EXPLORING RAPE MYTH ACCEPTANCE AMONG GENERAL MEDICAL PRACTITIONERS IN SOUTH AFRICA

By

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ABSTRACT

Exploring Rape Myth Acceptance Among General Medical Practitioners in South Africa

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Rape myths have several negative effects on society, and can affect those who come into contact with victims of sexual assault on a professional level. One group of professionals that assist victims are general medical practitioners and in a country like South Africa, that has a high rate of rape, it is not uncommon for general medical practitioners to find themselves assisting victims. Previous research has suggested that professionals who assist victims such as police officers and lawyers are susceptible to rape myth acceptance. In South Africa, research suggests that medical health professionals can have negative views of victims, depending on a number of factors such as the victim's behaviour and alcohol consumption. Presenting data collected using the Illinois Rape Myth Acceptance Scale (IRMAS) from a sample of 44 general medical practitioners in South Africa, it was found that the participants had low levels of rape myth acceptance. The findings indicated that not only were rape myths not strong influences within the sample, myths that related to the concept of 'real rape' were the least likely to be supported. Furthermore, additional questions in the survey revealed that general medical practitioners are not well-equipped to provide care to victims of sexual assault and more effort is needed with regards to service provision.

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1.1. Introduction

On October 7, 2016, a tape recording of a then-presidential candidate in the United States was released. This recording was of the candidate suggesting what many took to be sexual assault. While there were a host of reactions, there was a thought-provoking one that appeared on twitter: the hashtag, #notokay, in which women shared their stories of sexual assault. While this was interesting in itself, what was particularly note-worthy was the level of rape myths that were represented within these tweets. Some of the myths suggested that the women lied about the sexual assault or that she was held responsible for the crime, myths that, as this paper will show, are common in society.

Rape myths are complex concepts and the literature on these myths is vast in its scope. As will be discussed below, existing literature will show that there have been correlations between demographics, links between types of rape and rape myths, links between the media and rape myths, and associations with status, situational factors, and rape myth acceptance (RMA). Furthermore, the literature showed an abundance of research with regards to police officers and college students in relation to rape myths, and some research with regards to professionals in the fields of law and medicine. However, while the literature touches on rape myths in South Africa, or more often than not, on blame attribution, not many have focused solely on rape myths in the medical field. Furthermore, while research is conducted more in countries such as Germany, Australia, Spain, the United Kingdom, South Korea, and the United States, the literature does not explicitly elaborate on the condition of rape myths within South Africa, choosing to focus on attitudes of rape in different fields – which, admittedly, will lead back to rape myths whether explicit or not.

In an age where ‘rape culture’ is a phrase heard often, and where movements such as #MeToo have opened up the debate of what sexual assault does and does not look like, it is important to understand some of the myths that feed into this concept

of ‘rape culture’. Furthermore, it is also important to discover who is more susceptible to these myths, and what level of acceptance of these myths that individuals and groups have. However, what is more important, is to know whether or not victims can trust the professionals who they interact with after a sexual assault, such as criminal justice professionals and medical professionals. Furthermore, it is important to identify how these professionals understand their role toward victims.

As such, the proposed study aims to explore the level of RMA among general medical practitioners (GPs) within South Africa through the use of the Illinois Rape Myth Acceptance Scale – Short Form.

1.2. Rape in South Africa

In South Africa, rape is an epidemic. Statistics from the South African Police Service showed that between 1 April 2018 and 31 March 2019 there were a total of 52 420 sexual offences, 41 583 of which were classified as rape. Statistic South Africa estimated the number of women raped in South Africa is 138 women per 100 000 (Maluleke, 2018).

Rape is a crime which causes physical, mental, and emotional harm to the victims (Flowers, 2006). Victims of rape can experience post-traumatic stress disorder, depression, anxiety, and many of these victims also turn to alcohol or other substances. As such, rape victims need support from society. More importantly, they need support from those who they interact with after the crime has occurred, such as police officers, lawyers, psychologists, and doctors. Support may be difficult to find in a society in which rape myths are prevalent.

That said, it is important to understand the context of rape in South Africa with regards to the law, and how that law may link to the medical community. To begin with, the current law relevant to sexual assault in South Africa is known as the Criminal Law (Sexual Offences and Related Matters) Amendment Act, No. 32 of 2007. It was passed by Parliament and signed by the President on 13 December 2007.

The Act made a number of changes, including creating new offences, addressing issues related to the management of sexual assault, and redefining rape. For example, whereas the previous laws considered only men to be rapists and only women to be victims, the new Act broadened the definition of rape to be gender neutral. It also added additional actions that constituted rape, such as inserting objects into a victim's vagina or anus, as the previous law only considered the action of rape as a penis inserted into the vagina.

The act also expanded on the concept of consent by outlining instances in which consent cannot be given or consent is not consent because it was not given freely. In other words, the Act states that true consent cannot be given under certain circumstances, such as if the accused used force, threats of harm, abuse of power, or fraudulent claims.

With regards to the medical community, the law created provisions for medical professionals to follow, such as providing post-exposure prophylaxis (PEP) to a victim after an assault, compulsory HIV testing of an accused person (and testing of the victim), and mandatory reporting of offenses if the victim is a child or a person who is mentally disabled.

While the Act made strides with regards to how rape is perceived, especially with regards to the falsehoods of rape – such as men aren't capable of being raped or the countless arguments about what constitutes consent – in terms of the medical community, the Act falls short. The Act does not provide for thorough health care support, and does not cater to the psychosocial aspects of rape (Artz & Roehrs, 2009). In fact, in terms of medical care to the victim, the only provisions provided is HIV-testing, receiving PEP, and the rules around the victim's rights to receive PEP – and other information regarding sexually transmitted diseases. This leaves many gaps in how doctors – specifically GPs with their own practices – should proceed. These gaps can include actions such as administering a Sexual Assault Evidence Collection Kit (SAECK) – otherwise known as a rape kit – and how to treat a victim comprehensively, both physically and psychologically.

The Act itself appears to be comprehensive in how it defines rape and how it addresses issues around sexual assault in order to ensure that no one is violated sexually. However, in terms of the medical community, the law appears to be more HIV-focused compared to other aspects of healthcare and forensic examination.

That said, the Department of Health does have guidelines for assisting survivors of rape and other sexual offences. The guidelines outline ways to manage a victim, such as examining them, explaining the nature and purpose of the examination, getting consent for the examination, and recording detailed findings on a J88 form – a form that is filled in by the medical practitioner who is examining a rape victim, and is there to record dates, times, practitioner information, patient information, evidence, and extent of harm done to the victim.

1.3. Rape Myths: A Significant Problem

Rape myths have a number of negative effects on all aspects of sexual assault, from the crime, to the victim, to the criminal justice procedure. Rape myths tend to downplay the seriousness of the crime (Edwards, Turchik, Dardis, Reynolds & Gidycz, 2011), warp how rape is perceived and defined by society (Stromwall, Alfredsson & Landstrom, 2013b) and by victims (Peterson & Muehlenhard, 2004), legitimize sexual violence (Edwards *et al*, 2011), attribute to the fact that many victims do not come forward and report the rape (Bohner, Eyssel, Pina, Siebler & Viki, 2009), play a role in the misperceptions and treatment of victims when they do come forward (Chapleau, Oswald & Russell, 2008), cause those who have a high belief in rape myths to exonerate the perpetrator of blame and shift the blame onto the victim (Bohner *et al*, 2009; Flowers, 2006), and in some cases, may even be linked to outcomes within the criminal justice system (Patterson, 2011).

One reason these myths are pervasive in society is because we live in a media-saturated society, and these myths are perpetuated by the media. There have been numerous studies on the media and how it is related to rape myths (Franiuk, Seefelt, Cepress & Vandello, 2008; Franiuk, Seefelt & Vandello, 2008; Hust *et al*, 2013; Kahlor & Morrison, 2007; Vance, Sutter, Perrin & Heesacker, 2015).

For example, studies by Franiuk *et al* (2008) and Franiuk, Seefelt and Vandello (2008) both examined the Kobe Bryant sexual assault case and revealed how media could affect the perception of rape. In the first study, they found that 65 articles out of 156 sources mentioned at least one rape myth, while the second study into 555 headlines from US media not only revealed rape myths, but 10% of those headlines actively endorsed a rape myth. The second study in terms of media is alarming, as consumers are more likely to read just the headline of an article. Both studies also revealed that those who were reading the myth-endorsing articles were more likely to exonerate Kobe Bryant and accuse the victim of lying than those who were exposed to myth-challenging articles.

These studies are used to illustrate that the media is vital in defining rape to the general public. The reason for this is because the media can endorse stereotypes and myths of rape (Kitzinger, 2009), which in turn can affect attitudes towards rape (Edwards *et al*, 2011). The scale of this problem is only increased by the notion that media is influenced by dominant social attitudes (Kitzinger, 2009). As such, while media influences society, there is a chance that media itself is influenced by society, creating a cycle of perpetuating rape myths. This is harmful as it contributes to the major myths, such as victim blaming (Edwards *et al*, 2011).

As rape myths can have such detrimental effects on the victim and on the perceptions of rape in society as a whole, and as they are prominent in society, it is important to find ways to combat these myths. However, before this can be done, it is important to understand who believes in these myths and the extent of this belief. Furthermore, it is in the victims' best interests to understand RMA with regards to those who interact with them.

1.4. The Current Study

While there is research into the acceptance of rape myths, to the author's knowledge, no recent study has been done on GPs within South Africa. While research into police officers, law officials, and college students is quite common, GPs, to this author's knowledge, appear to have remained untouched. As victims are

more likely to tell a medical professional of their assault than the police (Orchowski & Gidycz, 2012), it would make sense to understand how personal doctors, specifically GPs, understand rape myths and how prepared they are to serve victims of sexual assault.

As such, this study aimed to answer two main questions:

- What, if any, was the level of rape myth acceptance among general medical practitioners in South Africa? Furthermore, the study explored if there was a significant difference with regards to rape myth acceptance within the sample of general medical practitioners, based off of characteristics such as age, length as a GP, and gender.
- How prepared were general medical practitioners to assist victims of sexual assault with regards to service provision?

Furthermore, an outcome of the current study was that it added to the existing body of knowledge on the topic of rape myths. Additionally, it gave insight into the phenomenon within a South African context and is one of the few studies to contribute to this phenomenon with regards to medical professionals. It is the hope that the study created knowledge that can be used as a step toward a greater study with regards to rape myths and professionals who come into contact with victims of sexual assault.

Finally, it should be noted that GPs were chosen for a number of reasons. First, there is an abundance of research on police officers and college students, yet there is little research on doctors. Secondly, they were believed to be easily accessible compared to other professions that come into contact with rape victims, such as police officers and prosecutors. Finally, the literature shows that education and status both have a relationship with RMA, and as doctors are both well-educated and considered to hold a high standing in society, they are an appropriate profession to examine.

1.5. Chapter Outline

The following section will outline the rest of the paper.

While chapter 1 explained the state of rape in South Africa, how the law links to the medical community, and the effects of rape myths, chapter 2 will explain in-depth what rape myths are, how individuals navigate them, and what their possible causes are. The chapter will then move on to detail the findings of existing literature, explaining how rape myths relate to demographic characteristics, different occupations, and situational factors.

Chapter 3 will detail the methodology of the study, touching on the sampling method used and why, the method of data collection, and the ethical considerations, such as risk of harm and anonymity.

Chapter 4 will present the results of the study and explain what they mean in relation to the rest of the results and previous findings. The chapter will also discuss the statistical methods that were used to establish if there were any significant relations between different variables. That chapter will be split between demographics, service provision, rape myth acceptance, and statistical analysis.

Chapter 5 will end the paper with discussion about the findings with regards to the literature review and the wider context of rape myths and service provision, as well as detail avenues for future research, limitations of the study, and reflections on the current study.

CHAPTER 2: LITERATURE REVIEW

This chapter will discuss the existing literature with regards to rape myths and RMA. The chapter will examine literature explaining what rape myths are, how they are navigated, and how they appear based on demographics, occupations, and situational factors.

2.1. Rape Myths and Rape Myth Acceptance: An Overview

Rape myths remain an intriguing, albeit problematic, part of society. In the wake of movements such as #MeToo and #TimesUp, sexual assault is becoming a crime that society as a whole is discussing more, and as a result, a conversation about the way society thinks and speaks about sexual assault, especially assault on females, is emerging. Within that conversation rape myths appear frequently, as they are expected to, and it is important for society to understand what rape myths are and what their effects are.

Rape myths can be defined as "prejudicial, stereotyped, or false beliefs about rape, rape victims, and rapists" (Burt, 1980) or as "attitudes and beliefs that are generally false but widely and persistently held, and that serve to deny and justify male sexual aggression against women" (Lonsway & Fitzgerald, 1994). These definitions are satisfactory with one exception on the second definition. The second definition implies that rape myths are linked only to male offenders and female victims which, ironically, gives credence to the rape myth that men cannot be raped by women. This is an issue that should be noted and considered in future research with regards to male rape victims and rape as a whole. However, as this study's survey particularly focused on female sexual assault victims with regards to rape myths, the definition is still satisfactory.

That being said, the problem with the definition was noted as an example of how rape myths can cause confusion within society, as they can not only affect definitions of rape, but also cause problematic assumptions, and distort the risk factors and consequences of rape (Bohner *et al*, 2009). These consequences, aside from the challenges they cause on the surface, can also lead to victims experiencing

more trauma after the rape as a result of non-supportive reactions (Campbell, Ahrens, Sefl, Wasco & Barnes, 2001; Suarez & Gadalla, 2010). Finally, these non-supportive reactions may stem from, and in some cases reinforce, rape myths. Then the cycle resets, with rape myths obscuring the conditions of rape, leading to victims being victimized once more, leading to non-supportive reactions.

This constant cycle can lead to warped views of rape, where victims and the act of rape are thought to have very specific characteristics. For example, many believe in the concept of 'real rape' (Anderson, 2007; Du Mont, Miller & Myhr, 2003; Horvath & Brown, 2009), in that rape should contain the following elements: the victim and rapist are strangers; the assault occurs outdoors; the victim actively resists; and the rapist uses or threatens force. Even though these views are not necessarily true, and are narrow in how people construct the act of rape in their minds, they are common views (Anderson, 2007) and, as such, are supported because rape myths are greatly influenced by culture (Flowers, 2006).

These views cause society to create what is considered a 'real' victim and a 'real' rapist, and this serves as a blueprint for the sexual assault cases that occur (Du Mont, Miller & Myhr, 2003). For example, McMahon, Postmus and Koenick (2011) found, in a study with 951 college students, that the participants were able to identify sexually aggressive acts on the more blatant side of the continuum as problematic – such as rape – more so than other more subtle forms. In other words, they viewed actions that were explicitly considered 'real rape' or close to 'real rape' as sexually aggressive, where as other types of sexual crimes were not as problematic because they did not match the overall narrative of what rape should look like.

There are four general types of rape myths (Bohner *et al*, 2009): victim-blaming myths, myths that question the legitimacy of the rape, myths that excuse the perpetrator, and myths that suggest that there is a specific type of woman who is raped. Some common myths are ones such as 'women lie about rape to get revenge', 'men cannot control their urges', 'women who drink too much are responsible for their rape', and 'women who dress promiscuously were asking to be raped'. In order to build upon the four main myths, Payne, Lonsway and Fitzgerald (1999) introduced seven domains of rape myths, namely: she asked for it; it wasn't really

rape; he didn't mean to; she wanted it; she lied; rape is a trivial event; and rape is a deviant event. These domains encompass the types of myths that are held within society.

With these myths prominent in society, it can be assumed that there are individuals who believe in these myths as though they were fact. After all, May (1990) argued that myths are used to make sense of the world and give significance to our existence (as cited in Ryan, 2011, pp. 774). As such, rape myths are used to make sense of one of society's worst crimes. Individuals who believe in these myths have different levels of RMA, which refers to the individual's belief that rape myths are true, depending on different factors. There are a wide range of studies that have been conducted to examine RMA, and they span across different demographics and different scenarios, which will be discussed below.

However, a common theme that appears across all studies is that most participants seem to have some form of RMA. In fact, the trend is not whether there are levels of RMA, but instead who – demographically – believes in rape myths and what types of rape myths are prevalent. There appears to be degrees at which these myths are accepted though, as the level of RMA appears to change in some individuals depending on the circumstances of the crime. As such, it would be more effective to split the rape myth research into two separate categories: the specific types of people that have been studied (which is further split between demographics and occupation), and aspects that affect RMA.

With that said, it is important to understand what can cause RMA. As such, before the types of people and aspects that are linked to RMA are explored, it would be advantageous to discuss causes of rape myths and how individuals navigate them.

2.2. Rape Myths: Causes and How Individuals Navigate Them

Rape myths are complex in how people understand them. Despite being falsehoods about rape, these myths manage to stay in the consciousness of society. Furthermore, how people think about their beliefs adds another layer of complexity

to rape myths and RMA. This section aims to discuss how people navigate rape myths and why they believe them.

