that is not provoked by the rape victim” (Dietz et al., 1982). Participants were still instructed to

score their agreement with the statements on a 7-point Likert scale. The Cronbach's alpha for the RES in this study was .78.

Dietz et al. (1982) reported an alpha coefficient for this scale of .84 utilizing a sample of psychology undergraduates and randomly selected individuals from jurors lists ( $n = 170$ ). Other studies have detailed similar alphas, including .82 when using a sample of Latina/o and White undergraduates (Jiminez & Abreu, 2003) and .80 when administered to an another set of college students (Chng & Burke, 1999).

Information is somewhat lacking concerning the validity of the RES, however, previous research utilizing the RES reports the instrument as being valid (Chng & Burke, 1999; Dietz et al., 1982). Convergent validity was determined by examining the relationship between scores on the RES and the Attitudes towards Women Scale (AWS) for the first group of participants utilized in creating the instrument, with a significant correlation of  $r = .33, p < .05$  (Dietz et al., 1982). The second group utilizing students showcased validity of  $r = .45, p < .001$ . Indications of discriminant validity were shown by the deficit of a significant relationship between the Marlowe-Crowne Social Desirability Scale and the RES,  $r = .05, ns$  (Dietz et al., 1982).

## Results

Research Question 1, analyzed via a Mann-Whitney test and descriptive statistics, obtained baseline levels of RMA and rape empathy among counseling professionals and trainees and examined whether there was a statistically significant difference between professionals' and trainees' levels of RMA and rape empathy. Results on the Mann-Whitney indicated that female RMA levels as measured by the MARS among trainees ( $Mdn = 86.00$ ) did not differ significantly from female RMA levels among professionals

( $Mdn = 86.00$ ),  $U = 4240.50$ ,  $z = -.910$ ,  $p > .05$ . Male RMA levels among trainees ( $Mdn = 43.00$ ) computed from scores on the MRMS also did not differ significantly from professionals' male RMA levels ( $Mdn = 43.50$ ),  $U = 4577.50$ ,  $z = -.032$ ,  $p > .05$ . Rape empathy levels as measured by the RES among trainees ( $Mdn = 114.00$ ) did not differ significantly from rape empathy levels among professionals in the sample ( $Mdn = 114.00$ ),  $U = 4327.00$ ,  $z = -.683$ ,  $p > .05$ .

Descriptive statistics run on scores from the MRMS, MARS, and RES for the overall sample yielded the following means: (1) Male RMA ( $M = 83.27$ ,  $SD = 11.72$ ), (2) Female RMA ( $M = 83.27$ ,  $SD = 10.17$ ), and (3) Rape empathy levels ( $M = 112.18$ ,  $SD = 12.63$ ). Baseline means were also computed comparing the two groups. On the MRMS, professionals had a slightly lower mean ( $M = 46.06$ ,  $SD = 10.94$ ) than trainees ( $M = 46.56$ ,  $SD = 12.75$ ). The MARS revealed a lower mean for professionals ( $M = 82.32$ ,  $SD = 11.21$ ) than trainees ( $M = 84.41$ ,  $SD = 8.64$ ). Finally, professionals held a lower mean ( $M = 111.38$ ,  $SD = 13.29$ ) than trainees ( $M = 112.96$ ,  $SD = 11.65$ ) on the RES.

Research Question 2 investigated to what degree demographic variables and rape empathy predict levels of female RMA and was examined using a Stepwise Regression analysis. The following variables were entered: (1) scores from the RES, (2) Gender, (3) Experience Rape, (4) Knowing a Rape Victim, (5) Hours Spent Training on the Subject of Rape, (6) Highest Completed Degree, (7) Age, (8) Race/Ethnicity, (9) Sexual Orientation, (10) Religious/Spiritual Orientation, and (11) reported level of Practicing their religious/spiritual orientation. Using the scores from the MARS, the results indicated that the only significant predictor of female RMA was sexual orientation,  $R^2 = 0.37$ ,  $F(1, 182) = 7.2$ ,  $p < .01$ .

Research Question 3 asked to what degree demographic variables and rape empathy predict levels of male RMA. This analysis was also conducted via a Stepwise Regression, and the same variables were entered as in Research Question 2. Scores from the MRMS were used for this procedure. No statistically significant predictive relationship was found between any of the demographic variables, rape empathy, and male RMA.

Research Question 4 investigated if a statistically significant relationship existed between rape empathy and female or male RMA. The analysis was done utilizing the Spearman Rho Correlation Coefficient procedure and used the participants' scores on the MRMS, RES, and MARS. The correlation between the RES and MARS was statistically significant,  $r_s = .18, p < .05$ , demonstrating that increased rape empathy levels were associated with more accurate perceptions of female rape (i.e., higher MARS scores). The correlation between RES and MRMS was not statistically significant,  $r_s = -.05, p > .05$ , thus indicating that there is no significant relationship between male RMA and rape empathy. However, a statistically significant relationship was found between the MRMS and the MARS,  $r_s = -.48, p < .001$ . This finding demonstrates that higher male RMA was related to higher female RMA (i.e., higher MRMS scores associated with lower MARS scores).

### **Discussion**

The purpose of this study was to investigate levels of male and female RMA and rape empathy among counseling professionals ( $n = 108$ ) and counseling trainees ( $n = 85$ ). The relationship between RMA and rape empathy was analyzed, as well as the predictive nature of demographic variables and rape empathy on RMA levels.

The results of this study indicated that there was no statistically significant difference between professionals' and trainees' levels of RMA and rape empathy . Baseline means were obtained for the overall sample, as well as for the two groups. Furthermore, this study found that demonstrating a statistically significant predictive relationship between rape empathy, demographic variables, and RMA remains somewhat elusive. Only one variable was found through a Stepwise Regression procedure to significantly predict female RMA, which was sexual orientation. No variables were found to significantly predict male RMA. The lack of a statistically significant predictive relationship between the other variables may be attributed to the current sample being homogenous and the previous studies being older, using different assessments, or using a sample that was not comprised of counseling professionals and students.

