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Attitude Towards Rape: A Comparative Study Among Prospective Physicians of Malaysia

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Summary

The global statistics reveal that at least one in every five women experiences rape or attempted rape during her lifetime. Rape myths encompass a set of (false) beliefs. Adolescents have high rates of rape victimization than other age groups. Rape myths among health care providers may have a negative influence on proper care of the victims. A total of 422 medical undergraduates of both sexes, studying at two Malaysian Institutes took part in the study. A validated questionnaire used in an earlier study was used for the present study, with a slight modification of scoring system. The age range of medical students was 17 to 34 years; mean ± SD of men and women, were 20.6 ± 2.1and 20.3 ± 2 respectively. Only about 19% of women and 11% of men had a very good positive attitude. Nearly 1/3 of women and 1/2 of men had a more negative attitude. On the whole the average total score of women was significantly higher (p=0.0004) than men. Nearly 50% of candidates with a village background carried more negative attitude. Violence against women is a significant public health problem. The major revelation of the present study is that only less than 20% of the medical undergraduates had a more positive attitude towards rape. Introduction of courses on 'sexual violence' in medical curriculum is likely to increase a) awareness, b) skills in management, c) in providing support and care for the victims and d) in implementing preventive actions.

Key Words: Rape myths, Sexual assault, Medical students, Questionnaire study

Introduction

Violence against women is an International human rights issue and a public health problem[1]. There are no reliable statistics on the global incidence of rape; those that do exist present a misleadingly low estimation of this social phenomenon. UNICEF estimates that one in ten women in the world will be a victim of rape at least once in her lifetime. The global statistics reveal that at least one in every five women experiences rape or attempted rape during her lifetime[2]. More shocking are the reports that the incidence of rape is increasing worldwide[3,4]. Regarding Malaysia, until 1990 there was no formal studies regarding violence against women. The WAO (Womens' Aids Organization), Malaysia has conducted an extensive survey and found that about 1.8 million Malaysian women, over age 15, are subjected to sexual assault of which an extremely meager (0.05%) number actually reported to the police[5]. The latest Malaysian statistics show that currently 9 women a day make a police report, 3 of whom report having been raped, 4 being battered and 2 being sexually harassed[6]. This may be only the tip of the iceberg since many victims are unlikely to report the incidence of rape due to embarrassment and social stigma[5,7].

Rape myths; encompass a set of (false) beliefs about rape that places the blame on the victim and not the

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perpetrator. Following are some of the commonly held myths and misconceptions-

- Rape is a crime of uncontrollable male sexual drive
- Rapists can be easily identified by their appearance and behavior
- Some girls encourage rape just by the way they dress
- No one can be raped against their will
- Most women are sexually assaulted by strangers
- Women frequently "cry rape" falsely for reasons of revenge, pregnancy, or to protect their reputation
- Most sexual assaults occur in isolated places
- A rape survivor will be battered, bruised and hysterical.

Adolescents have high rates of rape victimization and offending compared to other age groups, yet few studies have examined predictors of rape-supportive attitudes among adolescents[8]. Primary care medical practitioners are an important locus from which crime victims could be identified and their treatment options considered[9].

Rape myths and misconceptions among health care providers if present have a negative influence on proper, acute and follow up care of the victims. Most of the studies have focused on the degree to which an individual ascribes to rape myths and have mainly included college-aged participants but limited and inconsistent research exists regarding attitudes towards rape and acceptance of rape myths with respect to sex[10] and domiciliary status of the survey participants.

Keeping the above points in mind the present study was aimed; to assess the prevailing attitudes on rape among the medical students (the prospective physicians), whether sex and their domiciliary back ground have an influence over the same and to suggest potential interventional measures.

Materials and Methods

A previously validated 21-item self administered, anonymous questionnaire [11], with modification of one item and addition of an extra item, was used for the present study. The validity of the questionnaire used by us was discussed with a forensic expert and it was agreed upon to retain all the items. The reliability was subjected to Cronbach's alpha coefficient test which gave a score of 0.8.

The questionnaire was in English and also included the basic data like age, sex and domiciliary status. The responses to the questions were on a five point Likert scale, from 'strongly agree' to 'strongly disagree' interposed with an 'uncertain' column. A total of four hundred and twenty two, 1st and 2nd year, medical undergraduate students of both sexes, studying at two Institutes (AIMST, Kedah and USM, Kelantan) of Malaysia took part in the study. The students were assured of anonymity of information and verbally consented to participate following a briefing about the nature and potential value of the study. Questionnaires were administered between July and August of 2004.