There are different theories that suggest why RMA is found in certain individuals, however, the most prominent theory is the belief in a just world. That said, it should be noted that discussing rape myth theories is challenging as RMA itself is a theory of why rape is a prevalent problem. This distinction is made as this paper will discuss a theory that applies to rape myths and not the act of rape.

Just World Belief (JWB), a measurable theoretical construct of Lerner's just world theory, is the belief that the world is just and fair, and that good and bad things happen to people who deserve it (Hafer & Sutton, 2016; Hayes, Lorenz & Bell, 2013). It implies that individuals have many choices in any given situation, and therefore, if something negative happens to an individual, the fault lies with them because of their bad choices or behaviours (Lodewijkx, Wildschut, Nijstad, Savenije & Smit, 2001). However, this view of the world causes conflict within an individual with high JWB when the victim of a crime is innocent or a 'good' person, and as Lerner, Miller, and Holmes (1976) argued, when conflict occurs, people will justify their JWB in three ways (as cited in Lodewijkx *et al*, 2001, pp. 82):

- by trying to restore justice (by punishing the offender)
- by trying to deny or nullify the injustice (by blaming the victim)
- and/or by making the injustice tolerable enough for them to live with.

Two of these three points explain rape myths. Trying to deny or nullify the injustice, or trying to make it tolerable, link to some of the most prolific rape myths in society. For example, rape myths such as 'it wasn't rape if she didn't explicitly say no' and 'it implies consent if she didn't fight back' assist in nullifying the crime, while myths such as 'he was drunk' assist in making the attack more tolerable by providing an excuse for the offender. It should be noted that all three examples from above are myths found within the Illinois Rape Myth Acceptance Scale (IRMAS), the measurement that was used in this study.

Research suggests that those with high levels of JWB are more likely to subscribe to rape myths (Hayes, Lorenz & Bell, 2013; Stromwall, Alfredsson & Landstrom, 2013a; Stromwall, Alfredsson & Landstrom, 2013b). People with high levels of JWB were more likely to apply less blame to the perpetrator and more blame to the victim. However, there were other interesting findings within these studies that showed the complexity of RMA. Stromwall, Alfredsson and Landstrom (2013b) found that those with high levels of JWB blamed victims of stranger rape more than other types of rape, and participants with high JWB were less likely to consider certain scenarios put forward as legally rape. The former finding is interesting in that victim blame tends to decrease when the perpetrator is not known to the victim (Ferro, Cermele & Saltzman, 2008; Newcombe, van den Eynde, Hafner & Jolly, 2008; Sleath & Bull, 2015). Though, these outlier findings may be influenced by the type of JWB.

JWB can be split into two categories, JWB-Self and JWB-Other, and each category has been found to have different correlations with RMA (Hayes, Lorenz & Bell, 2013). JWB-self is negatively correlated, while JWB-other is positively correlated. In other words, those who subscribe to the JWB-others – those who believe the world is fair and just to other people – tend to believe that those who suffer sexual assault somehow 'brought it on themselves' because this is a just world, and as such, they did something to deserve the assault. Common rape myths suggest that this theory may be a plausible explanation, as common myths tend to put blame onto the victim – i.e. they took actions that caused the assault.

However, it must be noted that those high in JWB-self were less likely to blame the victim and believe in rape myths, because if they believe the events in their lives are just, then the sexual assault – an unjust act – must have been caused by external factors beyond their control (Fetchenhauer, Jacobs & Belschak, 2005). The aspect of JWB-self may explain why some studies (Culda, Opre & Dobrin, 2018) could not determine that higher JWB correlated with higher levels of victim blaming.

Furthermore, Lodewijkx *et al* (2001) found that the more participants identified with the victim, the more likely they were to think the crime was senseless. Anderson (2007), though they were not specifically looking at how participants

related to victims in their scenarios, found that when discussing victims of the same gender, both males and females, when tasked with writing about male and female rape, were more likely to consider the blame placed onto their own gender in the scenarios they constructed. As such, research suggests that while JWB is a factor in believing rape myths, identity and situational factors play a role in how people think about rape myths.

Aside from theoretical approaches, another significant aspect to understand about rape myths is how people navigate them. As it will be shown throughout this paper, RMA is complicated and most situations do not fit neatly into either 'high RMA suggests belief in all rape myths', or 'low RMA suggests belief in no rape myths'. The situation is complex, with different facets such as occupation, gender, and situational factors influencing the acceptance of these myths.

For example, there is evidence to suggest that some types of rape myths are more likely to be held than others. The IRMAS can be split into four sections of rape myths: 'she asked for it', 'he didn't mean to', 'it wasn't really rape', and 'she lied'. The reason for this is because it was understood that there were certain themes within rape myths that were more prominent than others, and understanding those themes could bring society closer to combatting RMA as there is no value in creating a society in which only one type of rape myth is eradicated while others remain firmly within the minds of ordinary people.

This notion of certain types of rape myths being stronger than others is reinforced by several studies (Carroll, Rosenstein, Foubert & Clark, 2016; Lee, Kim & Lim, 2010; McMahon, 2010). Lee, Kim and Lim (2010) found that their participants believed in rape myths that involved excusing men by suggesting they cannot control their urges more so than myths about the perpetrator's identity (e.g. the perpetrator is always a stranger), and McMahon (2010) found that the participants mostly supported the *he didn't mean to* and *she lied* myths. Carroll, Rosenstein, Foubert and Clark (2016) found that their participants also focused on specific rape myths, such as women lying about rape, denying the male perpetrator's culpability, or victim blaming with regards to drinking and clothes. This paper could span numerous paragraphs explaining the finer details of each study out there – and

below it will discuss the finer details of some – but the aim of these examples is to illustrate how having high RMA levels does not necessarily mean that individuals believe in all rape myths, or believe in all rape myths with equal value.

Furthermore, it should be noted that high RMA does not immediately signify that a person will blame the victim entirely, as high levels of blame for either the victim or the perpetrator does not mean low levels of blame for the other (Stromwall, Alfredsson & Landstrom, 2013a). For example, Newcombe *et al* (2008) found that despite the fact that those with high RMA placed more blame on victims in date rape scenarios than those of low RMA, when the high RMA participants' data was taken alone, they placed more blame on the perpetrators than victims across all rape scenarios (stranger, acquaintance, date, and marital). Deming, Covan, Swan and Billings (2013) found that there were scenarios where their participants would accept that the situation described to them was legally rape but continued to endorse rape myths such as excusing the perpetrator's behaviour. However, despite excusing the perpetrator, they were still more likely to place a higher degree of blame on the perpetrator than the victim. The notion that more blame is attributed to the perpetrator than the victim – even in instances where the victim is blamed to some extent – is a common finding (Stromwall, Alfredsson & Landstrom, 2013a). In today's society, it is not uncommon for studies to find that participants will speak to factors such as alcohol consumption, flirting/suggestive behaviours, and attire, but avoid directly blaming the victim for the crime (Ferro, Cermele & Saltzman, 2008; McMahon, 2007) – or, at the very least, blaming them fully.

These findings illustrate the complexity of belief in these myths. While people may believe the myths, and subscribe to some of them, it does not necessarily mean they consider something as not rape, nor does it mean they completely dismiss a claim. Instead, these myths lend themselves more to excusing rape and to decreasing the ramification of the crime. This is the more complex side of rape myths, in that they do not erase the rape, but they minimize the trauma of it.

This minimization is why these myths are as persistent as they are. It is not solely the problem that rape myths excuse rape, but also that they create doubt about the seriousness of the crime. In one study (Deming, Covan, Swan & Billings, 2013),

participants were tasked with debating if a victim should report a rape, and it was decided the victim should not report. The decision was based on rape myths, specifically victim-blaming (she consumed alcohol) and excusing the perpetrator (she had a prior sexual relationship with the perpetrator). These same participants negotiated with themselves on a number of topics, such as consent, alcohol, and reporting. In these conversations, it was clear that even when the participants considered the act as legally rape, a debate around the circumstances of the rape continued in order to attribute blame and decide if the rape should be reported. These factors that accompany rape – such as alcohol consumption and prior relationships – all feed into the notion of who is to blame.

This constant debate effects victims of rape as much as the broader society. Bondurant (2001) found that unacknowledged rape victims were more likely to hold to the view of 'real rape', in that they believed that what happened to them was not specifically rape – but some other type of assault – because the levels of violence were not high. These victims did not consider themselves victims because they had a specific view of rape and their rape did not fit the scenario. Of all the negative effects of RMA, the effects on the victims most likely cause the greatest damage, because if a victim cannot decide if what happened to them was indeed rape, then they may never report the crime. For example, Heath, Lynch, Fritch and Wong (2013) found that, although women were generally endorsing very low levels of rape myths, the myths were still relevant to the decision to report (or not report) the crime to the police. Furthermore, the same study found that women who were raped by a stranger were approximately 3.7 times more likely to report to the police than were survivors of sexual assaults committed by someone known (Heath *et al*, 2013). As such, rape myths not only play a role in shaping how society views rape, but in how victims determine what to do about their own rape.

2.3. Demographics and Rape Myths

2.3.1. Gender

RMA can be split through certain demographic lines, but no demographic dominates the research more than gender (Basow & Minieri, 2011; Boakye, 2009; Carroll, Rosenstein, Foubert and Clark, 2016; Chapleau & Oswald, 2013; Grubb & Harrower, 2009; Hayes, Lorenz & Bell, 2013; Sleath & Bull, 2015; Suarez & Gadalla, 2010). Research has shown that there is a strong correlation between gender and the level of RMA within an individual. Furthermore, it has also shown that men are more likely to believe in rape myths than women are. However, this is not to say that women do not believe in rape myths. There are studies (Deming, Covan, Swan & Billings, 2013; Kahlor & Morrison, 2007) focused solely on females that reveal that women are just as willing to accept rape myths as men are, some of which suggest that women may be more likely than men to believe certain myths – specifically ones that blame the victim (Culda, Opre & Dobrin, 2018).

While research tends to show that there is a relationship between gender and RMA, it should be noted that not all research has been able to find this relationship (Goodman-Delahunty & Graham, 2011; Wentz & Archbold, 2012). It should also be noted that while Wentz and Archbold (2012) found no relationship within their quantitative portion of their study, they found that women were more likely to subscribe to rape myths than men were, especially the 'she lied' myth, when they analysed the qualitative portion of the study. This is one of the few studies that found men had lower levels of RMA, even though the current trend is the opposite, and while it appears to be an outlier, it does illustrate that RMA is a phenomenon across genders. It should also be noted that the strength of gender as a factor in RMA levels is significantly reduced when other factors, especially education, are taken into account (Boakye, 2009).

The notion that RMA spans across genders is a fascinating one. On the surface, the data of males versus females shows that males are more likely to have high levels of RMA. However, when the data is examined in more detail, it is found that there are certain instances in which gender is important, and other instances in

which it is not. For example, Newcombe *et al* (2008) found that while there were gender differences when attributing seriousness to different rape scenarios – in that men found the rape less serious the more intimate the relationship between the victim and perpetrator – there was no difference when placing blame on the victim or the perpetrator. Lee, Kim and Lim (2010) found that gender played a role in myths about the type of person who commits a rape, but not in other types of rape myths. Carroll, Rosenstein, Foubert and Clark (2016) found that while men exhibited higher levels of RMA, there was no significant difference between men and women in the types of myths that were endorsed.

In other words, while men tend to have higher RMA levels than women, there are instances in which, when their RMA levels are equal, there is no difference between men and women in the myths they endorse and the blame they attribute. This is significant as it suggests that while gender is the most common aspect when handling sexual assault and rape myths, it must not be assumed that gender is the most significant aspect. In fact, there is some evidence to suggest that attitudes toward women, or benevolent sexist views of women, has a significant relationship with RMA (Abrams *et al*, 2003; Lee, Kim & Lim, 2010; Page, 2008), in that those who hold more traditional views of women are more likely to minimise the seriousness of the rape, adhere to stereotypical views of a perpetrator, and blame the victim. Notably, Lee, Kim and Lim (2010) also found that traditional attitudes toward women was a better predictor for RMA levels in their participants than gender was.

This could suggest that the way we socialize genders differently may play a greater role in RMA than actual gender. Men and women who are taught stereotypical gender roles are more likely to have higher levels of RMA, and as men are less likely to be affected by the stereotypical roles society places on women, they may be more likely to agree with them. If this is the case, it could explain why men have higher levels of RMA than women do across various studies.

In a study conducted on military cadets and college students (Carroll *et al*, 2016), one of the most interesting findings were that while the military and fraternity men displayed significant differences in their belief for 12 out of 17 myths, the

military and sorority women only had significant differences for 3 of the myths. This research suggested that even women in masculine social environments, such as the military, are still more closely aligned to women in feminine social environments. Therefore, it could be argued that the way women are socialised in society as a whole matters on how they view rape myths. However, situational factors could also be the reason military and sorority women are closely aligned with RMA opinions, as spending time on military and college campuses, two places notorious for sexual assault, could make women more aware of rape and its myths. However, even in that scenario, it is still the social environment that is influencing women's views, and not merely the fact that they are women.

Finally, with regards to gender, it should be noted that men and women use rape myths differently (Bohner *et al*, 2009; Franiuk, Seefelt & Vandello, 2008). While RMA in men is used to justify or rationalise their own tendencies for sexual aggression, RMA in women is used to lower anxiety when confronted with sexual violence. In other words, women use rape myths as a way to distance themselves from the type of women who get raped, and thereby protect themselves from the possibility of the same crime – a view that fits into the framework of JWB. This can been seen in Clark and Carroll's study (2008) in which college students were asked to describe what date rape was, and while both genders held similar views – the man was interested in sex, the woman was not ready – they diverged in how the rape occurred, with women focusing on 'real rape', as in the man is physically violent, and the men focusing on factors that exonerated the perpetrator, as in alcohol consumption was involved and the resistance was only verbal and not physical (i.e. she didn't really struggle or her resistance was unclear). In other words, women focused on the victim, her actions, and what happened to her, while the men focused on why the offender would commit the crime. Furthermore, women, who identify with other women more than with men, tend to attribute less blame to female victims than to male victims, while men, who identify with other men, attribute less blame to male victims (Idisis, Ben-David & Ben-Nachum, 2007), illustrating, once again, that identity plays a role in how rape is perceived.

2.3.2. Age & Race

A second aspect that has been examined in terms of demographics is age (Burt, 1980; Sussenbach & Bohner, 2011). It has been found that older people tend to be more accepting of rape myths than their younger counterparts. For example, Deming, Covan, Swan and Billings (2013), found that 4th-year college students were more likely to sanction a woman's behaviour than their 1st-year counterparts when confronted with a rape scenario. However, it should be noted that some studies (Boakye, 2009) found that RMA and age was not linear. Instead, the study found that younger adults had lower levels of RMA than compared to older adults as well as adolescents. This is an interesting finding as many studies only begin their analysis of age from those who are 18 years old and older.

That said, age has not been an important aspect to examine with regards to rape myths. In fact, when age is mentioned within the literature, it tends to be a passing finding, one that was not integral to the study as a whole. This does appear to be a blind spot for research, as age may give some hints as to how to contend with rape myths in society. If younger individuals are less inclined to believe rape myths, then that stands to reason that something within society has changed. However, before any research can be done on this, exploratory studies should be done to assess if there is a significant relationship between age and RMA.

Finally, race appears to be non-existent when it comes to the literature on RMA, at least to this author's knowledge. This is not surprising, as a majority of the research on gender and age is not specific to gender and age, but rather searching something else where demographic information is necessary. Furthermore, it may be a possibility that majority of the studies conducted on RMA did not have enough participants of different races to come to a significant conclusion.

2.4. Rape Myths and Occupation:

As mentioned above, demographic data on RMA often comes from studies focusing on something else. Most of those studies tend to focus on occupation of the participants, and the single biggest group used to examine rape myths and RMA is

college students (Anderson, 2007; Deming *et al*, 2013; Ferro, Cermele & Saltzman, 2008; Frese, Moya & Megías, 2004; Hust *et al*, 2013; Kahlor & Morrison, 2007; Lee, Kim & Lim, 2010; McMahon, 2010; Newcombe, van den Eynde, Hafner & Jolly, 2008; Sleath & Bull, 2015). College students appear to be the population that is focused on the most due to the high number of sexual offences reported on campuses as well as the fact that they tend to be easier to gain access to compared to other populations. However, research into students is not specific to them as students as it is with other professions because, unlike police, lawyers, or doctors, students do not offer services to victims or their cases. As such, many of the findings of these studies will fall under different headings, such as situational factors and education about sexual assault. They are simply mentioned here in order to illustrate that majority of research specific to examining RMA acceptance revolves around college students.

With regards to other professions, there are several interesting findings in the literature. Police officers, lawyers, and medical professionals are interesting populations to examine because the way they approach rape, and therefore their views on rape, will be linked to their purpose in the case. As such, as this paper discusses each occupation separately, it will do so through the lens of what each occupations' goal is when approaching a rape case.