Furthermore, rape empathy was also expected to have a predictive impact on RMA but was not indicated to do so even though previous research (Dietz et al., 1982; Sakalli-Urgulu et al., 2007) has found such a relationship. The current study differs from the previous research (Dietz et al., 1982) by using a sample of counseling professionals and students. Furthermore, the Sakalli-Urgulu et al. (2007) study utilized a 6-item version of the RES, yielding a Cronbach's alpha of .67, whereas this study used the assessment in its entirety.

Finally, this research discovered a significant relationship between rape empathy and female RMA, indicating that as rape empathy increases so do more accurate ideas regarding female rape myths. There was no statistically significant relationship between rape empathy and male RMA. One other statistically significant relationship uncovered by the Spearman Rho analysis was between male and female RMA. This finding

indicated that both male and female RMA increase together, insinuating that if an individual holds stereotypical beliefs about one gender and rape, they will likely hold similar preconceptions about the opposite gender as well.

### **Limitations of the Study**

History is a potential hindrance to the current research (Wiersma & Jurs, 2009). A rape may have occurred in the participant's life that altered their point of view regarding rape and rape survivors. Selection bias may also have affected this study. Participants were all ACA members, and only 10% of those solicited responded. This may be due to participants already having particular attitudes about rape that could have made participation in a study on rape more likely (Wiersma & Jurs, 2009). It is important to note that such a low response rate may indeed be because of the topic of rape, which may have made some individuals who were solicited uncomfortable and unlikely to complete the assessment packet. Participants may also have answered in a socially desirable manner since rape is an emotionally charged subject (Marczyk, DeMatteo, & Festinger, 2005). Due to participants knowing that their attitudes were being measured by the researcher, they may have chosen to alter their responses to be more empathic or less accepting of rape myths.

The main purpose of this study was to investigate the influence of demographic variables and rape empathy on RMA among those in the counseling field only. Since the focus was on one specific field, generalizability outside of the field could be a potential issue. Once again, it is important to note that low response rate, which may have affected external validity.

A Stepwise Regression procedure was chosen due to the current research being more exploratory in nature (Field, 2009). However, this method is not without its limitations. Field (2009) and Meyers, Gamst, and Guarino (2006) caution that because a computer program, in this case SPSS, is making decisions about which variables are included a researcher's control over the process is decreased. Furthermore, a stepwise regression may either over-fit a model by inputting too many variables that do not contribute much to the outcome of the study or may under-fit a model by utilizing too few variables that are indeed important predictors (Field, 2009). Meyers et al. (2006) further warns that just how significant an impact a predictor makes on the outcome is unknown.

Items were slightly revised on the RMAS (Burt, 1980) to form the MARS. By altering the wording of the scale, the psychometrics for the original assessment were changed and may have impacted the data. The new Cronbach's alpha for the MARS was .80. Furthermore, the results from this study indicated skewness levels outside of -1 and 1, thus indicating the data was skewed. This is perhaps because the sample was comprised of individuals who were all involved in the counseling field and therefore were more aware of rape related issues, making them more empathic and less accepting of rape myths.

### **Implications for Practice and Training**

The results from this research indicated that counseling professionals and counseling students did not have statistically significant different levels of RMA or rape empathy. The two groups also obtained means that belied more accurate perceptions of rape and higher levels of rape empathy. As previous studies have demonstrated, high



RMA and low rape empathy are harmful to rape survivors and clinical outcomes (Bohner et al., 2005; Burt, 1980; Campbell, Ahrens, et al., 2001; Campbell & Raja, 1999; 2005; Dietz et al., 1982; Sakalli-Ugurlu et al., 2007). Becoming more self-aware about one's own biases about rape and rape survivors may aid in ensuring that a client is not subjected to further victimization through negative attitudes and behaviors towards them. To further prevent secondary victimization, a counselor's work with a rape survivor may benefit from supervision or other self-care measures to help prevent or remediate vicarious trauma (McCann & Pearlman, 1990).

Training and highest degree completed were not found to significantly predict levels of RMA. The non-significant findings in this study may suggest that counselors are receiving adequate training and possess the necessary empathy and accurate attitudes about rape to effectively treat survivors. However, more research is needed since this sample was homogenous, with little variability regarding education and training.

Even though this study did not find significant results, previous research has indeed shown that education and training can increase rape empathy and lower RMA (Burt, 1980; Dietz et al., 1982; Kassing et al., 2005; Kassing & Prieto, 2003). Therefore, counselors should seek continuing education opportunities focused on rape. Furthermore, counselor educators may consider including extended information about rape and its consequences in the courses they teach to shape student attitudes "from the ground up" about the issues survivors face. Role playing in counseling labs or actual training experience with individuals presenting with rape issues could be very helpful to students prior to or in conjunction with their practicum or internship experience.

Sexual orientation significantly predicts female participants' levels of RMA, although not male RMA. This may be because more blame for a rape was attributed to those who were "perceived to be sex objects of the perpetrator" (Ford, Liwag-McLamb, & Foley, 1998, p. 261). Since the majority of this sample reported being heterosexual, participants may have answered questions with the male perpetrator-female survivor dynamic in mind due to their own innate sexuality and who they perceive to be the "sex object" of the perpetrator, who in most cases is a male. Therefore, educating counselors that a perpetrator may be a female and a survivor can be a male could be beneficial.

Higher rape empathy was associated with lower levels of female RMA. Since female rape is more common, participants may conceivably have more experience working with female clients and know more female survivors. These types of experiences lead to higher rape empathy (Chng & Burke, 1999). Due to these circumstances, a relationship between higher rape empathy and lower male RMA may not have been found. Exposing students to male survivors' stories and clinical cases may aid in furthering the relationship between high rape empathy and low male RMA.