A slightly modified scoring system was followed for the responses as compared to the British study[11]. The appropriate response for a positive attitude would be, Strongly agree=1, agree=2, disagree=4 strongly disagree=5, and uncertain=0 (except for the items 1, 9, 19 and 21 which consisted of Strongly agree=5, agree=4, disagree=2 strongly disagree=1, and uncertain=0). A score of $\leq$ 49 was considered as possessing, more negative attitude, $\geq$ 50 to 64 as satisfactory positive attitude, while $\geq$ 65 as more positive attitude towards rape, respectively. Theoretically a score of 105 was the maximum possible, since there were 21 items. The 'uncertain' response was deliberately awarded a score of zero instead of 3, since otherwise any person simply marking 'uncertain' for all the items would theoretically score a total of 63, which would otherwise suggest that they a have better attitude.

The descriptive statistics and the difference between the two given groups were analyzed by students't' test and Chi square test, wherever applicable, using GraphPad Instat Version 3.05.

Results

The age range of medical students was 17 to 34 years; Mean $\pm$ SD of men and women were 20.6 $\pm$ 2.1 and 20.3 $\pm$ 2 respectively. There was no significant difference between men and women with regard to age. The demographic details are presented in Table I.

According to the scoring system as mentioned earlier, 44.3% of men and 51.4% of women had a satisfactorily positive attitude (score of 50 to 64) towards rape. However, nearly 1/3 rd of women (29.8%) and 1/2 of men scored poorly (44.3%) indicating a more negative

attitude. Only a meager percentage of women (19%) and men (11%) had a very good positive attitude score. On the whole the average total score of women was significantly higher (p=0.0004) than men. (Table II)

About 50% of candidates of village and 1/3rd (30.8%) of town background respectively, had poor attitude scores. The average total score of candidates with a town background was significantly higher (p=0.0001) than those of village.

For the purpose of statistical calculation, the responses, 'strongly agree' were clubbed with 'agree' while 'strongly disagree' with that of 'disagree' (Table II and III). The data of 'uncertain' and blank responses are not provided in the table. The blank response (i.e. nil response) for any of the questionnaire item was within 1.4%. The responses of men differed significantly from women with respect to four items (1. A woman can be raped against her will, 2. Most women secretly desire to be raped, 3. Rape is a male exercise in power over women and 4. When a woman says 'no' she really means 'yes'), while that of the village group differed significantly from town group in 9 out of the 21 items (Tables III and IV).

Table I: The demographic details of the rape attitude survey participants

Category	Age in years	Number of participants		
	Mean + SD	Village	Town	Total*
Men	20.6 ± 2.1	34	116	158
Women	20.3 ± 2.0	63	183	255
Total	----	97	299	413

• The discrepancy in the total is due to the number of responders who gave a blank response for a given data.
Note: the data of blank responses is not provided.

Table II: The average of total rape attitude score of medical students

Score	n	Men	Women[a]	Town	Village[b]
≤49	152	70 (44.3)	76 (29.8)	94 (30.8)	49 (49.5)
≥50 to < 64	204	70 (44.3)	131(51.4)	153 (50.2)	43 (43.4)
≥ 65	66	18 (11.4)	48 (18.8)	58 (19.0)	7 (7.1)

The values in parenthesis are % score within the corresponding group.
ap=0.0004 women scored significantly higher then men; bp=0.0001 town group scored significantly higher then village group.
n= number of respondents

Table III: Percentage of men and women who had positive (agree) and negative (disagree) attitude towards rape.

No.	Items	Agree		Disagree		p	CI
		M	W	M	W		
1	A woman can be raped against her will	40.5	54.1	53.8	41.2	0.001	0.55-092
2	A woman should be responsible for preventing her own rape	20.9	27.1	63.9	55.3	NS	
3	A raped women is a less desirable woman	54.4	56.9	14.6	13.3	NS	
4	Most women secretly desire to be raped	58.9	91	10.8	1.96	0.0001	0.24-0.34
5	Most charges of rape are unfounded	17.1	10.2	46.2	52.2	NS	
6	In order to protect men it should be difficult for a women to prove rape has occurred	37.3	38.4	29.1	30.6	NS	
7	Rape is a male exercise in power over women	67.7	52.9	25.3	40.4	0.002	1.72-2.13
8	During a rape a woman should do everything she can to resist	6.96	4.31	86.1	89.8	NS	
9	Men raping a female child should be punished to death	77.8	90.2	13.3	8.24	NS	
10	The reason most rapists commit rape is for sex	8.86	6.67	77.8	85.9	NS	
11	A woman should feel guilty following a rape	71.5	59.6	13.3	17.3	NS	
12	A woman cannot be raped by someone she previously knew or had sex with	69.6	64.3	15.2	19.2	NS	
13	A woman cannot be raped by her husband	51.3	45.9	29.7	36.9	NS	
14	Most rapes are carried out by strangers	39.2	32.9	43.7	50.2	NS	
15	Most rapes involves violence and physical injury	5.06	2.75	83.5	89.8	NS	
16	When a woman says 'no' she really means 'yes'	50	86.3	12.7	3.53	0.0001	0.28-0.52
17	Rape happens when women go out alone at night or in unsafe places	15.2	22	72.8	67.5	NS	
18	A rape victim will be hysterical, shaky and distraught	8.86	7.06	74.1	76.9	NS	
19	Men cannot be raped	17.1	17.6	62	45.9	NS	
20	Rapists are emotionally disturbed and not responsible for their actions	55.1	58	33.5	33.7	NS	
21	Majority of rape cases are not reported to police because of family pride	81	87.5	6.33	3.92	NS	