2.4.1. Police Officers and Rape Myths

Of the three groups mentioned above, the population that is examined the most with regards to rape myths is police officers (Ask, 2009; Goodman-Delahunty & Graham, 2011; Lee, Lee & Lee, 2012; Page, 2008; Sleath & Bull, 2015; Wentz & Archbold, 2012), as they tend to be the professionals who first come into contact with victims of sexual assault. The role of police in these situations are to take statements, assess the situation, and investigate the crime. As rape myths tend to obscure how people think about rape, most research into rape myths focuses on how police interact with the victim.

Arguably, the most important factor for police when it comes to crime is that they believe the crime indeed occurred, and that could be a point of concern when rape cases are involved. For example, police officers must assess the situation and victim. If they believe in the 'real rape' scenario, it could cause them to overlook the seriousness of a crime that does not fit that scenario. According to a study by Goodman-Delahunty and Graham (2011), there are two judgements related to the likelihood of charging: the officers' assessments of the credibility of the complainant and their perceptions as to whether the alleged perpetrator was guilty of the crime of sexual assault. As such, police officer's views are important in assessing the crime.

Police officers, despite their specific job, are not immune to the effects of rape myths, and their levels of RMA can predict victim blaming (Sleath & Bull, 2015). Lee, Lee & Lee (2012) found that, for police, rape survivor myths played an important role in assessing crimes of rape. Rape survivor myths are myths that state that rape survivors have some responsibility for the crime through intoxication or lack of resistance. In other words, officers who believed these myths used the victim's intoxication and their physical state (if they have bruises or wounds) as factors in their assessment of the rape. While these factors may seem mundane to examine – or even necessary to some – it is the belief that these factors are more important than other factors that is the concern, as it was found that officers that held rape survivor myth beliefs considered rape to be less psychologically damaging or were reluctant to believe that a situation presented to them was rape (Lee, Lee & Lee, 2012).

Furthermore, it was found that police officers look for both verbal and non-verbal cues in victims to determine the veracity of their claim (Ask, 2008). This is problematic when combined with RMA as officers will be more inclined to look for a specific behaviour in the victim. If the victims appeared in control, it led the officers to believe that they were lying.

These findings illustrate the real problem rape myths cause. If police officers, one of the first people a victim will come into contact with, do not believe their assault was serious, it could have severe ramifications for the rest of the investigation. Furthermore, if police officers have a view of how victims should act,

any victim that strays from that view will be met with suspicion. This is problematic in all parts of society, but specifically with officers, as it was found that officers who endorsed more rape myths perceived the complainant as less credible, attributed her greater responsibility for the incident, were less likely to believe that she communicated non-consent, were less likely to regard the alleged perpetrator as guilty of sexual assault, and were less likely to recommend that he be charged (Goodman-Delahunty & Graham, 2011).

The greater concern with regards to police is not that they believe in myths, but rather that some myths are accepted and others are not (Page, 2008). This is a concern as believing a victim may occur simply because they were lucky in receiving an officer without those specific biases. For example, Sleath and Bull (2015) found that while 'she wanted it' and 'he didn't mean to' myths were prominent in their sample, many of the other myths had low levels of acceptance. Furthermore, while Ask (2008) found that officers used intoxication in their assessment, Goodman-Delahunty and Graham (2011) found that intoxication was not a factor in assessing the validity of the crime. However, they found that other factors were important, such as if the woman's attire was perceived to be sexually provocative. In those cases, she was attributed significantly more responsibility for the alleged sexual assault. That said, 'provocative' attire ultimately was not associated with diminished responsibility of the perpetrator, nor reductions in the determination that sexual assault occurred or the likelihood of charging the alleged perpetrator (Goodman-Delahunty & Graham, 2011). This may be explained by the notion, mentioned above, that in today's society, people are reluctant to blame the victim despite some misgivings. For example, Page (2008) found that a majority of officers in her study disagreed with statements that would blame the victim. However, they still had biases in who they would consider a victim, in that they were more likely to believe a claim from someone they know, a virgin, an elderly person, or a professional woman over a prostitute who claimed she was raped.

Once again, the complexity of rape myths is shown, as the factors in assessing an assault was not about whether it occurred but about the part the victim played in their own victimisation. In fact, RMA with regards to police may not play

a role in attributing blame to the perpetrator (Sleath & Bull, 2015), but instead focusing solely on the victim.

It should be noted that looking for verbal cues and behavior that fit with 'how a victim should act' was less prevalent in police officers with previous training in sexual assault (Ask, 2008). The disbelief in rape myths because of educational programmes was also found by Lee, Lee and Lee (2012), however, it should be noted that in that study the type of training was important. All police in the study were taught the procedure for rape crime scenes, and how to assist victims, however, it was the officers who attended programmes that specifically taught them about rape myths and attitudes on gender that showed less acceptance of 'real rape'. Finally, it should be noted that while some studies (Sleuth & Bull, 2015) found male officers were more likely to blame the victim in scenarios with high levels of rape myths in them, and more likely to focus on clothing and alcohol, no differences emerged between the male and the female officers on any measures of their responses to a sexual assault claim in other studies (Goodman-Delahunty & Graham, 2011; Wentz & Archbold, 2012)

2.4.2. Legal Professionals and Rape Myths

Lawyers and police research tend to overlap as they are both part of the criminal justice system. However, they are spoken about separately because they have different goals with regards to sexual assault cases. While police officers must assess and investigate, it is ultimately lawyers – or, rather, prosecutors – that must decide if the case is strong enough to take to court. As such, lawyers' opinions on rape and rape myths may be more important than the police.

To begin with, lawyers are as susceptible to rape myths as their police colleagues. For example, although prosecutors generally made more cautious estimates when compared to officers, false reports of rapes were still believed to be considerably more common than false reports of the other crime types (Ask, 2009). As such, prosecutors may already begin their assessment of a case with the notion that it is fake. Furthermore, Krahé, Temkin, Bieneck and Berger (2008) found that

lawyers considered the perpetrator was more liable when his victim was a stranger and he used force. These are two of the four elements of 'real rape' and suggest negative outcomes for other rape victims who are seeking justice. Furthermore, it was also found that lawyers still used rape myths as arguments and rebuttals when questioning victims in the court (Zydervelt, Zajac, Kaladelfos & Westera, 2017).

The situation in South Africa may not be better, as Rumney and van der Bijl (2010) found that most participants thought the rate of false rape reports were between 0 and 20 percent, with nearly a quarter thinking it was 21 percent, when the rate is far lower. Furthermore, their survey provided insight into how lawyers may assess victims in South Africa, with a majority of participants agreeing that they expected a woman to physically resist her attacker and to be visibly upset when reporting the crime. They also expected the victim to report the crime as soon as possible. These are aspects linked to rape myths that form the concept of 'real rape'. That said, the survey also showed a rejection of certain myths, as participants believed that a man could be raped by women and men (even if he was stronger and/or bigger than his attacker), and that rape by someone known to the victim is as serious as rape by a stranger.

Their study also suggested that legal training is focused solely on the legislation and letter of the law with regards to rape and sexual assault, as there was no differences between those who studied criminal law compared to those who did not (Rumney & van der Bijl, 2010).

The way lawyers approach cases of rape may be a byproduct of their job. For example, while above research shows that some rape myths are not believe, the ones that are believed appear to help either exonerate their client or help prosecutors avoid taking a case that they think they may lose.

2.4.3. Medical Professionals and Rape Myths

The literature regarding rape myths and rape in general with regards to medical professionals can be split into two categories: service provision and mental

health. While mental health services can be incorporated within service provision, it is often not and, therefore, is the focus of many studies.

For example, Lund *et al* (2008) found that South Africa does not have a well-integrated mental health service with regards to rape services. In South Africa, the focus on the care for sexual assault is on forensic examination, biomedical intervention, and legal advocacy, with mental health care not priotristised, and considered as a long-term service that can be served by others, such as NGOs (Gevers. Abrahams, Andrews & Toledo, 2015). Furthermore, the post-rape care services are geared toward adult women, making it harder to accommodate children, adolescents, and men (Gevers. Abrahams, Andrews & Toledo, 2015). It is possible that this comes from the long-standing myth that men cannot be raped and that only certain type of women are rape victims.

The research into mental health and rape within the medical community is not specific to South Africa. Campbell and Raja (1999) studied mental health professionals and secondary victimization. The study involved asking mental health professionals if they believed community professionals engage in harmful behaviour when assisting rape victims, and it was found that many professionals did believe this. They also found that those who assisted rape victims and had better training in terms of sexual assault were more likely to believe that the community as a whole were not helping victims, suggesting that exposure to numerous victims and education into sexual assault play a role in how medical professionals view victims and their role in assisting them. Furthermore, these findings are not unique, as Maier (2012) found that sexual assault nurse examiners believed victims were revictimized in the medical and justice systems.

This is concerning, as victims may turn to the medical professionals when they cannot turn to the police. In fact, Orchowski and Gidycz (2012) found that no woman in their study reported their experience of sexual victimization to the police. However, 44% of their participants did tell a mental health professional. While this study was specific to mental health, it is important in the bigger narrative, as a doctor – specifically a GP – is far closer to a mental health professional than a police officer. Furthermore, college women were found to be more likely to tell their

friends to seek medical help (Suzuki & Bonner, 2017) while college men were more likely to tell friends to contact the police (Suzuki, 2013). The reason this is a point of concern is because women were more likely to turn to a female peer than a male peer following a sexual assault (Orchowski & Gidycz, 2012), and as such, are more likely to be directed toward a medical professional.

However, not all of the literature suggests medical professionals are susceptible to rape myths. Idisis, Ben-David and Ben-Nachum (2007) conducted a study to examine how therapists and non-therapists differed with regards to perceptions of rape, and the most significant finding with regards to occupation of the participants was that therapists were more likely to classify the different rape scenarios as more severe than their non-therapist counterparts, regardless of prior acquaintance between the victim and offender. That said, no difference was found in how therapists and non-therapists attributed blame, with both groups attributing more blame to the victims in scenarios they were presented with. However, blame was relatively low to begin with.

While all occupations that interact with rape victims are important to examine, medical professionals are unique because, while they can harm victims a second time similar to other professions, they can also assist victims to recover physically and mentally. Victims of sexual assault need proper care that involves not only physical health but psychological counselling, as they themselves have demanded when asked about what they expect from the health care system (Li, Wu, Su, Chen, Shen, Chou, 2016). In South Africa, it was found that patients were even willing to trade certain things, such as lengthy time travelled and waiting, if they were ensured proper counselling and a rigorous examination (Kim, Askew, Muvhango, Dwane, Abramsky, Jan, Ntlemo, Chege & Watts, 2009). In fact, the same study found that having a lengthy examination that could influence the legal outcome was also viewed as desirable, especially among rural women. This is plausible as an examination after rape can be a harrowing experience and, if it is done, should ensure that proper evidence is collected and recorded.

That said, service provision itself may be a problem, as Fouche, Bezuidenhout, Liebenberg and Adefuye (2018) found that doctors lacked knowledge

on the basic principles of clinical forensic examination and that a substantial number had no prior knowledge of the SAECK. Both these aspects are vital in examining the victim, in order to not only ensure that they are properly treated, but to also ensure that evidence is properly collected. Furthermore, Christofides *et al* (2005) found that South African training in administering a rape kit did not associate with better quality care, suggesting that the content of the training may not be relevant to increased quality of service provision.

2.5. Situational Factors and Status:

With regards to status in society, Sussenbach and Bohner (2011) found that those lower in terms of income were more likely to believe in rape myths, though there was no explanation as to why this was. Education also played a role with regards to rape myths (Burt, 1980; Lee, Lee & Lee, 2012; Page, 2008; Sussenbach & Bohner, 2011), as those with lower education were found to have higher levels of RMA. This is an interesting finding, as it suggests that education may be one strategy in fighting RMA. That said, it should be noted that Wentz and Archbold (2012) found no influence on RMA acceptance in their respondents with regards to education.

Page (2007) found that police officers with a high school diploma or GED scored significantly higher on the Modern Sexism Scale (MSS) than police officers with a Master's degree. Furthermore, officers with a high school diploma or GED had significantly higher RMA scores than did officers with an Associate's degree. Police officers with a high school diploma or GED also scored significantly higher than did those who had a Bachelor's degree.

In terms of the status of those involved in the crime, Chapleau and Oswald (2013) aimed to see if the victim and offender's status affected the perception of rape, and found that despite the fact that the scenario given was not ambiguous and clearly described a rape, the participants were more likely to believe in rape myths when the offender was of a higher status and when the victim planned to turn in the offender of the higher status. When the roles were reversed, however, the level of

RMA decreased. RMA also decreased when the perpetrator was of a higher status, but the victim did not wish to come forward. However, in the same scenario where the victim did not come forward, those with low levels of RMA in the other scenarios subscribed to more myths. This study revealed important information with regards to RMA, in that the situation is an important aspect of how people perceive rape, and that even those with low RMA levels can be susceptible to rape myths when presented with certain circumstances.

Another situational factor that is important to examine is the type of rape, in that certain types of rape are trivialised more than others (Boakye, 2009). A number of studies into the type of rape showed that people were more likely to believe that stranger rape was more traumatic, and in that scenario, people were more likely to place blame on the perpetrator, whereas the victims were more to blame when it came to acquaintance, date, and marital rape (Abrams, Viki, Masser & Bohner, 2003; Ferro, Cermele & Saltzman, 2008; Frese, Moya & Megías, 2004; Grubb & Harrower, 2009; Newcombe; Patterson, 2011). In one study (Ferro, Cermele & Saltzman, 2008), participants were more likely to believe falsehoods about rape with regards to marital rape scenarios as opposed to acquaintance rape scenarios, Furthermore, Suzuki and Bonner (2017) found that students were more likely to tell their friend to seek medical professionals when the perpetrator was an acquaintance instead of a boyfriend. These studies suggest that the intimate relationship made people less likely to believe that sexual violence could occur between the two individuals in the relationship, which is a prominent rape myth in society.

These studies link back to the concept of ‘real rape’, in that a rape is considered more traumatic, and therefore more real, if the perpetrator is a stranger. For example, in a study (McMahon, 2010) conducted to see if bystanders would intervene in an assault, it was found that participants were willing to intervene if what they saw was overtly assault (i.e. offender appeared to be a stranger, offender was aggressive), while those who endorsed rape myths were less likely to intervene. This study, and the ones above, differ in their levels of intimacy, but they all share the common view that the less familiar the victim was with the perpetrator, the less blame was assigned to her. Furthermore, this type of research shows an insight into

why crimes such date rape are easier to excuse, and why myths such as ‘she lied’ or ‘she was asking for it’ are easier to believe when a victim accuses someone they have a previous relationship with.

Finally, situational factors may also contribute to who is to blame, even in a case where it was unambiguously rape. Deming *et al* (2013) found that their participants used timing of and type of consent as well as alcohol consumption to assign blame. Alcohol is one of the main situational factors that is used when assigning blame in a rape (McMahon, 2007; Maurer & Robinson, 2008; Stewart & Jacquin, 2010). Alcohol is used as an excuse for the perpetrator, in that it suggests the rape could happen ‘accidently’ or ‘unintentionally’, and is also used as a reason to find the victim less credible or more responsible for the rape. These factors have real-world consequences, as it was found that the presence of victim and perpetrator alcohol use at the time of the assault was associated with disclosure of sexual victimization (Orchowski & Gidycz, 2012), in that women would lean more toward not disclosing the assault if alcohol was involved.

These situational factors not only cause society at large to question the legitimacy of the rape claim, but for individuals to wonder whether or not to report the crime to the police (Deming *et al,* 2013). Myths force rape victims to fear coming forward, as they worry about not being believed or being accused of lying (Vetten, 2014)

2.6. Research in South Africa:

While there does not seem to be a lot of research specific to RMA in South Africa, there are studies that either include rape myths in the context of something else or examined aspects that may be useful in understanding the phenomenon of RMA. For example, a study (Müller, Rohrs, Hoffman-Wanderer & Moult, 2015) done to examine the decision-making by nurses in providing sexual and reproductive healthcare to teenagers suggested that nurses make moral judgments with regards to sexual and reproductive health care. It was suggested that they placed their own values above the legal instructions that they were meant to follow. While this

research was not specific to rape, it did reveal that it is possible for professionals to either not understand what is expected of them legally or choose to do it their own way based on personal opinion. If this can be done with regards to sexual health care, there is a chance that this can be done with regards to sexual assault.

In terms of sexual assault, a study was conducted around sexual violence, gender norms and HIV/AIDS risk in South Africa. In this study, Kalichman *et al* (2005) found that as many as one in five of their sample suggested that it was a woman's fault if she were raped. Furthermore, the study also found that both men and women believed women to be subservient and passive, which could also feed into the rape myths that exonerate the perpetrator. While this study was not specifically about rape myths or RMA, it did show that these beliefs could play a role in sexual violence.