Finally, this study found that male RMA and female RMA increase together. In other words, as belief in rape myths about males increase, so do belief in rape myths about females. This implies that in whatever form of training an individual engages in, be it self-study, workshops, or hearing material presented in a counseling course, both male and female rape myths should be addressed and combated.

### **Implications for Future Research**

While this study did not find a statistically significant predictive relationship between training, education, and RMA, perhaps due to the homogeneity of the sample,

future research could compare groups of counseling professionals and trainees against individuals who are not in the counseling field to assess differences in rape attitudes. This could perhaps lend some support to the current training and educative practices in the counseling field and their potential positive impact on RMA.

Furthermore, additional research is warranted to investigate whether rape empathy is predictive of RMA, as this study did not yield such a finding. Perhaps new studies could utilize different assessment tools or regression methods to study this relationship further. Since a statistically significant relationship was found between male and female RMA, future investigations could examine which type of RMA may be more prominent and focus trainings accordingly.

Additionally, more research is needed on a male survivor's experience following a rape. For example, a qualitative study could focus on their stories of their treatment during a PERK, when obtaining counseling services, or when undergoing the reporting process. By illuminating their experiences, hopefully an increasing number of professionals will feel more comfortable working with male rape survivors and are better able to provide more tailored services to them.

Close in nature to earlier work by Dye and Roth (1990), research could also be conducted to find out how much counseling professionals know about treating a survivor. This would provide a broad picture of the techniques and theories counselors are currently using and what the issues are that they deem most important. Such a study would also illustrate how many professionals know about and understand the evidence collection process, as well as the other systems survivors cycle through once they report.

## **Conclusion**

This study examined the influence of rape empathy and demographic variables on counselor RMA and investigated any potential relationship between rape empathy and RMA. Professionals and trainees were found to have no statistically significant difference in levels of RMA and rape empathy. Rape empathy and acceptance of rape myths about females were significantly related, although male RMA and rape empathy were not. Male and female RMA were discovered to have a statistically significant relationship. Of all of the variables analyzed for predictive influences on RMA, only sexual orientation was a statistically significant predictor of acceptance of rape myths about females. No predictors were found for male RMA. As this research was indeed an exploratory study, further analysis is needed to investigate rape empathy, male and female RMA, and the various demographic variables' relationship to these concepts.

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# Appendix A:

## Human Subjects Application and Approval

### OLD DOMINION UNIVERSITY

### APPLICATION FOR EXEMPT RESEARCH

Note: For research projects regulated by or supported by the Federal Government, submit 10 copies of this application to the Institutional Review Board. Otherwise, submit to your college human subjects committee.

<b>Responsible Project Investigator (RPI)</b> The RPI must be a member of ODU faculty or staff who will serve as the project supervisor and be held accountable for all aspects of the project. Students cannot be listed as RPIs.		
First Name: Danica	Middle Initial: G.	Last Name: Hays
Telephone: 757.683.6692	Fax Number: 683-5756	E-mail: dhays@odu.edu
Office Address: ED 110-C, Darden College of Education		
City: Norfolk	State: Virginia	Zip: 23529
Department: Counseling and Human Services	College: Darden College of Education	
Complete Title of Research Project: THE INFLUENCE OF RAPE EMPATHY AND DEMOGRAPHIC VARIABLES ON COUNSELOR RAPE MYTH ACCEPTANCE		Code Name (One word): Myths
<b>Investigators</b> Individuals who are directly responsible for any of the following: the project's design, implementation, consent process, data collection, and data analysis. If more investigators exist than lines provided, please attach a separate list.		
First Name: Julia	Middle Initial: M.	Last Name: Forman
Telephone: 601.668.3717	Fax Number:	Email: jform004@odu.edu
Office Address: C/O Dr. Danica Hays, 110 Education Building, Old Dominion University		
City: Norfolk	State: VA	Zip: 23529
Affiliation: <input type="checkbox"/> Faculty <input checked="" type="checkbox"/> Graduate Student <input type="checkbox"/> Undergraduate Student <input type="checkbox"/> Staff <input type="checkbox"/> Other _____		
List additional investigators on attachment and check here: ____		
<div style="text-align: center;">Type of Research</div>		

**1. This study is being conducted as part of (check all that apply):**

<input type="checkbox"/> Faculty Research	<input type="checkbox"/> Non-Thesis Graduate Student Research
<input checked="" type="checkbox"/> Doctoral Dissertation	<input type="checkbox"/> Honors or Individual Problems Project
<input type="checkbox"/> Masters Thesis	<input type="checkbox"/> Other _____

**Funding**

**2. Is this research project externally funded or contracted for by an agency or institution which is independent of the university? Remember, if the project receives ANY federal support, then the project CANNOT be reviewed by a College Committee and MUST be reviewed by the University's Institutional Review Board (IRB).**

☐ Yes (If yes, indicate the granting or contracting agency and provide identifying information.)  
☒ No

**Agency Name:**

**Mailing Address:**

**Point of Contact:**

**Telephone:**

**Research Dates**

**3a. Date you wish to start research (MM/DD/YY)**      3/15/10  

**3b. Date you wish to end research (MM/DD/YY)**      3/14/11  

**Human Subjects Review**

**4. Has this project been reviewed by any other committee (university, governmental, private sector) for the protection of human research participants?**

☐ Yes  
☒ No

**4a. If yes, is ODU conducting the primary review?**

☐ Yes  
☐ No (If no go to 4b)

**4b. Who is conducting the primary review?**

**5. Attach a description of the following items:**

X\_ Description of the Proposed Study

X\_ Research Protocol

X\_ References

X\_ Any Letters, Flyers, Questionnaires, etc. which will be distributed to the study subjects or other study participants

N/A If the research is part of a research proposal submitted for federal, state or external funding, submit a copy of the FULL proposal

Note: The description should be in sufficient detail to allow the Human Subjects Review Committee to determine if the study can be classified as EXEMPT under Federal Regulations 45CFR46.101(b).