M=men; W=women
p= on comparison between agree and disagree data in the corresponding rows
NS= Not significant
CI= Confidence interval

Table IV: Percentage of candidates of town and village groups who had positive (agree) and negative (disagree) attitude towards rape.

No.	Items	Agree		Disagree		p	CI
		T	V	T	V		
1	A woman can be raped against her will	47.4	52.5	50.7	33.3	0.05	0.8-0.99
2	A woman should be responsible for preventing her own rape	29.6	10.1	52.6	77.8	0.0001	1.19-1.49
3	A raped women is a less desirable woman	57.9	48.5	13.5	18.2	NS	
4	Most women secretly desire to be raped	79.9	75.8	4.61	7.07	NS	
5	Most charges of rape are unfounded	13.5	10.1	52.6	41.4	NS	
6	In order to protect men it should be difficult for a women to prove rape has occurred	42.4	27.3	28	38.4	0.01	1.04-1.37
7	Rape is a male exercise in power over women	55.6	67.7	38.2	22.2	0.009	0.76-0.95
8	During a rape a woman should do everything she can to resist	6.25	2.02	87.8	89.9	NS	
9	Men raping a female child should be punished to death	84.5	89.9	10.5	8.08	NS	
10	The reason most rapists commit rape is for sex	8.55	5.05	79.9	89.9	NS	
11	A woman should feel guilty following a rape	68.8	47.5	13.5	25.3	0.001	1.08-1.6
12	A woman cannot be raped by someone she previously knew or had sex with	68.1	58.6	15.8	26.3	0.03	1.01-1.44
13	A woman cannot be raped by her husband	51	36.4	31.9	41.4	0.03	1.02-1.31
14	Most rapes are carried out by strangers	38.5	29.3	46.1	50.5	NS	
15	Most rapes involves violence and physical injury	3.62	4.04	87.8	85.9	NS	
16	When a woman says 'no' she really means 'yes'	73.4	69.7	6.58	8.08	NS	
17	Rape happens when women go out alone at night or in unsafe places	21.7	12.1	66.1	78.8	0.03	1.04-1.32
18	A rape victim will be hysterical, shaky and distraught	7.24	9.09	75	75.8	NS	
19	Men cannot be raped	16.4	22.2	54.3	45.5	NS	
20	Rapists are emotionally disturbed and not responsible for their actions	63.2	40.4	27.3	49.5	0.0001	1.14-1.52
21	Majority of rape cases are not reported to police, because of family pride	83.6	88.9	4.93	4.04	NS	

T=Town; V=Village
p= on comparison between agree and disagree data in the corresponding rows
NS= Not significant
CI= Confidence interval

Discussion

Violence against women is a significant public health problem, which impacts women, men, and children. Rape victims may seek legal, medical, and mental health assistance, but the literature indicate that many survivors are denied help, often leaving them with negative experiences, which have been appropriately termed as "the second rape"; or "secondary victimization" [12].

Educating young adolescents about the nature of rape and the rights and roles of women are logical points of intervention to decrease acceptance of rape myths that target the victim. As a prelude to educate our health personnel the appropriate early step would be to remove any existing myths and misconceptions about rape. In this direction this study focused on the prevalent attitude among the medical students.

There has been no such work carried out in Malaysia among the medical students especially with a focus on sex and domiciliary status. Despite the methodological flaws in the questionnaire as accepted in the previous study, the present study was aimed to unravel the prevailing myths and misconceptions among the future health care professionals.

The major and significant revelation of the present study is that only less than 20% of the population surveyed had a more positive attitude towards rape. This being the story with the present survey population (with a good educational back ground), one can imagine about the situation among the less educated and illiterates, since there is evidence that younger and better educated people reveal less pro-violence attitudes and less rape myth acceptance [13].