These attitudes were also found to extend to those in South Africa who are meant to help victims of sexual assault. A research report by the Gender, Health and Justice Research Unit (Rohrs, 2011) found that police believe that women lay false charges of rape for a number of reasons, such as access to health care services, to avoid parental punishment, or other personal reasons. It was also found that the police in the sample tend to look for signs that link to 'real rape', and become suspicious should they not find these signs. Furthermore, in the same study, health care professionals were found to also have negative views, specifically when the victims were not injured, did not appear traumatized, or were intoxicated at the time. An especially troubling finding within the research report with regards to medical professionals was that some showed restraint to examining a rape victim if they had not gone to the police first, and this action was used to judge whether or not the rape claim was real. This view could easily cause secondary victimization, as there are any number of reasons a victim would rather see a doctor before a police officer. This finding, while only part of a bigger research paper, illustrates the need to understand how those who interact with rape victims think about rape and the myths that come with the crime.

2.7. Education About Rape

The evidence with regards to specifically being educated about sexual assault and RMA is mixed. While there are some studies that suggest educational programmes can help lower RMA, there are others that have found no correlation. This is not to say that educational programmes do not work. It could rather mean that the focus of the programmes is what needs to be examined.

For example, some educational programmes were found to only decrease the acceptance of certain rape myths, such as myths about the perpetrator (Lee, Kim & Lim, 2010), while other programmes were found to have no significant effect (Lee, Lee & Lee, 2012; Sleath & Bull, 2015). Other studies report that despite having received some formal education and training, qualified medical practitioners continue to demonstrate poor GBV knowledge and identification rates (Haist, Wilson, Lineberry & Griffith, 2007; Hinderliter, Doughty, Delaney, Pitula & Campbell, 2003).

These findings are cause for concern, as it suggests that either education in sexual assault is not good enough, or education does not work. However, it is most likely the former option, as it has been found that the content of education was important to views on sexual assault, whether it was formal or informal (Boakye, 2009).

2.8. Conclusion

The current chapter has reviewed relevant literature on the topic of RMA, and has found the phenomenon is related to numerous factors, such as belief in a just world, gender, perception of gender roles, age, education, and situational factors. Furthermore, RMA appears to be approached different depending on the occupation of the individual. Chapter 3 will explain step-by-step the research design, so that it is clear how the data was collected and with what instrument it was collected.

CHAPTER 3: METHODOLOGY

The following chapter will discuss the research design of the current study by outlining the methodology used within the study, such as the research approach, the sampling method, the data collection method, and the data analysis method. The chapter will end with the ethical aspects that were taken into consideration.

3.1. Research approach

A quantitative research approach was followed in order to measure the level of RMA among GPs, as well as explore if those levels were significantly related to other variables, such as age or gender. Quantitative research is used to measure a concept or phenomenon using quantifiable data. In other words, quantitative research entails collecting numerical data (Bryman, 2012), and employing statistical techniques that analyse that data (Bhattacherjee, 2012; Greener, 2011). This research produces data that is presented as counts, correlations, and other statistical formulae (Curtis & Curtis, 2011). Quantitative research is used to answer 'what'-type questions, as opposed to 'why'-type (Greener, 2011). There are three advantages to quantitatively measuring a concept or phenomenon (Bryman, 2012), namely:

- We can find fine differences between people in terms of characteristics.
- We have a consistent device for which to measure and gauge differences.
- We can be more precise in our estimates of how two concepts relate to one another.

As the nature of this study was to measure the levels of RMA in GPs and compare the scores using different variables such as age, gender, and formal training to see if there was any significant difference between the groups, a quantitative approach was appropriate for the study. The study used a scale to measure RMA levels, thereby quantifying the phenomenon by producing scores that were analysed with statistical techniques to find if they correlate with other factors and/or variables. A quantitative method was also appropriate as the research questions being asked

referred to what the phenomenon is and its extent, rather than why it exists. Finally, with regards to the three advantages named above, the study meets them:

- The study is attempting to find differences between RMA levels using different demographic and experience questions.
- The Illinois Rape Myth Acceptance Scale, which will be discussed below, is being used to measure RMA and its scores can be used to gauge differences between respondents.
- The demographic and service provision questions can be used in correlation analysis, providing information in how two variables relate to one another.

The current study is descriptive in nature. Descriptive research is used to describe the characteristics of a specific phenomenon by making careful observations and basing these observations on the scientific method (Babbie, 2016; Bhattacherjee, 2012). In other words, the observations or inferences must be based on logical principles of reasoning, must be able to be replicated, must match with the evidence, and must be able to withstand scrutiny from other researchers. It is used to provide systematic information about that phenomenon that assists others in understanding it. As such, descriptive statistics focuses on the 'what' of a phenomenon, as in what is the nature of the phenomenon, more than why the phenomenon exists. With regards to quantitative research, descriptive research is used to collect quantifiable information to use for statistical analysis.

Therefore, the study can be classified as descriptive, as it used the data collected through a survey to make observations about the views of GPs on sexual assault. The study will be able to be replicated, and any observations made were based on the results of the survey, as well as based on previous research within the field of rape myths.

That said, the study also possesses hints of exploratory research. Exploratory research is usually used for a phenomenon which is relatively new to the researcher (Babbie, 2016). This research involves either exploring the magnitude of a phenomenon, generating initial ideas about a phenomenon, or testing if there is need

for a more extensive study of a phenomenon (Bhattacherjee, 2012). The shortcoming for this research, however, is that it does not, or will not, necessarily provide satisfactory answers to research questions (Babbie, 2016).

The reason that it can be argued that this research is exploratory is that there had been little research focused specifically on RMA levels in South Africa, and no research, to the author's knowledge, on RMA specifically with regards to GPs. As such, the current study was conducted to explore the current levels of RMA and views of sexual assault in GPs in South Africa as much as it was conducted to describe those findings.

3.2. Sampling and sampling method

Sampling is the statistical process of selecting a sample or subset of a population in order to either make observations or inferences about that population (Babbie, 2016; Bhattacherjee, 2012).

The sampling process has three stages (Bhattacherjee, 2012), namely:

- Defining a population with the characteristics that the researcher wants to study. A population is the total group of units from which the sample is selected (Bryman, 2012).
- Choosing a sampling frame, which is an accessible section of the population where a sample can be drawn (Bryman, 2012).
- And choosing a sample from the sampling frame using a sampling technique.

Furthermore, all units in the sample should share at least one characteristic, and this characteristic should connect to the research question (Pascoe, 2014).

The population of the study were GPs practicing in South Africa. The sampling frame involved two databases, namely the Discovery Insurance Database and the Alliance of South African Independent Practitioners Associations (ASAIPA) Database. However, live medical events were also attended in order to find respondents, the reasons for which will be explained below with regards to sampling

techniques. All participants shared the characteristic of being GPs. The sample was comprised of 44 GPs practicing in South Africa.

The following sections will discuss sampling techniques and why they were used, and then go on to detail how participants were recruited.

3.2.1. Sampling techniques

Non-probability sampling was utilised for the study. Non-probability sampling is used when the units are selected based on certain non-random criteria (Bryman, 2012; Bhattacherjee, 2012). Non-probability sampling may be subjected to a sampling bias and, therefore, information from a sample cannot be generalised back to the population (Bhattacherjee, 2012). Specifically, two types of non-probability sampling were used. The first type was purposive sampling, specifically expert sampling, and the second was snowball sampling.

Purposive sampling is an appropriate technique when selecting a sample based on the knowledge of the population, its elements, and the purpose of the study (Babbie, 2016). The sample is selected based on the researcher's judgment about which participants will be most useful. Expert sampling, particularly, focuses on choosing participants who have expertise in a certain area or phenomenon (Bhattacherjee, 2012).

As this study specifically focused on GPs currently practicing in South Africa, certain people in the medical field were disqualified, as well as those who had the knowledge but did not meet the other parameters. For example, GPs who expressed interest but were not currently practicing were removed from the list of possible respondents.

This sampling technique was used because the study's aim was to examine RMA with regards to GPs who were currently practicing. While using the above databases to contact respondents, it was discovered that the databases were slightly outdated, with some doctors either no longer practicing or no longer practicing as GPs. As such, purposive sampling was deemed more appropriate for the aims of the study.

While the sample may not be able to represent every general medical practitioner in the country, the results could be useful because, with the sample being within a specific parameter, it would be easier to generalise the opinions of the sample to other samples that do not share their characteristics. In other words, this research can be used to compare GPs to other medical fields, or to other professionals who interact with sexual assault victims, in similar studies.

The second technique used to collect responses was snowball sampling. Snowball sampling involves research participants recruiting other participants (Bryman, 2012; Bhattacherjee, 2012). Snowball sampling is used when participants are hard to find (Babbie, 2016; Bhattacherjee, 2012), which was not the case in this study. However, it was used regardless for reasons stated below:

- The sample parameters were broad and there were no other specifics such as age, race, gender, or experience, and as such, it would have been easy for other respondents to send the survey on without too many complications.
- With the parameters being as broad as they were, it could still have been possible to generalise the results.
- The topic of the study – despite not being directly related to the participants – is still considered a sensitive subject in today's society, and it was assumed that it would be easier to consider the survey were it to come from another doctor.
- Snowball sampling is useful for exploratory studies (Babbie, 2016).

Finally, as this study was quantitative in nature, this paper should touch upon why probability sampling – sampling in which every unit in the population has a chance of being chosen for the sample (Bryman, 2012; Bhattacherjee, 2012) – was not used. To begin with, as there is no database the researcher could access that had every general medical practitioner in South Africa, the study already began with the notion that not every unit had the chance to be chosen. Second, an attempt to randomise the doctors contacted through the Discovery database was made, however, when the researcher was met with the low response rate, coupled with the fact that some of the doctors who were classified as GPs were not or no longer

practicing as GPs, the sampling method needed to be revised. Finally, the inclusion of live events made it impossible to ensure a random sample as the units that would make into the sample would be respondents who would go to those specific events, based on the event's subject/topic.

3.2.2. The current sample

The sample used for this study consisted of 44 respondents. The parameters for who could participate within the study were simple and consisted of three aspects.

- The first was that the participant needed to be a general medical practitioner.
- The second was that the participant needed to be currently practicing (as a general medical practitioner).
- The third was that the participant needed to be practicing in South Africa.

Participation in the study was completely voluntary and anonymous. The details of possible respondents were found through the Discovery Insurance Database and the ASAIPA database. These databases had phone numbers and, in some instances, email addresses of GPs from across the country. In the case of phone numbers, these GPs were contacted, the study was explained, and their email addresses were obtained. Once a list of email addresses was constructed by the researcher, an email with the information sheet and the link to the survey (of which the first page was the consent form) was sent out.

The researcher also delivered hardcopies of the survey to nearby practices in Cape Town as well as attended medical events in which a table was set up. The delivered copies were handed to the receptionists for the doctors or to the doctors themselves in an unmarked envelop along with an information sheet detailing the study. Once completed they were handed to reception where they were collected by the researcher, ensuring that the researcher did not know which doctor in the practice answered the survey.

The table at the live events consisted of information sheets and physical copies of the survey. The survey could also be conducted electronically, using one of three iPads. Participants were instructed that the researcher could not discuss the survey before or during its completion. Once the survey was completed, it was taken and placed into a sealed box which was only opened once the researcher had left the premises.

The data obtained from the physical copies was uploaded onto the website with the rest of the survey data, and their hardcopies are (and will stay) in the possession of the researcher with accordance to the University of Cape Town's data storage policy.

3.3. Measurement

An electronic survey was used to collect data for the current study. Surveys are used to collect and measure unobservable data, such as attitudes, behaviours, and beliefs, and are ideal for remotely collecting information from a population too large to observe directly (Bhattacherjee, 2012). They are useful for getting a large sample and compiling data quick (Jones, Baxter & Khanduja, 2013)

The survey was a self-completion questionnaire. These types of questionnaires have several advantages, such as being cheaper and quicker to administer, avoiding interviewer effects, and being convenient for respondents (Bhattacherjee, 2012; Bryman, 2012), all advantages of the current study. However, there were a number of disadvantages which needed to be addressed. These disadvantages were (Bryman, 2012):

- not being able to prompt, probe, or ask difficult questions that need lengthy answers.
- the questionnaire can be read as a whole before it is answered and the participants may do so, therefore answering questions without them being independent of questions further down the survey.
- the researcher cannot be absolutely certain who answers the survey.

- not appropriate for respondents who are illiterate or do not speak the language of the survey.
- greater risk of missing data.
- lower response rates.

Certain actions were taken to ensure that the current survey had as few of these disadvantages as possible. To begin with, four disadvantages were not a concern for the current study. The first – not being able to prompt, probe, or ask difficult questions – was not seen as a concern as the study's aim needed only simple answers, especially with regards to RMA levels. Furthermore, questions that may have needed elaboration had an 'other' option attached to them where the participant could write an answer in.

The second disadvantage – illiterate respondents – was not a concern as all participants were practicing GPs who had to have obtained a high-level degree to gain that title.

The third disadvantage – the survey being read as a whole – would have been difficult and time-consuming considering the means in which the survey was delivered. The survey was electronical and only presented one question at a time. It was possible for participants to move forward through the survey and then go back, but it would seem unlikely that any respondent would move through all 34 questions only to return to the beginning and answer them.

The fourth disadvantage – not knowing who responds – was not a concern as electronic surveys were sent to the doctors' personal emails or were handed to them in person at their offices or at the medical events. There were only two ways for the survey to be available to participants who did not meet the criteria of the sample, the first being if the receptionists of the medical practices answered the survey, and the second being if the participants forwarded the survey link to individuals who were not GPs. Both scenarios are unlikely.

The survey questions were designed to be simple, easy to understand, and requiring minimal effort to respond in order to ensure that response rates were not

low and that the surveys were not partially completed. Furthermore, multiple reminders to answer the survey were sent out to participants.

That said, non-response was still a concern as the topic of sexual assault is a serious and, in some cases, controversial topic within society, and there was a chance some respondents would not feel comfortable responding. In order to mitigate this problem, every participant was given a detailed information sheet about what the survey entailed and were encouraged to call the researcher if there were any concerns. Furthermore, the first section of the survey were basic questions about service provision (explained below) which would allow the respondents to ease into the survey.

The survey used for this study could be split into three sections. Section 1 and 3 consisted of questions pertaining to service provision (e.g. such as whether or not the doctors had been trained to assist victims of sexual assault, trained in the law regarding sexual assault, or if they had rape kits in their offices) and demographic questions including gender, age, and how long the participant had been a general medical practitioner, respectively. The service provision questions were to understand how prepared GPs thought they were to assist victims of sexual assault and how they understood sexual assault with regards to their profession.

Section 2 of the survey consisted of the Illinois Rape Myth Acceptance Scale (IRMAS), which was used to measure the level of RMA among the sample. The scale was designed in 1980 (Burt, 1980) and has been updated throughout the years (McMahon & Farmer, 2012; Payne, Lonsways & Fitzgerald, 1999). The scale was designed in order to measure the level of RMA in a particular person. The updated scale (McMahon & Farmer, 2012) consists of 22 statements, with each statement ranked on a scale of 1 to 5 where 1 is ‘strongly disagree’ and 5 is ‘strongly agree’. The scale can be split into four separate constructs regarding rape myths, namely ‘she asked for it’, ‘he didn't mean to’, ‘it wasn't really rape’, and ‘she lied’. All questions, and therefore all constructs, were used. The survey includes statements such as “rape happens when a guy's sex drive goes out of control”, “if a guy is drunk he might rape someone unintentionally”, and “if both people are drunk it cannot be rape”. The cumulative score of the scale shows whether a participant has a high level

of RMA or not. The overall Cronbach's alpha for the measure was a .87, with the Cronbach's alphas of the subscales ranging from .64 to .80. The Cronbach's alpha is used to measure internal reliability – whether respondents' scores on any one indicator tend to be related to their scores on the other indicators – and the closer the number is to 1, the better the reliability (Bryman, 2012). With the score of .87, the IRMAS has a high level of internal reliability.

There are two concerns that should be noted with regards to the scale. The first is that the scale implies that the offender is always male and the victim is always female. While there are arguments to be made about using this scale to measure rape myths across genders, this study was focused specifically on female rape, and therefore the measure was deemed acceptable.

The second concern is that the scale was designed in relation to rape myths that were prevalent within the United States. However, the scale has been used in order to design other RMA measures outside of the United States, such as the Korean Rape Myth Acceptance Scale (Oh & Neville, 2004) and the Chinese Rape Myth Acceptance Scale (Xue, Fang, Huang, Cui, Rhodes & Gelles, 2016), and as such is deemed as a scale that can be used outside of the United States.

3.4. Ethical Considerations

There are four concerns with regards to ethics, namely risk of harm, consent, privacy, and deception (Bryman, 2012). With regards to this study, the first three are relevant as deception was not used nor needed. Each concern will be briefly discussed below.

3.4.1. Risk of Harm

Harm to participants can be viewed in a number of ways, such as physical harm, harm to participants' personal development, and psychological harm by

inducing negative emotions or responses, such as stress (Bryman, 2012). The current study has no risk of harm to the participants[1].