**Exemption categories****1. Identify which of the 6 federal exemption categories below applies to your research proposal and explain**

**why the proposed research meets the category. Federal law 45 CFR 46.101(b) identifies the following EXEMPT categories. Check all that apply and provide comments.**

**SPECIAL NOTE:** The exemptions at 45 CFR 46.101(b) do not apply to research involving prisoners, fetuses, pregnant women, or human in vitro fertilization. The exemption at 45 CFR 46.101(b)(2), for research involving survey or interview procedures or observation of public behavior, does not apply to research with children, except for research involving observations of public behavior when the investigator(s) do not participate in the activities being observed.

\_\_\_\_ (6.1) Research conducted in established or commonly accepted educational settings, involving normal educational practices, such as (i) research on regular and special education instructional strategies, or (ii) research on the effectiveness of or the comparison among instructional techniques, curricula, or classroom management methods.

**Comments:**

\_X\_ (6.2) Research involving the use of educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures or observation of public behavior, unless: (i) Information obtained is recorded in such a manner that human subjects can be identified, directly or through identifiers linked to the subjects; AND (ii) any disclosure of the human subjects' responses outside the research could reasonably place the subjects at risk of criminal or civil liability or be damaging to the subjects' financial standing, employability, or reputation.

**Comments:**

**This research will be nonexperimental survey research that will be administered via SurveyMonkey. The Rape Myth Acceptance Scale (Burt, 1980), the Rape Empathy Scale (Dietz, Blackwell, Daley, & Bentley, 1982), and the Male Rape Myth Scale (Melanson, 1999) will be the assessments utilized in this study. Participants will be emailed to solicit their participation. However, the researcher will not identify any of the individuals on the obtained ACA list during the analysis or write-up process. The email list will be kept on a password protected computer. The computer is further protected by Norton protection software. Correspondence with participants will be deleted after the study is completed and will also be kept on the password protected computer. The ACA list will be deleted following the conclusion of this study.**

\_\_\_\_ (6.3) Research involving the use of educational tests (cognitive, diagnostic, aptitude,



achievement), survey procedures, interview procedures, or observation of public behavior that is not exempt under paragraph (b)(2) of this section, if:

(i) The human subjects are elected or appointed public officials or candidates for public office; or (ii) federal statute(s) require(s) without exception that the confidentiality of the personally identifiable information will be maintained throughout the research and thereafter.

**Comments:**

\_\_\_\_ (6.4) Research, involving the collection or study of existing data, documents, records, pathological specimens, or diagnostic specimens, if these sources are publicly available or if the information is recorded by the investigator in such a manner that subjects cannot be identified, directly or through identifiers linked to the subjects.

**Comments:**

\_\_\_\_ (6.5) Does not apply to the university setting; do not use it

\_\_\_\_ (6.6) Taste and food quality evaluation and consumer acceptance studies, (i) if wholesome foods without additives are consumed or (ii) if a food is consumed that contains a food ingredient at or below the level and for a use found to be safe, or agricultural chemical or environmental contaminant at or below the level found to be safe, by the Food and Drug Administration or approved by the Environmental Protection Agency or the Food Safety and Inspection Service of the U.S. Department of Agriculture.

**Comments:**

**PLEASE NOTE:**

1. You may begin research when the College Committee or Institutional Review Board gives notice of its approval.
2. You MUST inform the College Committee or Institutional Review Board of ANY changes in method or procedure that may conceivably alter the exempt status of the project.

**Responsible Project Investigator** (Must be original signature)

**Date**

## APPENDIX A, CONTINUED

### DESCRIPTION OF THE PROPOSED STUDY

**Study Title:**

THE INFLUENCE OF RAPE EMPATHY AND DEMOGRAPHIC VARIABLES ON  
COUNSELOR RAPE MYTH ACCEPTANCE

**Rationale:**

Although many studies exist examining rape myth acceptance and empathy towards rape victims, the literature is scarce or nonexistent when specifically addressing these concepts among counseling practitioners and counseling trainees. As many counseling professionals and students will come into a professional relationship with survivors, it is important to investigate the degrees to which clinicians and trainees espouse rape myths and to assess their levels of empathy concerning rape victims. As previous research has indicated that training, education and experience can lower levels of rape myth acceptance (Burt, 1980; Kassing & Prieto, 2003) and increase empathy (Chng & Burke, 1999), the findings of this research could have far reaching impacts on how Master's and doctoral students are educated in our counseling programs and how practitioners choose to obtain their continuing education units. Even if the results of this study indicated that amount of training or education do not affect levels of rape myth acceptance or rape empathy, this research will contribute to the literature by describing the biases and rape empathy levels among counseling practitioners and trainees, allowing for a snapshot of the current counseling field and what survivors are facing when seeking services. As there is virtually no literature addressing these concepts in the counseling field specifically, this research is needed for an accurate representation of the discipline.

**Method:**

Participants will be counseling trainees and counseling practitioners. To obtain this sample, a randomized list from the American Counseling Association shall be purchased with equal numbers of practitioners and trainees. This list is being chosen as the sampling method for this study because it will have up to date information on ACA members since membership must be renewed annually. Furthermore, members of ACA will likely self-identify as counseling professionals or students, a criteria for participation in this research, and the low cost for several contacts and ease of use of the ACA randomized member list helps to potentially ensure greater returns and also allows for an equal distribution of trainees and practitioners.