The second significant finding of the present study is, a sizeable percentage of women either possessed satisfactory (51.4%) or more positive (18.8%) attitude (women are less accepting of rape myths) than men students. Our results are in agreement with the British study[11]. It has been reported that female police officers evaluated the rape victim more favorably than male officers, which is an indirect, supporting evidence for the present study, regarding the gender difference [14]. This is further supported by the finding that men were more tolerant of rape, more likely to attribute blame for rape, to the victim, and less negative in their views of rapists than women were[15]. It is presently not possible to hypothesize for the significantly more positive rape attitude carried by women. But the fact that men carry more negative attitude calls for specialized, targeted, educational interventions. An increasing number of sexual assault educators agree that sexual assault prevention seminars for men are most effective in all-male groups, an approach borne out by several studies[16]. But we are unable to say at present, to what extent an approach involving co-education would be effective.

The third significant revelation of the present study is that 50% of candidates with a village background carry more negative rape attitude. It is interesting to note that rape is not significantly related to village or town background [17], but the volume of myths they carry may differ as evinced by the present study.

Data pertaining to rural-urban divide in attitude towards rape is almost non-existent. It has been found that the higher the adversarial sexual beliefs, and acceptance of interpersonal violence, the greater a respondent's acceptance of rape myths [13]. This may be interpreted as 'in general people belonging to village background are more likely to tolerate sexual violence and carry more rape myths'. The close-knit, self-contained and often conservative attitude may be some of the reasons for the significant attitudinal differences. A recent report has stressed for additional research regarding the question of prevalence on a wide variety of rural configurations and cultural characteristics [18]. However, as has been pointed, what we do not know about rural sexual assault far outweighs what we know, which alone is a strong reason for additional studies, taking into account other variables like, ethnicity and economic status of the respondents.

Contrary to the stated gender and domiciliary differences, there is a commonality among the respondents in one particular attitude. Majority of the respondents favored aggressive law enforcement especially regarding 'child rape'.

Among the suggested policy responses are a) improvements in the databases on rape incidence, b) a higher priority for teaching about rape at various levels viz. Community, adolescent education and health care institutes c) interventions and research on afore mentioned approaches d) measures towards empowerment of women and e) tightening of laws with more stringent punishment [19]. In the current scenario, as has been rightly pointed "Education is the most favored approach to reduce sex-related violence in the community, followed by increased punishment of the offender" [20].

Physicians are an important potential source of assistance for traumatized crime victims[21]. The International medical advisory panel of the 'Planned Parenthood Foundation' recommends that healthcare professionals should provide advocacy, alongside increasing their awareness of sexual violence and their skills in managing victims, providing support and care for the victims, and implementing preventive actions[1].

Educating young adolescents about the nature of rape and the rights and roles of women are logical points of intervention to decrease acceptance of rape myths that target the victim[8].

To our knowledge, education on gender violence doesn't find a place in the medical curricula, at least in Malaysia. Introduction of courses on 'sexual violence' in medical curriculum, is likely to increase a) their awareness, b) skills in managing victims, c) in providing support and care for the victims, d) in implementing preventive actions. All these, if implemented, is more likely to lead to a decrease in the incidence of rape [22] and e) better management of victims [11].

It is pertinent to stress the following limitations in the study which may have significant bearing especially on the applicability of the findings in other situations- the study was undertaken on a convenient sample hence bias due to non-randomization effect is likely; influential parameters like culture, religion, socioeconomic status and ethnic status were not considered because of the sensitiveness and potential embarrassment to the participants; findings from studies undertaken in one country (e.g. Malaysia) may not be directly applicable to other countries (especially the Western) because of the different ways in which rape may be viewed and punished. For instance, under Malaysian law, marital rape does not exist[23]. Lastly, the questionnaire used in the present study is the same (though slightly modified) as used in the British study involving medical students.

Discrimination based on gender, sexual orientation, race, and religion, social, political, and economic status is not a monopoly to certain countries alone. Whatever may be the status of a country we also need to acknowledge that rape continue to happen and the fear of rape pervades the lives of all women, though in varying degrees[22]. Physicians in every field of practice can expect to be called upon to care for victims who have been affected by sexual assault. By the time of graduation, all medical students should be able to demonstrate appropriate attitudes, knowledge, and skills in assessment and intervention of patients at risk. The importance of Faculty development efforts to address this problem by way of introduction of lessons related to sexual violence, which are already developed and implemented in certain medical schools[24], cannot be overemphasized.

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