With regards to physical harm and developmental harm, there is no risk seen. There is nothing physically strenuous about the study and there are no personal questions asked from the respondents aside from basic demographic questions. There are no instances in which the respondents must answer questions that break doctor-patient confidentiality, and any service provision questions are simple and precise. As such, there is no concern for harm to personal (or professional) development.

3.4.2. Informed Consent

Informed consent refers to participants being informed formally about the study, which is done for them to have a clear understanding of what is required, in order to provide consent to continue with the study (Bhattacherjee, 2012; Bryman, 2012). As such, participants were given a detailed information sheet which explained what the research involved, why they were chosen, consent, anonymity, and storage of data. This was done to ensure that they were completely aware of what was expected of them and what would happen to the data they provided. If they agree to partake in the survey, the first page they would have been presented with was a consent form which was asking consent of two different aspects of the study:

- Consent to participate in the study and complete the survey.
- Consent that the data they provided would be published within a dissertation, thesis and/or journal article.

Once consent was given, the survey would move on to section one.

[1] The only foreseeable harm was if the respondent is a victim of sexual assault, however, it was deemed in appropriate for the research to ask this of participants. With regards to this concern, the researcher ensured the participants were given a detailed information sheet about what the study entailed which also encouraged them to call the researcher should they have any concerns or questions. Furthermore, in the act of acquiring the email addresses of the participants as described above, the study was explained, allowing participants to know what the subject matter was before the information sheet was delivered. Furthermore, participants were given the option to skip any questions that made them uncomfortable as well as leave the study before or during the completion of the survey.

3.4.3. Anonymity

The current study ensured anonymity for the participants. Anonymity refers to having no record of identity and no potential way for those reading the results to identify the participant through their responses (Bhattacherjee, 2012). Anonymity has two broad benefits, one practical and one ethical (Greener, 2011). With regards to ethics, anonymity ensures that respondents will face no adverse consequences for answering the survey, as no one knows who the participants are. With regards to practice, anonymity can lead to participants being more honest about a topic as controversial as sexual assault and myths/beliefs associated with it. That said, it should be noted that this point is still in disagreement as some researchers suggest anonymity gives people more confidence to lie about aspects such as test scores and experience.

Anonymity was chosen for a number of reasons. First, the survey needed no identifiable information in order to conduct the research, and as such, it was seen as more efficient for the study to be anonymous. Second, with the survey asking questions about a controversial topic – specifically about attitudes on the subject – it was assumed that anonymity would allow participants to be more comfortable answering the survey. With regards to honesty, there was no benefit for participants to lie in section one and three, as they asked no questions about skill or experience aside from how long one had been a doctor. With regards to section two, the section regarding beliefs, honesty was assumed as participants had five options from which to choose from about the statements they were given. This, coupled with the fact that they could choose to skip a question, made it unlikely a respondent would lie.

Finally, it should be noted that while the personal details were needed in order to contact the doctors and acquire their emails, this information is only known by the researcher, and there is still no way to know if those specific doctors answered the survey or what their answers were.

3.5. Conclusion

In this chapter, the research approach was defined and explained. This was followed by explaining the process of the study, detailing the sampling method and the data collection method. Finally, ethical considerations such as informed consent, anonymity, and risk of harm were discussed. Chapter 4 will discuss how the data was analysed and what the results were.

CHAPTER 4: RESULTS

With the data collected through the surveys, there were a number of findings and inferences that could be made. This chapter will detail the findings of the survey, beginning with the demographic data that was collected. The chapter will then move on to discuss the descriptive data found within the service provision questions as well as what the answers to the IRMAS suggest about the current sample. Finally, the chapter will end with the findings of the statistical analyses conducted with the survey data, namely Chi-Square and Regression Analysis tests.

4.1. Demographic Data:

While 44 surveys were answered in total, only 42 respondents answered the demographic section. As shown in Figure 1, the majority of respondents (N = 16) fell between the ages of 35-44 years old. The second highest age grouping was 45-54 years old (N = 12), followed by 25-34 years old (N = 11), and ending with 55+ years old (N = 3).

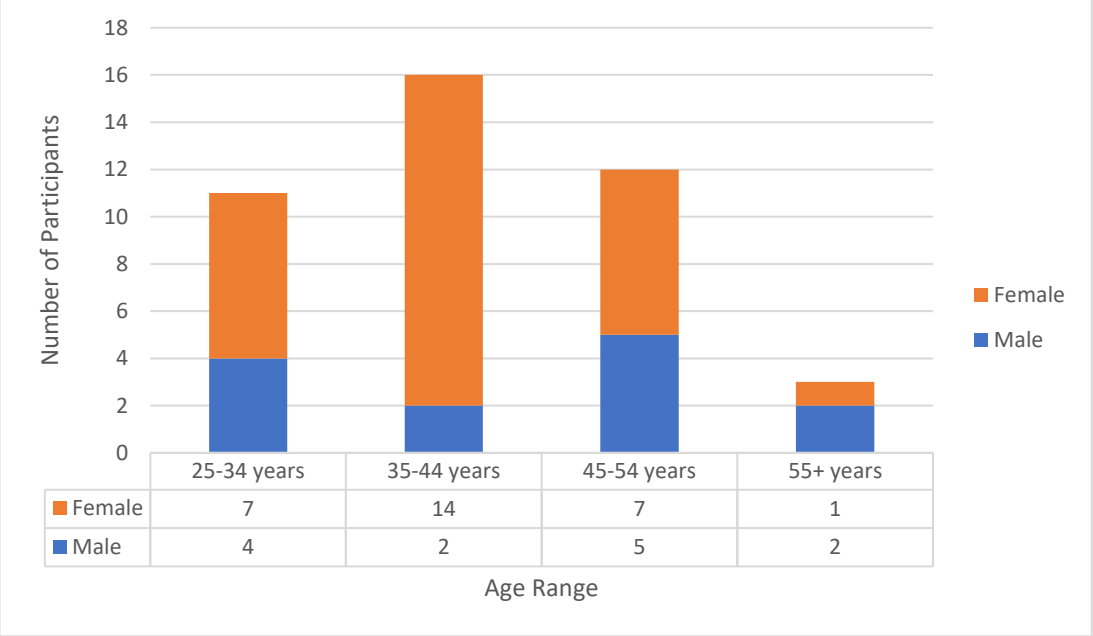

Figure 1: Number of Participants Separated by Age and Gender.

Majority of respondents had less than 5 years of experience as a general medical practitioner (N = 11), followed by 11 and 15 years of experience (N = 10).

This was followed closely by 16 to 20 years of experience (*N* = 9), 6 to 10 years of experience (*N* = 4), 21 to 25 years of experience (*N* = 3) as well as 30+ years of experience (*N* = 3), and ending with 26 to 30 years of experience (*N* = 2).

The survey was answered by more female respondents (*N* = 29) than male respondents (*N* = 13). With women respondents over double that of the men, it could suggest that women may be more comfortable dealing with the topic of sexual assault than men are. Observations made when the survey was physically presented at medical events suggested this, as women were far more likely to approach the researcher (whether or not they took the survey) than men were.

Majority of female respondents (*N* = 14) fell between the ages of 35-44 years old. The second highest age grouping was split between 25-34 years old (*N* = 7) and 45-54 years old (*N* = 7), which was followed by 55+ years old (*N* = 1).

Majority of male respondents (*N* = 5) fell between the ages of 45-54 years old. The second highest age grouping was between 25-34 years old (*N* = 4), while the lowest age groupings were split between 35-44 years old (*N* = 2) and 55+ years old (*N* = 2).

4.2. Service Provision Data:

The South African medical system has several faults, and there is no difference with regards to sexual assault. All hospitals across the country struggle with this problem, as Christofides *et al* (2005) found that there was no definitive pattern of better management when different levels of hospitals – district hospitals, regional hospitals, tertiary hospitals – were compared. Furthermore, survey research carried out at 31 health facilities around the country that treat rape survivors found that one in three health practitioners said they did not consider rape to be a serious medical condition (Gevers, Abrahams, Andrews & Toledo, 2015). As such, it is important to understand how prepared doctors are with regards to rape, as well as their attitudes toward victims and the act.

All 44 surveys were used for the following section, as these questions were to do with service provision of GPs regardless of age, race, and gender. There were several interesting observations found within section one of the survey.

First, while 56.8% of respondents had no formal training in assisting victims of sexual assault and 75% had no formal training with regards to the law, 79.6% of respondents had assisted a victim of sexual assault in their career. There are two pieces of information that can be inferred from this data. The first is that victims of sexual assault do go to their doctors when in need of treatment. The second is that while GPs are not always formally trained with regards to sexual assault and the law pertaining to it, they nevertheless find themselves assisting victims. This is a point of concern, as it has been found that those with high levels of knowledge in assisting sexual assault victims have a more appropriate attitude toward those victims (Jina, Jewkes, Christofides & Loots, 2013).

It should also be noted, as shown in Figure 2, that there are differences in knowledge between doctors who have been GPs for different lengths of time. For example, those who have been doctors for less than 5 years were the only group that had more formal training in assisting a victim of sexual assault than the victims they had assisted. They also had the second highest score for formal training, with the 30+ years group having the highest score. That said, there were more participants in the former group as opposed to the latter, and that could explain the differences. Furthermore, with the need for continuing educational points, it is possible that doctors who have been practicing for 30 years or more have been to conferences and events that in some way handled sexual assault and the law. This is considered plausible, as the 26 to 30-year-old group had higher scores relative to the other groups, especially with regards to the law. This result is counter to previous research, as it was found that older medical providers had lower odds of having high knowledge levels of rape and sexual assault compared to their younger counterparts (Jina, Jewkes, Christofides & Loots, 2013). That said, Christofides *et al* (2005) did find that older staff at health care facilities provided the best care. However, this was found to be linked to the experience those participants had with assisting previous victims, suggesting that more contact with victims may increase service provision.

However, as this study did not ask how many victims a doctor had specifically treated, it is impossible to determine if a higher number has any significant effect.

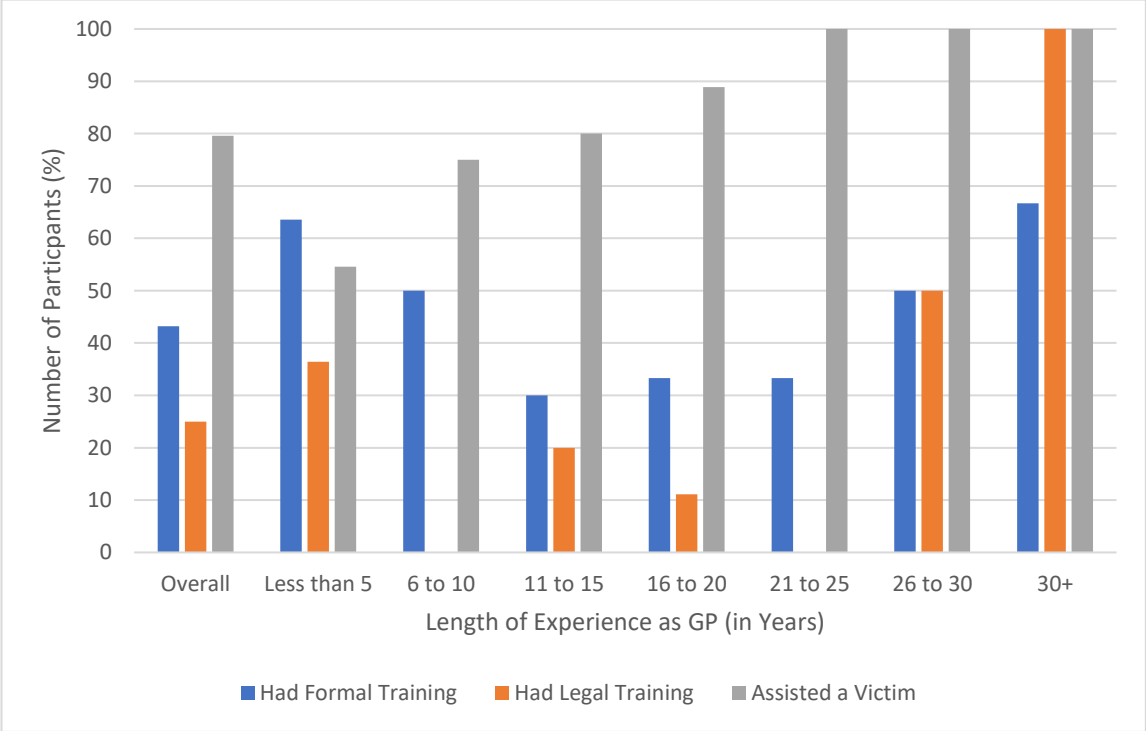

Figure 2: Comparison of Formal Training and Legal Training to Assisting a Victim of Sexual Assault by Years of Experience as a GP.

With regards to the younger group, it is possible that their score for assisting a victim is lower because they have been in the job for less time than other groups, and therefore have had less exposure to victims. This is assumed because as the length as a GP increases, the percentage of assisted victims increases as well. That said, the fact that they have higher levels of formal training than other groups suggest that something has changed either in society or in medical education. Both scenarios are possible.

With the rise of movements against sexual assault such as #MeToo, which reached popularity in 2017, but was used and created by Tarana Burke in 2006, and Time's Up, which was created in 2018, sexual assault is not only something more discussed in society, its myths are also being fought against. In a study conducted to

study rape culture on Twitter (Stubbs-Richardson, Rader & Cosby, 2018), one of the main themes found in a host of tweets was ‘rape myth debunking to support victims’. While those who debunked rape myths were less likely than those who blamed victims to get retweeted, the myth busting was still an integral part of the conversation on the social media site. As such, society is being exposed to a counter-narrative of ‘real rape’ and rape myths, and this could be affecting how different groups – especially those who have a high probability of meeting a victim of sexual assault in their career – are being educated.

Universities across the country, at the very least, appear to be taking sexual assault more seriously on their campuses, as a number of them have updated their sexual harassment policies over the last few years:

- Policy on Unfair Discrimination and Harassment (which includes sexual harassment), Stellenbosch University. Updated 2016.
- Policy on Prevention and Management of Student Sexual Harassment and Rape, University of Johannesburg. Updated in 2018.
- Sexual Offences Policy for Students, Rhodes University. Updated 2019.

Furthermore, universities are attempting to broaden their responses to sexual assault, such as UCT, who has created a specialised sexual offences tribunal (Bernardo, 2019). It is also possible that curriculums are being changed in order for medical students to understand how to assist a victim of rape. That said, curriculums for most universities are not detailed and as there is no one subject at the major institutions across South Africa – Wits, UJ, UCT, UWC, Rhodes, etc. – that is specific to victims of sexual assault, it’s not possible to know if some modules include a section on the crime. However, Fouche *et al* (2018) found that an overwhelming majority of their participants – South African doctors – had undergone some undergraduate training on the management of rape and sexual assault cases. The extent of the training, however, was not specified.

There is data to suggest conflicting feelings with regards to GPs and how they view themselves with regards to victims of sexual assault. For example, while an overwhelming number of respondents (95.5%) believed that GPs should have a greater understanding of sexual assault and its effects than other medical fields, the respondents were split when asked if victims of sexual assault would find better assistance at a hospital emergency room (52.4%) or at their general medical practitioner (47.6%).

Furthermore, when provided with different options on what to do when a victim comes to their practice (as shown in Figure 3), only 18.2% of respondents said they would examine the victim at their offices. Most respondents said they would direct the victim to either a police station (20.5%) or to a hospital (31.8%). It should also be noted that a substantial number of respondents (29.6%) chose the 'other' option and wrote in answers, where just under half stated they would take the victim somewhere else. The other half expanded on what they would do to examine the victim, such as obtaining the necessary equipment. In total, 65.9% of respondents suggested taking the victim somewhere else over treating them at their offices.