Participants must self-identify as practicing counselors, counselor educators, or counseling students/trainees. They must not self-identify with any other helping discipline such as social work or psychology. Participants must be currently working in the field as a clinician or educator or must currently be enrolled in a Master's or doctoral level counseling program. This is because there is a significant gap in the literature of a counseling field specific study concerning rape empathy, rape myth acceptance and the impact of demographic variables on these constructs. All participants by nature of the

criteria needed are expected to be over 18. If any individual is under 18, they will be excluded from the study. The specific demographic variables under study include age, gender, whether the participant knows a victim or has experienced assault themselves, religion/sexual orientation, training/educative experience and sexual orientation.

For the purposes of this study, a list containing a minimum of 1,000 individuals (500 trainees, 500 practitioners) will be purchased. Assuming a moderate effect size at  $P = .80$ , a sample of 147 (74 per group) will be needed for this research if the hypotheses are tested at the .01 alpha level (Cohen, 1992). 107 participants (54 per group) will be needed if the hypotheses are tested at the .05 level. Although this research will only need approximately 150 participants, buying extra participant information will establish a safeguard in the case that not all individuals complete the assessment packet.

These individuals will then be sent an email (attached) to invite them to participate in the current research. Once the participants have been selected, an email from the researcher will be sent out thanking them for their help and supplying the link to the measures that will be used: the Rape Myth Acceptance Scale, the Male Rape Myth Scale, the Rape Empathy Scale, and the demographic information collection sheet (attached). The Rape Myth Acceptance Scale will be altered on four items to provide the participant a more open interpretation of who a perpetrator might be. Specifically, the following were altered for this study: (1) A woman who goes to the home or apartment of a *person* (previously “man”) on their first date implies that she is willing to have sex; (2) A woman who is stuck-up and thinks she is too good to talk to *potential partners* (previously “guys”) on the street deserves to be taught a lesson; (3) If a woman gets drunk at a party and has intercourse with an *individual* (previously “man”) she’s just met there, she should be considered “fair game” to *others* (previously “males”) at the party who want to have sex with her too, whether she wants to or not; (4) What percentage of women who report a rape would you say are lying because they are angry and want to get back at the *person* (previously “man”) they accuse? The participants will then be asked complete the measures within the chosen deadline for inclusion in the study. Participants will be sent another email after two weeks to follow-up and remind them of the study.

The assessments will be uploaded onto Survey Monkey following receiving permission for use. To control for ordering bias, the assessments will appear in a random order for each individual that participates in the study (i.e., participants will receive randomized links to 1 of 3 orders in their solicitation letter). Participants will be assigned a participant code that will match with their demographic data and assessment answers. Upon receipt of an adequate number of returns for this study, the participant answers will be uploaded from Survey Monkey to SPSS where the need statistical procedures will be run, analyzed, and written up. Descriptive statistics will be utilized indicate the sample’s demographic makeup, including age, gender, educational and training background, religious/spiritual orientation, sexual orientation, and exposure to sexual assault.

## APPENDIX B

### THE RAPE EMPATHY SCALE (RES)

#### Permission For Use:

Copyright © 1982 by the American Psychological Association. Reproduced [or Adapted] with permission. The official citation that should be used in referencing this material is

Dietz, S.R., Blackwell, K.T., Daley, P.C., & Bentley, B.J. (1982). Measurement of empathy toward rape victims and rapists. *Journal of Personality and Social Psychology*, 43(2), 372-384. doi: 0022-3514/82/4302-0372

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**Instructions:** Choose the statement from each item that you prefer. Indicate your degree of preference for one statement over the other. Indicate your preference on the 7 point Likert scale. A 1 indicates strong agreement with the statement. A 7 indicates strong disagreement with the statement.

1. I feel that the situation in which a man compels a woman to submit to sexual intercourse against her will is an unjustifiable act under any circumstances.

1.....2.....3.....4.....5.....6.....7

Strongly Agree

Strongly Disagree

2. In deciding the matter of guilt or innocence in a rape case, it is more important to know about the past sexual activity of the alleged rapist than the past sexual activity of the alleged rape victim.

1.....2.....3.....4.....5.....6.....7

Strongly Agree

Strongly Disagree

3. In general, I feel that rape is an act that is not provoked by the rape survivor.

1.....2.....3.....4.....5.....6.....7

Strongly Agree

Strongly Disagree

4. I would find it easier to imagine how a rape victim might feel during an actual rape than how a rapist might feel.

1.....2.....3.....4.....5.....6.....7  
Strongly Agree Strongly Disagree

5. I cannot understand why a man would use force to obtain sexual relations with a woman under any circumstances.

1.....2.....3.....4.....5.....6.....7  
Strongly Agree Strongly Disagree

6. In a court of law, I feel that the rapist must be held accountable for his behavior during the rape.

1.....2.....3.....4.....5.....6.....7  
Strongly Agree Strongly Disagree

7 A woman has the right to dress in a sexually attractive way whether she is really interested in having sexual relations or not.

1.....2.....3.....4.....5.....6.....7  
Strongly Agree Strongly Disagree

8. I would find it easier to empathize with the shame and humiliation a rape victim might feel during a trial to prove a rape than with the feelings a rapist might have during the trial.

1.....2.....3.....4.....5.....6.....7  
Strongly Agree Strongly Disagree

9. If a man rapes a sexually active woman, his actions would not be justified by the fact that she chooses to have sexual relations with other men.

1.....2.....3.....4.....5.....6.....7  
Strongly Agree Strongly Disagree

10. I don't believe that any women secretly want to be raped.

1.....2.....3.....4.....5.....6.....7  
Strongly Agree Strongly Disagree

11. In deciding whether a rape has occurred or not, the burden of proof should rest with the man, who must prove that a rape has not actually occurred.

1.....2.....3.....4.....5.....6.....7  
Strongly Agree Strongly Disagree

12. a) I believe that it is impossible for a rape survivor to enjoy being raped.