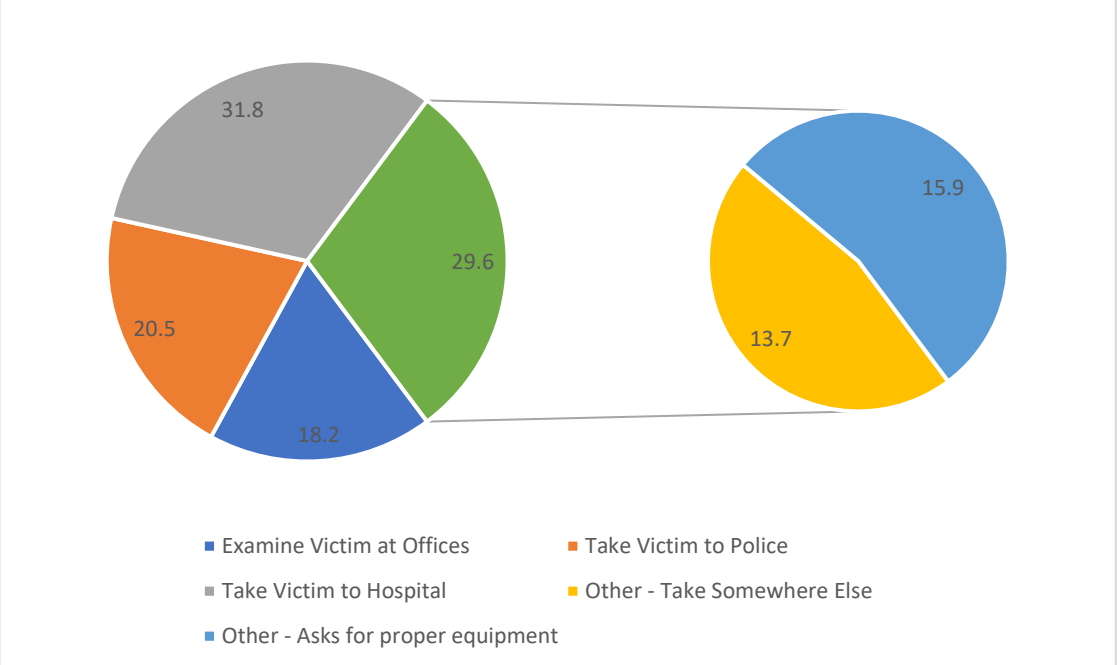

Figure 3: Responses on What GPs Would Do If A Victim Came to Their Offices

This suggests that while these doctors believe they should know more, many of them, at present, have some reason to believe they are not equipped – either physically or with regards to knowledge – to provide better services to the victim than an emergency room or by following the directions of the police. This is understandable, as Fouche *et al* (2018) had two relevant findings on a study of South African doctors: the first was that a substantial number of their participants had no prior knowledge of the Sexual Assault Evidence Collection Kit (SAECK), and the second was that some participants lacked knowledge on the basic principles of clinical forensic examination. As such, doctors may be nervous to assist victims because they are not certain how to.

However, other findings suggest the above attitude could change. When asked if there was anything that could make GPs more prepared to assist victims, only 2.3% said no. The other respondents were split between needing the proper equipment (18.6%), getting online courses with regards to assisting victims (14%), and having formal training with regards to the law (37.2%). However, of the 27.9% of respondents that chose 'other', exactly half stated that all three options were needed. Two other respondents wrote that only the formal training and proper equipment were needed, while the remaining 'other' answers, with one exception, involved acquiring or learning how to use a rape kit. These findings are similar to previous research that showed that health professionals emphasised that the lack of education, protocols, and officially distributed information are important obstacles to overcome with regards to assisting rape victims (Djikanovic, Celik, Simic, Matejic & Cucic, 2010). This makes the fact that many chose to write in 'all options' interesting, as it suggests that not only is the proper equipment needed, but any information, whether it pertains to the law or to service provision, can be used.

There are two observations made from this data. The first involves the law. The fact that many respondents felt the need to understand the law is telling, as it may provide a reason as to why some doctors may not want to examine a victim at their office: they do not know what they are legally allowed to do. If this is the case, it may be considered easier for GPs to send the victims to either a hospital, the police, or another group – such as an NGO – who understand the intricacies of these

cases. Previous research supports this, as Fouche *et al* (2018) found that not all the participants in their study had sufficient knowledge of the J88 form that they were required to complete, a form vital for the investigation into the rape.

The second observation is that majority of respondents need the proper equipment. 79.6% of respondents do not have a SAECK in their offices. While only 18.6% chose the 'proper equipment' option when asked what could be done to improve them assisting a victim, that number rises when the 'other' option is included. Including the respondents who suggested getting proper equipment in their written answers, the number of respondents who want the proper equipment doubles, rising to 37.2%. However, it is not enough to deliver the equipment, but to also have appropriate training.

4.3. Illinois Rape Myth Acceptance Scale Data:

While 44 surveys were answered in total, only 39 respondents answered all questions. As such, a total score could only be found for 39 respondents.

The IRMAS was used to determine the level of RMA of an individual. The scale is comprised of a Likert-type scale with the option of selecting numbers from 1 (strongly disagree) to 5 (strongly agree). The score of each question is added together in order to get a final score. The higher this score, the higher the individuals' RMA levels are. The highest score an individual could obtain was 110. This is mentioned because not only did no respondent reach a score close to that, only one respondent scored over half that number – their score was 56. Every other respondents' scores were lower than 55. The distribution of scores is shown in Figure 4.

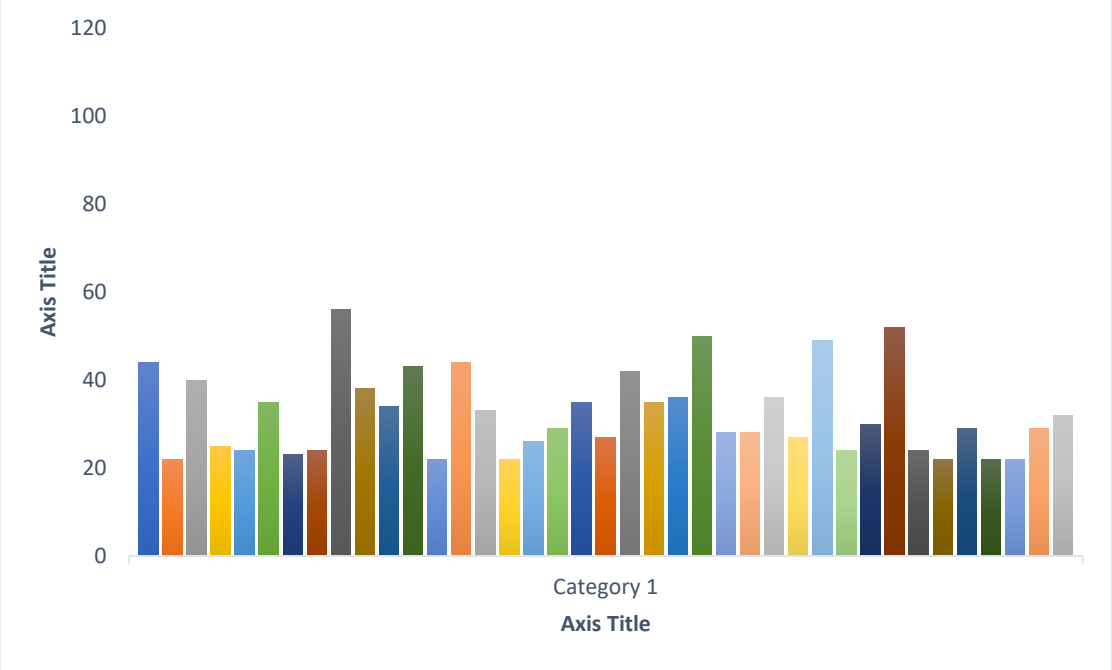

Figure 4: Distribution of Total Scores on the IRMAS for Each Respondent

These scores illustrate that the respondents have low levels of RMA. Using SPSS to calculate the median of each respondent, and therefore be able to get a result in which one of the options from the Likert-scale could be attached to, it was found that all with the exception of one respondent fell between 1 and 2, suggesting that majority of respondents either 'strongly disagree' or 'disagree' with rape myths in general, and therefore have a low level of RMA. The one respondent that scored higher than 2 had a score of 2.5, suggesting that even the highest level of RMA within the sample was closer to the lower levels of RMA.

This is a positive finding, as not only was it found that health care providers with a more appropriate attitude towards rape had significantly greater odds of having high levels of knowledge in rape and sexual assault (Jina, Jewkes, Christofides & Loots, 2013), it was also found that victims valued emotional support from physicians in the form of confidentiality, careful and non-judgmental listening, and reassurance that the abuse is not their fault (Feder, Hutson, Ramsay & Taket, 2006). Those with lower levels of RMA are more likely to treat victims the way they need to be treated.

That said, there is other information that can be seen within this data with regards to specific myths. The IRMAS can be split between four separate subsets, namely: she asked for it; he didn't mean it; it wasn't really rape; and she lied. Within these subsets, the lowest score by a substantial amount were the myths that subscribed to the 'it wasn't really rape' subsets. This suggests that even with those who had higher scores on other constructs, there is a notion that a rape – no matter the 'mitigating' circumstances – is still believed to be a rape. This pattern of not blaming the victim, even with 'mitigating' circumstances present, is found in the literature (Ferro, Cermele & Saltzman, 2008; McMahon, 2007), and thus, the finding is not surprising.

Another finding of interest was how varied the responses of any one respondent was, in that one could assume a respondent who answered 'agree' or 'strongly agree' to certain questions may answer 'agree' or 'strongly agree' to most questions. However, this was not the case. While there were respondents who had 'strongly disagree' across all 22 questions, not one respondent had only 'agree', 'neutral', or 'strongly agree' across the survey. Every respondent answered 'strongly disagree' or 'disagree' numerous times. This adds to the notion that certain myths are more prevalent in society and that the respondents in this sample do not give the same weight to all rape myths, which, once again, are similar findings to previous studies (Carroll, Rosenstein, Foubert & Clark, 2016; Lee, Kim & Lim, 2010; McMahon, 2010).

With regards to separate questions, there were certain myths that had a range of answers (see Table 1). While many myths had moderate to strong levels of 'strongly disagree' (60% or higher), there were some where 'strongly disagree' fell below 50%. For example, with the myth suggesting that men get sexually carried away, 'strongly disagree' was only on 47.6%. Neutral was at 11.9% and agree was at 9.5%. However, the interesting number for this question was 'disagree', which was at 31%. This suggests that while there was a good number of respondents who felt this myth was completely false, a substantial size of respondents felt the myth had enough validity to choose the 'disagree' option.

Table 1

Frequency of Each Category for Each Statement in the IRMAS with Percentage

Question	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
She Asked For It					
Q1	39 (88.6%)	4 (9.1%)	1 (2.3%)	0 (0%)	0 (0%)
Q2	36 (81.8%)	5 (11.4%)	1 (2.3%)	1 (2.3%)	1 (2.3%)
Q3	36 (81.8%)	7 (15.9%)	1 (2.3%)	0 (0%)	0 (0%)
Q4	26 (59.1%)	7 (15.9%)	5 (11.4%)	6 (13.6%)	0 (0%)
Q5	32 (74.4%)	10 (23.3%)	0 (0%)	0 (0%)	1 (2.3%)
Q6	28 (63.6%)	8 (18.2%)	4 (9.1%)	3 (6.8%)	1 (2.3%)
He Didn't Mean It					
Q7	27 (61.4%)	10 (22.7%)	4 (9.1%)	1 (2.3%)	2 (4.6%)
Q8	20 (46.5%)	14 (32.6%)	5 (11.6%)	4 (9.3%)	0 (0%)
Q9	27 (61.4%)	11 (25%)	3 (6.8%)	2 (4.6%)	1 (2.3%)
Q10	25 (56.8%)	11 (25%)	4 (9.1%)	4 (9.1%)	0 (0%)
Q11	40 (90.9%)	1 (2.3%)	2 (4.6%)	1 (2.3%)	0 (0%)
Q12	35 (79.6%)	7 (15.9%)	1 (2.3%)	1 (2.3%)	0 (0%)
It Wasn't Really Rape					
Q13	38 (86.4%)	5 (11.4%)	0 (0%)	1 (2.3%)	0 (0%)
Q14	37 (84.1%)	6 (13.6%)	1 (2.3%)	0 (0%)	0 (0%)
Q15	39 (90.7%)	4 (9.3%)	0 (0%)	0 (0%)	0 (0%)
Q16	41 (93.2%)	2 (4.6%)	1 (2.3%)	0 (0%)	0 (0%)
Q17	32 (74.4%)	8 (18.6%)	2 (4.7%)	1 (2.3%)	0 (0%)
She Lied					

Q18	21 (47.7%)	14 (31.8%)	9 (20.5%)	0 (0%)	0 (0%)
Q19	21 (48.8%)	11 (25.6%)	10 (23.3%)	0 (0%)	1 (2.3%)
Q20	23 (53.5%)	13 (30.2%)	6 (14%)	1 (2.3%)	0 (0%)
Q21	25 (58.1%)	13 (30.2%)	2 (4.7%)	1 (2.3%)	2 (4.7%)
Q22	16 (38.1%)	13 (31%)	5 (11.9%)	8 (19.1%)	0 (0%)

The above observation may appear innocuous; however, it provides insight into how people construct their opinions of rape myths. Linking to the notion that respondents grappled with different rape myths in different ways, and therefore provided a range of answers across the twenty-two myths, these results show that for certain myths, while there is overall 'disagreement' of them, there is something about them that forces a good chunk of respondents to find some validity within them.

In the question given above, less than half strongly disagreed with the myth. This means that over half of the respondents had some reservations about it being a complete myth. Other myths that fall into this category include 'a lot of times, girls who say they were raped agreed to have sex and then regret it' (Q18), 'rape accusations are often used as a way of getting back at guys' (Q19), and 'girls who are caught cheating on their boyfriends sometimes claim it was rape' (Q22). It should be noted that of the four myths where 50% or less of respondents chose 'strongly disagree', three of them are in the subcategory 'she lied'. This is interesting, as previous research (McMahon, 2010; Wentz & Archbold, 2012) has found this subset to be prominent compared to other subsets.

While there were four myths that fell under 50% for strongly disagree, there were three myths that had 90% or more for strongly disagree. These myths were: 'it shouldn't be considered rape if a guy is drunk and didn't realize what he was doing' (Q21), 'a rape probably doesn't happen if a girl doesn't have any bruises or marks' (Q25), and 'if the accused "rapist" doesn't have a weapon, you really can't call it rape' (Q26). Two of the three appear in the 'it wasn't really rape' subset, a subset where all five questions have high levels of disagreement. However, it is of note that

the two that breached the 90% mark were the two that suggested the threat or the suffering of physical violence.

Another observation that should be noted is the first myth of the three, in that it shouldn't be considered rape if he is drunk and didn't realise what he was doing. This is of interest because of the myth before it: 'if a guy is drunk, he might rape someone unintentionally' (Q20). While these two myths are different, they share common themes: alcohol consumption, which is a significant aspect in assessing sexual assault, and exonerating the perpetrator. What is interesting about these myths is that while the first has 'strongly disagree' at 90.9%, the second question has it at 56.8%. Therefore, in the same sample of doctors, there is something about these two myths – myths that are next to each other in the scale – that means one is considered more viable than the other. Once again, this illustrates how different myths, and even different wording, can affect how individuals understand and react to these myths.

4.4. Statistical Analysis

A regression analysis was conducted to establish if there was a relationship between the IRMAS total scores and the variables of age, gender, length as a GP, formal training with regards to sexual assault, and if they have assisted a victim of sexual assault or not. There was no significant relationship found between RMA scores and any of the other variables. Furthermore, when a regression test was run for the separate subsets of the IRMAS against the same variables, there was no significant relationship found.

Multiple chi-squared tests were run in order to determine if RMA levels differed with regards to the variables of age, gender, length as a GP, formal training with regards to sexual assault, and if they have assisted a victim of sexual assault or not. The level of RMA of participants did not differ by: gender, X^2 (1, N = 37) = 1.53, p = .39; age, X^2 (1, N = 37) = 1.71, p = .64; length as a GP, X^2 (1, N = 37) = 5.37, p = .36; formal training, X^2 (1, N = 39) = .07, p = 1; or assisting a victim of sexual assault or not, X^2 (1, N = 39) = .002, p = 1. There was also no significant

relationship found when the same test was run but the total score was replaced with the scores of each subcategory.

These results are mostly counter to findings in other studies. For example, while gender is found non-significant in some studies (Goodman-Delahunty & Graham, 2011; Wentz & Archbold, 2012), an overwhelming number found that men were more likely to believe in rape myths than women (Basow & Minieri, 2011; Boakye, 2009; Carroll, Rosenstein, Foubert and Clark, 2016; Chapleau & Oswald, 2013; Grubb & Harrower, 2009; Hayes, Lorenz & Bell, 2013; Sleath & Bull, 2015; Suarez & Gadalla, 2010). Age was also a factor that was found to predict RMA (Burt, 1980; Sussenbach & Bohner, 2011). That said, formal training has not always been found to decrease RMA (Lee, Lee & Lee, 2012; Sleath & Bull, 2015).

It is possible that there is no significant relationship between the above variables and RMA levels in this study. However, it should be noted that because of the small size of the sample, it could be that there are not enough data points to find a relationship if one exists. However, as it stands, there is no significant relationship found within this specific sample.

4.5. Observations of Live Events

While the study was quantitative in nature, there were interesting observations made at the live events where certain surveys were completed. To begin with, as mentioned above, female doctors were far more interested than male doctors in approaching the table. Secondly, gynaecologists were more interested in discussing the subject matter and the study, even after they were informed that they did not fit the parameters of the survey. This could be an avenue for future research, as female victims may be more comfortable confiding in their gynaecologists than their GPs.

Thirdly, many participants commented on the current events that had occurred in recent times, namely the protests for Uyinene Mrwetyana and the conversations discussing the effects of gender-based violence in South Africa. This

may have had an effect on those who chose to answer, affecting either their actual answers or their decision to take the survey.

Finally, a number of participants wished to speak about specific questions, illustrating their thought processes in their answering. For example, one participant asked how the survey, and the study, was defining the word ‘slut’ which appeared in one of the statements. The participant suggested that the word ‘slut’ would have different meanings to different people, some of whom may not care about how promiscuous a woman is or is perceived to be.

Another participant left a note on their survey, specifically for the statement (Q31): ‘a lot of times, girls who claim they were raped have emotional problems’. While the participant had answered ‘agree’ to the statement, their comment suggested the opposite, as they took the question to mean that anyone who is raped will have emotional problems, while the myth that the question is referring to is that women lie about rape because they have emotional problems. These interactions may be anecdotal, however, they do illustrate the complexity of how individuals think about rape myths and the terms that come along with rape and sexual assault.

These questions and conversations were only addressed and discussed after the participant had finished the survey and it was placed in the box.

4.5. Conclusion

Using the data collected with the survey, a number of observations were made with regards to GPs and how prepared they are to provide services to victims of sexual assault. The data was also used to gauge the level of RMA of the sample, which is considered low. Chi Squared and Regression Analysis tests were run to determine if there were any significant relationships between the scores and the variables of gender, age, length as a GP, formal training, and the assistance of a victim. There was no significant relationship found within this sample.

Chapter 5 will discuss the interpretation of this data in relation to the literature review discussed in Chapter 2. The chapter will also contain limitations of the current study, suggestions for future research, and concluding thoughts.

CHAPTER 5: INTERPRETATION, LIMITATIONS OF RESEARCH, AND CONCLUSION

The aim of the current study was to explore knowledge and attitudes about sexual assault with regards to general practitioners. This was done through the use of a survey that both asked about provision questions and examined the strength of their beliefs in certain rape myths. There were several findings – explained in Chapter 4 – that assisted in understanding how GPs consider and think about rape. As such, the current chapter will discuss each of these findings in relation to the literature review discussed in Chapter 2. Furthermore, once these findings are addressed, the chapter will end off with reflections on the study, the value of the study, and suggestions for future research.

5.1. General Medical Practitioners and Overall Rape Myth Acceptance

The sample of the current study were revealed to have low levels of RMA, with only one respondent getting over half the total possible score. Though research suggests the concept of 'real rape' is prominent in society (Anderson, 2007; Du Mont, Miller & Myhr, 2003; Horvath & Brown, 2009), it is not a prominent finding in this study. In fact, the statements closest to 'real rape', statements which included the victim not resisting or the offender exhibiting greater acts of violence, had some of the highest 'strongly disagree' scores in the study.

This raises the question of the strength of 'real rape' in the medical field. Combatting rape myths through the years has been focused on the concept of 'real rape'. However, if 'real rape' is not a concern within the medical field, it may be prudent to focus on the myths that were more prevalent. In other words, while the movement in society has appeared to have a positive effect in this sample of medical practitioners with regards to 'real rape', it may be time to discuss more ambiguous myths. Furthermore, it may also be prudent to discover the kind of training GPs are receiving that has assisted in lowering their levels of RMA, in order to see if it can be viable for other types of medical professionals as well as other professionals (e.g. lawyers, nurses, police officers) that come into contact with sexual assault victims.

There are four general types of rape myths (Bohner *et al*, 2009): victim-blaming myths, myths that question the legitimacy of the rape, myths that excuse the perpetrator, and myths that suggest that there is a specific type of woman who is raped. It has been shown that specific types of rape myths are believed more than others (Carroll, Rosenstein, Foubert & Clark, 2016; Lee, Kim & Lim, 2010; McMahon, 2010). The current study somewhat supports these findings. Even though the overall RMA was low, there were certain myths that caused more uncertainty than others. These myths were interesting as three of them were part of the subset 'she lied'.

Furthermore, as seen in Table 1 (see Chapter 4), the subsets that received the least 'strongly disagree' scores were 'he didn't mean it' and 'she lied'. This is interesting as it fits with other studies that have examined subsets. For example, McMahon (2010) and Carroll *et al* (2016) both found that their most prominent rape myths involved women lying about rape and denying the perpetrator's culpability. It is possible that these two subsets are the most common subsets as they speak specifically to the people as individuals, instead of the crime and the context of the crime.

The reason for this assumption is because research has found that even in situations where the crime is unambiguously rape, there are still people who endorse rape myths which excuse the perpetrator's behavior (Deming *et al*, 2013). As such, it is possible that these subsets should be separated into two categories: the context of the crime ('it wasn't really rape' and 'she asked for it') and the motives of the victim and offender ('she lied' and 'he didn't mean to').

For medical practitioners, the fact that 'she lied' myths are the most prominent myths – despite overall RMA being low – is a concern, as medical practitioners will assist the people those myths are ascribed to. While police and prosecutors may struggle with rape as a crime, doctors will always be faced with the individual who the crime was committed against. If their biases allow them to judge a victim based on what they assume her motives are, it may lead to lower levels of appropriate care – if the doctor chooses to examine her at all.

This raises questions about a point made above, in that if ‘real rape’ is not as prominent a concept in medical communities as it is in society as a whole, are there certain myths that are prominent? The answer may be yes, in which case further care should be taken in how medical practitioners are educated about sexual assault, including information dispelling myths about how victims should behave.

It should be noted that the ‘it wasn’t really rape’ subset was the subset with the lowest scores. However, this was unsurprising as most of the statements for that subset placed blame on the victim, and as it was established, it is not uncommon for studies to find that participants avoid directly blaming the victim for the crime (Ferro, Cermele & Saltzman, 2008; McMahon, 2007)

Finally, education appears to play a role with regards to rape myths (Burt, 1980; Lee, Lee & Lee, 2012; Page, 2008; Sussenbach & Bohner, 2011), as those with lower education were found to have higher levels of RMA. The current study somewhat supports this finding, as doctors are highly educated and the participants in the study had low levels of RMA. However, as education was not a specific variable that was studied, this is an assumption based on the respondents’ experience and status as doctors.

That said, the fact that all participants had low levels of RMA does suggest that something about the medical field could be influencing how GPs view sexual assault. While it may be education as a whole, other factors could be involved, such as specific seminars for continuing education points. Furthermore, education may be less of a factor than physical exposure to victims of sexual assault, which doctors – and specifically the participants of this study – are likely to come into contact with. It may be that doctors are learning with each new victim which, while not a desired form of education, may be influencing their views, nonetheless.

5.2. General Medical Practitioners, RMA, and Demographics

The current study did not find the same results as other studies with regards to gender and RMA. Majority of studies found that there is a relationship between RMA and gender (Basow & Minieri, 2011; Boakye, 2009; Carroll, Rosenstein,

Foubert and Clark, 2016; Chapleau & Oswald, 2013; Grubb & Harrower, 2009; Hayes, Lorenz & Bell, 2013; Sleath & Bull, 2015; Suarez & Gadalla, 2010), in that men were more likely to believe in rape myths than women were. However, this study's results resembled that of Goodman-Delahunty and Graham (2011) and Wentz and Archbold (2012), who found no relationship on gender.

However, it should be noted that there may be two reasons why the common finding did not appear in this study. The first is that the sample was too small to find any significant difference. The second reason may be because of the nature of the sample, in that they were doctors. The strength of gender as a factor in RMA levels is significantly reduced when other factors, especially education, are taken into account (Boakye, 2009) and as doctors are highly educated, it is possible that the effect of gender was minimised. However, as this study did not collect information on the different education the respondents have gotten, and only asked about years as a GP, this notion is mere speculation.

It is also possible that those who took the survey were less likely to hold traditional views on gender roles, which are linked to high levels of RMA. However, once again, views of gender roles were not examined in this study, and as such, cannot be spoken to. With that said, the fact that there was no correlation with this sample is a positive finding, as it suggests that factors other than gender may be more crucial to examining RMA.

With regards to age, there was no significant relationship found. This goes against previous findings (Burt, 1980; Deming *et al*, 2013; Sussenbach & Bohner, 2011). That said, it is possible that, once again, the sample was too small to find a significant relationship. However, it should be noted that the oldest respondents in the study scored high in formal training in sexual assault and formal training in the law about sexual assault, and as such, understood more about rape than ordinary people. This implies that specialized training may have the effect of lowering RMA.

5.3. General Medical Practitioners, RMA, and Other Professionals:

While it is difficult to speak to how medical practitioners and other occupations compare on how they approach victims of rape, because they approach them with different goals in mind, it is possible to compare the specific myths they believe. For example, while Ask (2008) found that officers used intoxication in their assessment, the current study showed that three of the four rape myths that referenced alcohol all had high levels of 'strongly disagree' – all around 90%. These three myths spoke to the victim's behavior – the aspect the police used intoxication to assess – while the fourth myth was specifically about the perpetrator.

With regards to lawyers, there were also differences in this research compared to other studies. For example, Krahé, Temkin, Bieneck and Berger (2008) found that lawyers considered the perpetrator was more liable when his victim was a stranger and he used force – two of the four elements of 'real rape'. Furthermore, a South African study (Rumney & van der Bijl, 2010) revealed that lawyers expected a woman to physically resist her attacker and to be visibly upset when reporting the crime. Once again, RMA was low for the current study, and with regards to the myths regarding the 'victim physically fighting back or it could not be considered rape', both statements – statement 23 and 24 – had high levels of strongly disagree (86.4% and 84.1%, respectively).

This presents an interesting question: is there overlap of how different professions interact with sexual assault victims? If police, lawyers, and medical professionals focus on the victims, then it may be prudent to examine how they approach victims differently. Furthermore, the inverse is also something to consider: are there myths that certain professions believe that others do not? This is something to consider, as it was shown in this study that alcohol consumption had low scores for acceptance, while for police officers it was considered an important aspect in some cases. That said, the difference may be because officers are attempting to measure the validity of the claim, while a doctor's duty is to provide healthcare. As such, different professionals approach the crime differently, and that should be taken into account when examining the prominent myths in each field.

Finally, Rumney and van der Bijl (2010) found that there were no differences between those who studied criminal law compared to those who did not with regards to their views on rape myths. This suggests that a certain level of education may not matter when compared to the type of education. In other words, it may be beneficial to not only teach doctors about the law, but also about how the law is applied and what their responsibilities are. If there were no differences found for lawyers, it is possible that doctors learning about the law and only the law may not be enough to curb certain views on rape, and on how rape victims should behave. As such, South Africa should consider a comprehensive, holistic view when teaching medical professionals subjects that interact with sexual assault. In other words, doctors should be able to attend continuing education events that focus specifically on the law, assisting victims of rape both medically and legal (e.g. filling out the J88 form), and sexual assault.

5.4. General Medical Practitioners and Service Provision

In South Africa, the focus on the care for sexual assault is on forensic examination, biomedical intervention, and legal advocacy (Gevers, Abrahams, Andrews & Toledo, 2015). This finding is somewhat at odds with the current study, as the results suggested that many doctors neither had nor knew how to properly use a rape kit. As such, it is possible that the notion that the focus of sexual assault is on forensic examination is about practitioners in emergency rooms or hospitals at large. However, private GPs may not have the focus on forensic examination that other types of doctors have. Furthermore, though it was not asked, it can be assumed that the doctors in this sample were not familiar with certain legal and investigative requirements, such as the J88 form, as many of them (58%) suggested that they needed training in the law.

In a country where sexual assault rates are high, the need to have proper evidence and documentation is important to giving the victims justice. The findings relating to the readiness of doctors to treat victims – such as having a rape kit, or having formal training in the law – are concerning, as it appears that most doctors in

this sample are not ready to assist a victim, despite many having done so before. As such, this raises the question of the readiness of doctors to assist patients from a healthcare perspective, but also help law enforcement from a forensic perspective. This lack of readiness may add trauma to an already traumatic experience.

Victims of sexual assault need proper care that involves not only physical health but psychological counselling, as they themselves have demanded (Li, Wu, Su, Chen, Shen, Chou, 2016). In South Africa, it was found that patients were even willing to trade certain things, such as lengthy time travelled and waiting, if they were ensured proper counselling and a rigorous examination (Kim *et al*, 2009). In fact, the same study found that having a lengthy examination that could influence the legal outcome was also viewed as desirable, especially among rural women.

These views are somewhat shared by the respondents of the current study, as only 2.3% suggested that nothing more could be done to prepare GPs for assisting victims, while an overwhelming 95.5% of respondents believed that GPs should have a greater knowledge of sexual assault than other medical fields. As such, it is possible that while GPs are not as adept in rape kits and knowledge of the law as they would prefer to be, they are willing to learn in order to deliver the proper care.

That said, service provision itself is a problem, as Fouche, Bezuidenhout, Liebenberg and Adefuye (2018) found that doctors lacked knowledge on the basic principles of clinical forensic examination and that a substantial number had no prior knowledge of the SAECK. This finding is supported in this study, as not only did a substantial number of respondents (37.2%) stated they needed proper equipment to assess a victim and an overwhelming number of respondents (79.6%) stated they did not have a SAECK in their offices, almost one in three respondents (31.8%) suggested that they needed proper courses in assisting victims of sexual assault.

This is another point of concern. The fact that GPs may not have a SAECK in their offices is concerning. While some may argue that most sexual assault victims should report to a police station or emergency room and, therefore, GPs do not necessarily need SAECKs on-site, the reality of rape in South Africa is counter to that argument. Rape is a crisis in South Africa, and as it is a crime that is known to

be underreported, the numbers of rape cases may be higher than the country knows. As such, it is not implausible – and in the context of the data this study found, uncommon – for victims to assume GPs can assist them. As such, the nature of this crime as well as the results of this study suggest that, not only should GPs have a greater knowledge of the crime and how to assist victims both legally and physically, they need to have access to the proper equipment as well.

The current study found that while GPs think they should have a greater knowledge of sexual assault, they are still cautious when assisting a victim. For example, a majority of them (65.9%) stated they would take a victim somewhere else were they to come into their office. This suggests that the current sample believes that in some way either the police or hospitals, or in some cases NGOs, have better experience with assisting victims. This finding is interesting, because it may support or be counter to one by the Gender, Health and Justice Research Unit (Rohrs, 2011) in which medical professionals showed restraint to examining a rape victim if they had not gone to the police first because they believed the victim may be lying. It is possible that the current sample suggested taking the victim somewhere else because they were skeptical of whether or not the victim was being truthful. However, considering the low levels of RMA in the sample, it is possible that the opposite is true, in that they believed the victim and considered their skills or resources inadequate for the situation.

Finally, the Gender, Health and Justice Research Unit (Rohrs, 2011) found that health care professionals had negative views of victims, specifically when the victims were not injured, did not appear traumatised, or were intoxicated at the time. These findings were not supported in this study as the participants had low levels of RMA and the statements that were related to violence and alcohol had high levels of ‘strongly disagree’. However, this does raise the question of the difference between doctors in private practices and other types of medical fields, in that those who work in hospitals or as professionals that are not GPs may have vastly different views than those of this study.

5.5. Reflections on the study

The current study was conducted to examine GPs' knowledge and attitudes associated with sexual assault. The study's findings with regards to attitudes was encouraging, in that all participants had fairly low levels of RMA. While there were myths – as discussed above – that still held some 'mitigating' factors, overall, the results were positive. All rape myths had high levels of disagreement, which suggests that something – be it society, training, or exposure – is ensuring that medical practitioners are at least thinking through the myths that are presented.

Furthermore, the fact that the subset 'it wasn't really rape' returned some of the lowest scores of the survey was encouraging, as many of those statements were related to the concept of 'real rape'. This suggests that the concept was not strong within this sample. However, while that remains a positive point, it must be noted that other studies have found that doctors in South Africa do not think rape is a serious crime (Gevers, Abrahams, Andrews & Toledo, 2015; Rohrs, 2011). These studies suggest that the story of RMA and service provision in hospitals may be counter to the findings of this study. As such, there is more work to be done with regards to rape myths and doctors with regards to what the community as a whole thinks, but also the differences between those who work in private practices versus doctors who work in emergency rooms.

With regards to the knowledge GPs possess, and as such, the level of service provision they provide, the results are not as encouraging. To begin with, the lack of training with regards to sexual assault as a crime and with regards to the law is concerning, specifically because doctors need to attend events for continuing education points. This suggests that either events are not covering topics related to victims of sexual assault or the law regarding the crime, or doctors are not attending those events. Either case is worrying.

Secondly, the lack of SAECKs in doctors' offices is another point of concern, which was discussed above. However, the lack of equipment combined with the lack of formal training shows a gap in service provision when it comes to GPs assisting sexual assault victims. Considering that almost 80% of the sample in this study

assisted a victim of sexual assault, there should be a significant movement to get doctors the proper equipment and training. For a healthcare perspective, the benefits of this appear to be obvious: if doctors are better prepared, then there will be better service provision. However, with regards to how doctors are linked to the law with regards to rape cases (such as using the J88 form), another benefit to having proper training and equipment may be better outcomes in the justice system. Proper records of the incident as well as evidence that was collected correctly can have significant effects on, at the very least, separate cases.