1.....2.....3.....4.....5.....6.....7  
Strongly Agree Strongly Disagree

13. I can really empathize with the helplessness a victim might feel during a rape if all of her attempts to resist the rape have failed.

1.....2.....3.....4.....5.....6.....7  
Strongly Agree Strongly Disagree

14. a) After a rape has occurred, I think the woman would suffer more emotional torment in dealing with the police than the man would.

1.....2.....3.....4.....5.....6.....7  
Strongly Agree Strongly Disagree

15. I feel it is possible for a man to rape a woman against her will.

1.....2.....3.....4.....5.....6.....7  
Strongly Agree Strongly Disagree

16. If a rape trial were publicized in the press, I feel the rape victim would suffer more emotional trauma from the publicity than the rapist.

1.....2.....3.....4.....5.....6.....7  
Strongly Agree Strongly Disagree

17. Even if a couple has had sexual intercourse before, if the man forces the woman to have sexual intercourse with him against her will, this should be considered rape.

1.....2.....3.....4.....5.....6.....7  
Strongly Agree Strongly Disagree

18. I can understand a wife's humiliation and anger if her husband forced her to have sexual relations with him.

1.....2.....3.....4.....5.....6.....7  
Strongly Agree Strongly Disagree

19. If I were a member of the jury in a rape trial, I would probably be more likely to believe the woman's testimony than the man's, since it takes a lot of courage on the woman's part to accuse the man of rape.

1.....2.....3.....4.....5.....6.....7  
Strongly Agree Strongly Disagree

## APPENDIX C

### THE MYTHS AND ATTITUDES ABOUT RAPE SCALE (MARS)

**Permission For Use:**

Adapted from Burt's (1980) Rape Myth Acceptance Scale (RMAS). Permission for use granted by the creator of the RMAS, Dr. Martha Burt, with the caveat of a new name for the scale if any items were changed. See Chapter Three for an in-depth discussion of alterations.

**Instructions:** Indicate your level of agreement with each statement. 1 is "*strongly agree*" and 7 is "*strongly disagree*."

1. A woman who goes to the home or apartment of a *person* on their first date implies that she is willing to have sex.

1.....2.....3.....4.....5.....6.....7  
Strongly Agree Strongly Disagree

2. Any female can get raped.

1.....2.....3.....4.....5.....6.....7  
Strongly Agree Strongly Disagree

3. One reason that women falsely report a rape is that they frequently have a need to call attention to themselves.

1.....2.....3.....4.....5.....6.....7  
Strongly Agree Strongly Disagree

4. Any healthy woman can successfully resist a rapist if she really wants to.

1.....2.....3.....4.....5.....6.....7  
Strongly Agree Strongly Disagree

5. When women go around braless or wearing short skirts and tight tops, they are just asking for trouble.

1.....2.....3.....4.....5.....6.....7  
Strongly Agree Strongly Disagree

6. In the majority of rapes, the survivor is promiscuous or has a bad reputation.

1.....2.....3.....4.....5.....6.....7  
Strongly Agree Strongly Disagree



7. If a girl engages in necking or petting and she lets things get out of hand, it is her own fault if her partner forces sex on her.

1.....2.....3.....4.....5.....6.....7  
Strongly Agree Strongly Disagree

8. Women who get raped while hitchhiking get what they deserve.

1.....2.....3.....4.....5.....6.....7  
Strongly Agree Strongly Disagree

9. A woman who is stuck-up and thinks she is too good to talk to *potential partners* on the street deserves to be taught a lesson.

1.....2.....3.....4.....5.....6.....7  
Strongly Agree Strongly Disagree

10. Many women have an unconscious wish to be raped, and may then unconsciously set up a situation in which they are likely to be attacked.

1.....2.....3.....4.....5.....6.....7  
Strongly Agree Strongly Disagree

11. If a woman gets drunk at a party and has intercourse with a *an individual* she's just met there, she should be considered "fair game" to *others* at the party who want to have sex with her too, whether she wants to or not.

1.....2.....3.....4.....5.....6.....7  
Strongly Agree Strongly Disagree

12. What percentage of women who report a rape would you say are lying because they are angry and want to get back at the *person* they accuse?

Almost All, About  $\frac{3}{4}$ , About Half, About  $\frac{1}{4}$ , About None

13. What percentage of reported rapes would you guess were merely invented by women who discovered they were pregnant and wanted to protect their own reputation?

Almost All, About  $\frac{3}{4}$ , About Half, About  $\frac{1}{4}$ , About None

14. A person comes to you and claims they were raped. How likely would you be to believe their statement if the person were:

Your best friend?

An Indian woman?

a young boy?

a black woman?

a white woman?

Always, Frequently, Sometimes, Rarely, Never

## APPENDIX D

### THE MALE RAPE MYTH SCALE (MRMS)

**Permission For Use:** Obtained from Dr. Ron Holden, Chair for the thesis during which Melanson created the MRMS

**Instructions:** Indicate your level of agreement with each statement. 1 is “*strongly disagree*” and 6 is “*strongly agree*”.

1. It is a terrible experience for a man to be raped by a woman.

1.....2.....3.....4.....5.....6  
Strongly Disagree Strongly Agree

2. The extent of a man’s resistance should be a major factor in determining if he was raped.

1.....2.....3.....4.....5.....6  
Strongly Disagree Strongly Agree

3. Any healthy man can successfully resist a rapist if he really wants to.

1.....2.....3.....4.....5.....6  
Strongly Disagree Strongly Agree

4. If a man obtained an erection while being raped it probably means he started to enjoy it.

1.....2.....3.....4.....5.....6  
Strongly Disagree Strongly Agree

5. A man can enjoy sex even if it is being forced upon him.

1.....2.....3.....4.....5.....6  
Strongly Disagree Strongly Agree

6. Most men who are raped by a woman are very upset by the incident.

1.....2.....3.....4.....5.....6  
Strongly Disagree Strongly Agree

7. Many men claim rape if they have consented to homosexual relations but have changed their mind afterwards.

1.....2.....3.....4.....5.....6  
Strongly Disagree Strongly Agree

8. Most men who are raped by a woman are somewhat to blame for not escaping or fighting off the woman.

1.....2.....3.....4.....5.....6  
Strongly Disagree Strongly Agree

9. If a man engages in necking and petting and he lets things get out of hand, it is his own fault if his partner forces sex on him.

1.....2.....3.....4.....5.....6  
Strongly Disagree Strongly Agree

10. Male rape is usually committed by homosexuals.

1.....2.....3.....4.....5.....6  
Strongly Disagree Strongly Agree

11. Most men who are raped by a man are somewhat to blame for not escaping or fighting off the man.

1.....2.....3.....4.....5.....6  
Strongly Disagree Strongly Agree

12. A man who has been raped has lost his manhood.

1.....2.....3.....4.....5.....6  
Strongly Disagree Strongly Agree

13. Most men who are raped by a woman are somewhat to blame for not being more careful.

1.....2.....3.....4.....5.....6  
Strongly Disagree Strongly Agree

14. If a man had told me that he had been raped by another man, I would suspect that he is homosexual.

1.....2.....3.....4.....5.....6  
Strongly Disagree Strongly Agree

15. Most men who have been raped have a history of promiscuity.

1.....2.....3.....4.....5.....6  
Strongly Disagree Strongly Agree

16. No self-respecting man would admit to being raped.

1.....2.....3.....4.....5.....6  
Strongly Disagree Strongly Agree

17. Women who rape men are sexually frustrated individuals.

1.....2.....3.....4.....5.....6  
Strongly Disagree Strongly Agree

18. A man who allows himself to be raped by another man is probably homosexual.

1.....2.....3.....4.....5.....6  
Strongly Disagree Strongly Agree

19. Most men would not enjoy being raped by a woman.

1.....2.....3.....4.....5.....6  
Strongly Disagree Strongly Agree

20. Men who parade around nude in a locker room are asking for trouble.

1.....2.....3.....4.....5.....6  
Strongly Disagree Strongly Agree

21. Male rape is more serious when the survivor is heterosexual than when the survivor is homosexual.

1.....2.....3.....4.....5.....6  
Strongly Disagree Strongly Agree

22. I would have a hard time believing a man who told me that he was raped by a woman.

1.....2.....3.....4.....5.....6  
Strongly Disagree Strongly Agree

## APPENDIX E

### DEMOGRAPHIC SHEET

**Age:**

**Gender:** Male Female Transgender

**Race/Ethnicity:** African-American Asian-American Hispanic Native American White  
Other

Have you experienced rape or threat of rape? Y N

Do you know someone who has experienced rape or threat of rape? Y N

**Sexual Orientation:** Gay Lesbian Heterosexual Bisexual Questioning

**Religious/Spiritual Orientation:** Christian Jewish Buddhist Muslim Hindu Agnostic  
None Other

Are you Practicing Somewhat Practicing Not Practicing?

Check all that apply: Are you a **counseling practitioner**\_\_\_\_\_ **counselor educator**\_\_\_\_\_

**Master's counseling student**\_\_\_\_\_ **Doctoral counseling student**\_\_\_\_\_?

Which is your primary role? **counseling practitioner**\_\_\_\_\_ **counselor educator**\_\_\_\_\_

**master's counseling student**\_\_\_\_\_ **doctoral counseling student**\_\_\_\_\_?

Did you **graduate** from a **CACREP accredited university**? Y N Unsure

What **licenses/certifications** do you have? LPC NCC LMFT CSAC CRC Other  
None

What is your **highest completed degree**? Associate's Bachelor's Master's PhD Ed.D  
Ed.S Other

How many **total clients in the past year** have you seen that have presented with rape  
issues?\_\_\_\_\_

How many **hours of training** (conference presentations, material presented in university courses, seminars, trainings at your job site, workshops, self-study {including reading}, CEU opportunities, etc.) have you received on rape related issues in the past year? \_\_\_\_\_

If you are a **counseling practitioner or educator**, how many years have you been in the field?

If you are a **counselor educator**, do you include rape information in your curriculum? Y  
N N/A

Do you **teach** at a CACREP accredited university? Y N Unsure

If you are a **counseling student**, how many **credit hours** have you **completed** in your program?

## **APPENDIX F**

### **INFORMED CONSENT**

**Project Title: THE INFLUENCE OF RAPE EMPATHY AND DEMOGRAPHIC VARIABLES ON COUNSELOR RAPE MYTH ACCEPTANCE**

The purpose of this document is to provide you with information regarding the purpose of this research so that you can make an informed decision as to whether you want to say YES or NO to participate in this study. This document will also provide further information to those who choose to say YES to participating in this project.

The primary investigator of this study is Julia M. Forman, M.A., NCC, a doctoral candidate in the Department of Counseling and Human Services in the College of Education at Old Dominion University. Danica Hays, PhD, LPC, NCC, a professor in the Department of Counseling and Human Services in the College of Education at Old Dominion University, will be supervising this research as it is conducted as per the requirements for the successful completion of the PhD program in Counselor Education and Supervision.

This purpose of this quantitative research is to assess attitudes and empathy towards rape survivors among counseling practitioners and trainees. Both male and female rape myths will be examined. The impact of several demographic variables on attitudes and empathy will be investigated as well, and these variables include race/ethnicity, exposure, religious/spiritual orientation, sexual orientation, gender, age, and experience/education.