Despite interesting findings, the current study had a number of limitations, all of which stem from one concern. Firstly, because of the small sample, the findings could not be generalised to the greater population. Furthermore, it is plausible with a larger sample size, significant differences may appear with regards to variables such as gender, age, and experience.

A second limitation was the nature of the sampling. With low response rates, live events needed to be attended in order to get enough surveys. It is possible that those who chose to take time out of the conference to complete the survey were more knowledgeable, or at least interested, in the subject of sexual assault with regards to their field. As such, it is possible that the level of RMA in this study was low because those who answered it chose to do so based on personal beliefs and feelings.

Finally, as Bryman (2012) has stated, surveys pose a greater risk of missing data and lower response rates. Both these disadvantages were found within the current study, and contributed to the small sample size. Future research should take this into account and try to find a way to balance needing information from individuals with time-consuming jobs about controversial topics.

These three limitations all share a common theme: sampling, sample size, and the difficulty of doctors participating in the current study. The current sample size is small, which is a concern considering how labour intensive the search for participants was. The study began with asking doctors to answer the survey online, finding their emails or contact details through databases. When the responses where minimal, the researcher began physically delivering the surveys to doctors' offices.

Furthermore, continuing education events were attended in order to receive more responses. Through two streams of physical copies (offices and events) and an online link, the study only returned 44 surveys over a year and a half. This is a point of concern in terms of research with regards to GPs, as access to this population is difficult.

It is not entirely known what the exact difficulty of accessing this population is, but there are number of assumptions that can be made. The first is their lack of time, as GPs do have active schedules. The second assumption as to why response rates were low is the nature of the current study. While there may have been professionals who answered the survey because they were more knowledgeable or interested in the subject, there may have been those who avoided the topic – especially in the year 2019, when there were protests and public discussions about GBV. Furthermore, there were moments in which the researcher was referred to the practice director, who would often suggest that they would need to see if the doctors could legally answer the survey – these statements were usually said before a copy of the survey was presented but after the topic was revealed. As such, it is possible that it was not the topic that was the point of concern, but the fear of legal retribution. What that retribution would be is unknown, but the assumption can be something along the lines of breaking doctor-client confidentiality.

As GPs were found to be a difficult population to gain access to, there should be more focus in future research on how to address this problem. There are two avenues one could take in order to do this: the path of access and the type of research. In terms of access, it may be beneficial if research similar to this was conducted with the help of an organisation that has links to GPs, such as governmental health departments, or private medical organisations, such as ASAIPA. These organisations/departments will not only have access to a database of doctors, but they will also bring a level of credibility and reassurance to the study – especially for controversial or severe topics.

In terms of the type of research, it may be more prudent to conduct research with GPs as action-oriented research. As GPs tend to have active schedules, it may be easier to have them participate if they knew the research being conducted was for

the purpose of improving practices, strategies, and knowledge. In other words, if they found that they would receive something from the research to improve their service provision, it may be an incentive for more of the population to participate.

5.7. Future Research

There are a number of avenues future research could take. Firstly, the study could be replicated but with a larger sample. Secondly, based on the comments received at the live events, a qualitative study could be conducted on specific rape myths statements to understand how participants formulate their opinions on these myths. Thirdly, more in-depth research into the knowledge GPs have could be conducted, such as learning if they know how a rape kit works, if they know any legal aspects of rape cases, and if they have any knowledge of the J88 form. Finally, research into RMA should not stop at GPs, and the RMA levels of other professions that interact with rape victims – such as police, lawyers, judges, nurses, and therapists – should be studied.

5.8. Value of the study

The current study has value as it has provided insight into how GPs in South Africa think about rape myths and sexual assault. Furthermore, the study revealed some gaps in assisting victims of sexual assault, such as the lack of SAECK in offices, and lack of knowledge in the law. As such, this research could be used to help develop educational programmes to assist GPs on assisting victims that they come into contact with. Finally, while it is acknowledged that information from the current study cannot be generalized due to the sampling method and small sample size, it has value as it provides information regarding RMA in GPs, which can be used as a stepping-stone to a bigger, more comprehensive study of this phenomenon.

5.9. Conclusion

Rape myths and RMA are complex concepts that deserve further examination. Furthermore, the service provision for rape victims in South Africa is not at the high standard it could be with regards to GPs. The current chapter examined these concepts and problems, using the data of the study and the literature review to provide a view into how GPs think about rape and the gaps in assisting victims of sexual assault. The concluding thoughts were that, even though this sample had low levels of RMA, more work needs to be done in service provision. The current study was not without its limitations, and there is more research to be conducted in order to effectively understand how doctors think about rape and rape myths. With that being said, the researcher believes that this study has added some helpful insight into the knowledge and attitudes of GPs with regards to sexual assault, and it is hoped that this study's contribution will motivate further research.

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APPENDIX A: CONSENT FORM

Project Title: Exploring Knowledge and Attitudes About Sexual Assault Among General Medical Practitioners in South Africa

Chief Researcher: Dr Kelley Moult

Student Researcher: Demitri Liountris

I have been asked to take part in the University of Cape Town research project specified above. I have read and understood the Explanatory Statement and I hereby consent to participate in this project.

Furthermore, by marking this document, I understand that:

- My participation was entirely voluntary
- My identity and the identity of others will be anonymous
- The data provided will be stored and held for a 10-year period

I consent to the following:	Yes	No
Participating in this project and completing the survey.	☐	☐
The data I provide (in conjunction with other data) will be published within a dissertation, thesis and/or journal article.	☐	☐

APPENDIX B: INFORMATION SHEET

Project: Exploring Knowledge and Attitudes About Sexual Assault Among General Medical Practitioners in South Africa

Kelley Moult	Demitri Liountris (Student Researcher)
Director of the Centre for Law and Society Phone: 021 650 1285 email: kelley.moult@uct.ac.za	Phone: 082 605 1018 email: dimitri.liountris@hotmail.com

Hello, my name is Demitri and I am conducting research towards a Masters Degree. You are invited to take part in this study. Please read this Information Sheet in full before deciding whether or not to participate in this research. If you would like further information regarding any aspect of this project, you are encouraged to contact the researchers via the phone numbers or email addresses listed above.

What does the research involve?

The aim of the study is to explore knowledge and attitudes about sexual assault from general medical practitioners. The research also involves questions with regards to service provision towards victims of sexual assault.

You will be asked to participate in a survey containing several questions about sexual assault. Please read this explanatory statement in full to understand the details of the study, after which you will be asked to give consent. The survey will take anywhere between 5 to 10 minutes to complete.

Why were you chosen for this research?

You were chosen to participate in this research as it is specifically focused on general medical practitioners. The recruitment took place across a range of medical practices across the country, and participants needed to be practicing as general medical practitioners at the time of the study. Your contact details were either obtained from the Discovery insurance database, online websites, at medical events,

or the survey was delivered directly to your offices.

Consenting to participate in the project and withdrawing from the research:

This study is completely voluntary and you are under no obligation to participate. A consent form will be provided (both physically and/or electronical) and must be completed. With this consent, you will be agreeing to take part in the study and have the data from your survey used in a Masters Dissertation. You may withdraw at any time before the survey is returned. However, once the survey is submitted, participants may no longer withdraw.

Possible benefits and risks to participants:

Through your participation in the study, you will benefit in contributing to the existing body of knowledge within the field. If the participants wish, they may opt to receive a fact sheet or links with more information about sexual assault and aspects related to the crime. There are no known physical or psychological risks in taking part in this study.

Confidentiality/Anonymity:

The survey will be anonymous. The survey will not record any identifiable information such as a name or identification number, nor will your details be placed on any other kind of documentation. The data you provide today will be input into a database with other data. At no point will your name be on any piece of paper or database that this data appears.

Storage of data:

The data will be stored on a secure computer and external hard-drive. The data will be kept for 10 years, after which it will be disposed of in accordance to the University of Cape Town policy and regulations.

Results:

The results will be available in thesis form and should be expected sometime at the end of the year 2019. If participants wish to view these results, they may request access to the results via the student researcher, Demitri Liountris, in which they will receive a research brief with the findings of the current study.

Concerns About The Study:

If you have concerns about the research, its risks and benefits or about your rights as a research participant in this study, you may contact the Law Faculty Research Ethics Committee Administrator, Mrs Lamize Viljoen.

Phone Number: 021 650 3080

Email: lamize.viljoen@uct.ac.za.

Alternatively, you may write to the Law Faculty Research Ethics Committee Administrator:

Room 6.28, Kramer Law Building, Law Faculty, UCT, Private Bag, Rondebosch 7701.

APPENDIX C: SURVEY

I have been asked to take part in the University of Cape Town research project specified above. I have read and understood the Explanatory Statement and I hereby consent to participate in this project.

Furthermore, by marking this document, I understand that:

- **My participation was entirely voluntary**
- **My identity and the identity of others will be anonymous**
- **The data provided will be stored and held for a 10-year period**

1 I consent to participate in this project and complete the survey

- ☐ Yes
- ☐ No

2. I consent that the data I provide (in conjunction with other data) will be published within a dissertation, thesis and/or journal article.

- ☐ Yes
- ☐ No

Part 1: Knowledge and Service Provision

3. Have you ever had any formal training is assisting victims of sexual assault?

- ○ Yes
- ○ No

4. Have you ever had formal training specifically with regards to the Criminal Law (Sexual Offences and Related Matters) Amendment Act 32 of 2007?

- ○ Yes
- ○ No

5. Have you ever assisted a victim of sexual assault in your time as a general medical practitioner?

- ○ Yes
- ○ No

6. **What would your response be to a victim of sexual assault that has come to your office?**

- ◯ Examine them there
- ◯ Direct/take them to a hospital
- ◯ Direct/take them to a police station
- ◯ Other (please specify)

7. **Does your office hold a Sexual Assault Evidence Collection Kit (otherwise known as a rape kit) or anything similar?**

- ◯ Yes
- ◯ No

8. **Do you think general medical practitioners should have a greater understanding of sexual assault and its effects than other medical fields?**

- ◯ Yes
- ◯ No

9. **In your opinion, do you think victims of sexual assault would find better assistance visiting an hospital's emergency room or their own general medical practitioner?**

- ◯ Hospital Emergency Room
- ◯ General Medical Practitioner

10. Is there anything you believe could make you more prepared to assist victims of sexual assault?

- ○ Yes, the proper equipment
- ○ Yes, formal training with regards to the law
- ○ Yes, online courses with regards to assisting victims of sexual assault
- ○ No
- ○ Other (please specify)

Part 2: Attitudes and Opinions

11. If a girl is raped while she is drunk, she is at least somewhat responsible for letting things get out of hand.

○ Strongly Disagree ○ Disagree ○ Neutral ○ Agree ○ Strongly Disagree

12. When girls go to parties wearing slutty clothes, they are asking for trouble.

○ Strongly Disagree ○ Disagree ○ Neutral ○ Agree ○ Strongly Disagree

13. If a girl goes to a room alone with a guy at a party, it is her own fault if she is raped.

○ Strongly Disagree ○ Disagree ○ Neutral ○ Agree ○ Strongly Disagree

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

○ Strongly Disagree ○ Disagree ○ Neutral ○ Agree ○ Strongly Disagree

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

○ Strongly Disagree ○ Disagree ○ Neutral ○ Agree ○ Strongly Disagree

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

○ Strongly Disagree ○ Disagree ○ Neutral ○ Agree ○ Strongly Disagree

17. **When guys rape, it is usually because of their strong desire for sex.**

○ Strongly Disagree ○ Disagree ○ Neutral ○ Agree ○ Strongly Disagree

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

○ Strongly Disagree ○ Disagree ○ Neutral ○ Agree ○ Strongly Disagree

19. **Rape happens when a guy's sex drive goes out of control.**

○ Strongly Disagree ○ Disagree ○ Neutral ○ Agree ○ Strongly Disagree

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

◯ Strongly Disagree ◯ Disagree ◯ Neutral ◯ Agree ◯ Strongly Disagree

21. It shouldn't be considered rape if a guy is drunk and didn't realize what he was doing.

◯ Strongly Disagree ◯ Disagree ◯ Neutral ◯ Agree ◯ Strongly Disagree

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

◯ Strongly Disagree ◯ Disagree ◯ Neutral ◯ Agree ◯ Strongly Disagree

23. If a girl doesn't physically resist sex—even if protesting verbally—it can't be considered rape.

◯ Strongly Disagree ◯ Disagree ◯ Neutral ◯ Agree ◯ Strongly Disagree

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

◯ Strongly Disagree ◯ Disagree ◯ Neutral ◯ Agree ◯ Strongly Disagree

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

○ Strongly Disagree ○ Disagree ○ Neutral ○ Agree ○ Strongly Disagree

26. If the accused "rapist" doesn't have a weapon, you really can't call it rape.

○ Strongly Disagree ○ Disagree ○ Neutral ○ Agree ○ Strongly Disagree

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

○ Strongly Disagree ○ Disagree ○ Neutral ○ Agree ○ Strongly Disagree

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

○ Strongly Disagree ○ Disagree ○ Neutral ○ Agree ○ Strongly Disagree

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

○ Strongly Disagree ○ Disagree ○ Neutral ○ Agree ○ Strongly Disagree

30. A lot of times, girls who say they were raped often led the guy on and then had regrets.

○ Strongly Disagree ○ Disagree ○ Neutral ○ Agree ○ Strongly Disagree

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

○ Strongly Disagree ○ Disagree ○ Neutral ○ Agree ○ Strongly Disagree

32. Girls who are caught cheating on their boyfriends sometimes claim it was rape.

○ Strongly Disagree ○ Disagree ○ Neutral ○ Agree ○ Strongly Disagree

Part 3: Attitudes and Opinions

33. How old are you?

- ○ 25-34 years old
- ○ 35-44 years old
- ○ 45-54 years old
- ○ 55+ years old

34. Please specify your racial background:

- ○ White
- ○ Black
- ○ Coloured
- ○ Indian/Asian
- ○ Prefer not to answer
- ○ Other (please specify)

35. Have you ever assisted a victim of sexual assault in your time as a general medical practitioner?

- ○ Male
- ○ Female
- ○ Other (please specify)

36. How long have you been a general medical practitioner?

- ○ Less than 5 years
- ○ 6-10 years
- ○ 11-15 years
- ○ 16-20 years
- ○ 21-25 years
- ○ 26-30 years
- ○ 30+ years

APPENDIX D: ETHICAL CLEARANCE

Faculty of Law: Research Ethics Committee

Private Bag X3 ▪ Rondebosch ▪ 7701 ▪ South Africa Room 6.29 ▪ Kramer Building ▪ Middle Campus Tel: +27 021 650 3080 Fax: +27 021 650 5660
E-mail: lamize.viljoen@uct.ac.za Internet: www.law.uct.ac.za

Certificate of (1) Renewed Approval; (2) Amendment to original protocol

PRINCIPAL INVESTIGATOR/SUPERVISOR: KELLEY MOULT	**ETHICS REFERENCE NUMBER: L0062-2017**
STUDENT: DEMITRI LIOUNTRIS - LNTDEM001	ORIGINAL APPROVAL DATE: 29-March-2018
FACULTY: LAW	RENEWED ON: 14-October-2019 (1st)
DEPARTMENT: PUBLIC LAW	APPROVAL EXPIRY DATE: 13-October-2020

PROJECT TITLE: Exploring Rape Myth Acceptance Among General Practitioners in South Africa.

PURPOSE OF RESEARCH: Masters of Philosophy in Criminology, the Law and Society. The proposed study aims to explore the level of rape myth acceptance among general practitioners within South Africa through the use of the Illinois Rape Myth Acceptance Scale – Short Form (IRMA-SF). There is little research on medical professionals and rape myth acceptance, and even less on general medical practitioners specifically. The study also aims to explore if there is a significant difference with regards to rape myth acceptance within the sample of general practitioners, based off of characteristics such as age, race, gender, and if they have ever assisted a victim of sexual assault.

CONDITIONS OF APPROVAL

This Certificate of Approval is valid for the above term provided there is no change in the protocol.

Modifications
To make any changes to the approved research procedures in your study, please submit a formal "Request for a Modification" to the REC Administrative Office. You must receive ethics approval before proceeding with your modified protocol.

Renewals
Your ethics approval must be current for the period during which you are recruiting participants or collecting data. To renew your protocol, please submit a "Request for Renewal" form before the expiry date on your certificate. You are responsible for submitting this by at least 2 months prior to the expiry date of clearance date issued.

Project Closures
When you have completed all data collection activities and will have no further contact with participants, please formally notify the REC: Law as well as your supervisor where applicable.

Certification

This certifies that the University of Cape Town Law Faculty's Research Ethics Committee has examined this research protocol and concluded that, in all respects, the proposed research meets the appropriate standards of ethics as outlined by the University of Cape Town Research Regulations Involving Human Participants.

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Dr Shane Godfrey
LAW REC: LEAD REVIEWER

Certificate Issued On: 16/10/2019