The collection of data and the analysis of collected data are projected to occur between March 2010 and November 2010. If you choose to participate, you will be asked to complete a Demographic Sheet and an assessment packet distributed via SurveyMonkey which contains the Rape Empathy Scale, the Male Rape Myth Scale, and the Myths and Attitudes about Rape Scale (MARS; adapted from Burt's [1980] Rape Myth Acceptance Scale). This will take approximately 30 minutes to complete. All information will be collected during one session. The primary investigator will have no knowledge of your identity. All information will remain confidential. Following the collection of data, the data will be analyzed and the results written per the PhD program requirements.

Participation in this study is completely voluntary. You may choose to opt out of this study at any time if you do not want to participate.

This project poses no foreseeable risks. All information obtained about you will be kept confidential. The results from the data may be used in reports, presentations, and publications, but no identifying information will be used whatsoever.

As previously stated, your participation in this project should be completely voluntary. Do not participate if you do not want to, and please understand that if you choose to say NO to the project even after saying YES to participation previously, there will be no consequences for this decision to withdraw from the study. In the remote possibility of



harm befalling you via this research project, neither the researchers nor Old Dominion University will be able to provide any money, insurance coverage, free medical care, or any other compensation whatsoever. In the event that you suffer harm from participation in this research study, please contact Dr. Danica Hays at 757-683-6692 who will discuss your grievance with you.

By hitting “next” and completing the assessment packet, you have indicated that you have read, or had this read to you, this form and understood its contents. You are indicating you understand the research project and the risks and benefits associated with it. If you have any questions at any point during or after this study, please contact the primary investigator, Julia Forman at 757-683-3326 or [jform004@odu.edu](mailto:jform004@odu.edu) or the supervising faculty member, Dr. Danica Hays at 757-683-6692 or [dhays@odu.edu](mailto:dhays@odu.edu).

Julia M. Forman, M.A., NCC

Doctoral Candidate, Old Dominion University

Department of Counseling and Human Services

[Jform004@odu.edu](mailto:jform004@odu.edu)

## APPENDIX G

### LETTER OF INVITATION

Greetings! My name is Julia Forman, and I am in the data collection process of my dissertation studying the influence of rape empathy and demographic variables on counseling practitioners, educators, and trainees' rape myth acceptance. I am a Ph.D. candidate supervised by Dr. Danica Hays at Old Dominion University in the Department of Counseling and Human Services in Norfolk, VA. This study has been approved by Old Dominion University's Institutional Review Board (IRB Number: 200902083).

Since the focus of my study is rape myth acceptance and empathy among those specifically in the counseling field, I am contacting you to request your participation in this research because you are a member of the American Counseling Association (ACA). To qualify for this research, you must self-identify primarily as a counseling practitioner, counselor educator, or counseling student. By participating in this study, client services may potentially be improved by obtaining an accurate reflection of the attitudes and beliefs espoused by those who are charged to assist them.

To participate in this research, please click on the below link which will direct you to SurveyMonkey, an online assessment website. Once there three assessments will need to be completed: the Myths and Attitudes about Rape Scale (MARS; adapted from Burt's [1980] Rape Myth Acceptance Scale), the Rape Empathy Scale (RES), and the Male Rape Myth Scale (MRMS). The three assessments will take approximately 20-30 minutes to complete. Demographic information will also be collected but will be provided by you anonymously. All data will be kept confidential, and you will not be identified in any way. If the provided link does not work by clicking on it, please copy and paste it into your web browser.

By electronically completing the RES, the MARS, the MRMS and the demographic sheet, you provide your consent for your participation in this study. Participation is not required and is completely voluntary. You will find the full informed consent included in the assessment packet. Even if you begin the assessments, you are not required to complete them and may withdraw from this research at any time. No risks to you are anticipated by participating in this study. However, if you become uncomfortable due to the focus on rape, please contact 911 in the case of an emergency or the Rape, Abuse, and Incest National Network (RAINN) hotline at 1.800.656.HOPE (4673). Benefits include supplementing the current body of literature by examining counseling professionals' and trainees' rape myth acceptance and rape empathy, which may have impacts on client outcomes.

Please feel free to contact me, Julia Forman, at [jform004@odu.edu](mailto:jform004@odu.edu) with any questions or concerns regarding this study. Dr. Danica Hays, under whose direction this dissertation is being conducted, may be contacted by telephone (757-683-6692) or via email [dhays@odu.edu](mailto:dhays@odu.edu).

Thank you for your time and consideration in this research.

Sincerely,

Julia M. Forman, M.A., NCC  
Old Dominion University  
110 Education Building  
Norfolk, VA 23529  
[Jform004@odu.edu](mailto:Jform004@odu.edu)

## VITA

Julia M. Forman earned a Bachelor's of Science degree in Psychology in 2004 from Mississippi College. In 2008, she was awarded a Master's of Arts degree in Community Counseling from Regent University. Ms. Forman completed this research at Old Dominion University. The specific address is as follows: Old Dominion University, Department of Counseling and Human Services, 110 Education Building, Norfolk, Virginia, 23529. She is now working to obtain licensure to practice counseling and already holds the National Certified Counselor credential. Ms. Forman maintains memberships in the American Counseling Association (ACA), as well as several of its divisions.

Julia Forman has supervised Master's counseling students, has taught undergraduate Human Services courses, and has served as an undergraduate academic advisor. She has assisted the clinical coordinator with organizing the Master's counseling students' practicum and internship experiences. Clinically, Ms. Forman has worked with both sexual assault survivors and with the geriatric population.

Since enrolling as a doctoral student, Ms. Forman has published three articles in refereed journals and has been published in two books. She has presented at national, regional, and local conferences. Her primary research interests include intimate partner violence, sexual assault, vicarious trauma, feminist therapy, and gerontology. Ms. Forman has been the co-editor of ODU's Counseling and Human Services Department newsletter, *Reflections*, for over a year, and she has served as Secretary and Awards Chair for ODU's Chi Sigma Iota National Honor Society chapter.