Myths and taboos – students’ attitudes towards and knowledge about intimate partner violence (IPV)

**Background:** Violence against women is a world health problem which is to be targeted by educational nursing programmes. **Objective:** To explore knowledge and attitudes among students in an educational nursing programme regarding myths and beliefs about intimate partner violence (IPV). **Method:** Data were collected through questionnaires and focus groups interviews. **Results:** Survey data suggest that some nursing students did not believe in the myths about IPV. The students who still believed in the myths marginally manifested a change in attitude towards the myths. The focus group interviews yielded three main themes: “guilty or not guilty”; “a complex story”; and “from uncertainty to security”, and showed an increase of knowledge in IPV. **Conclusion:** Prior to their training, the students manifested both a belief in common myths about IPV and appropriate knowledge and understanding. Post-training demonstrated a minor increase of knowledge and change in beliefs. Training may alter these beliefs and contribute to changes in behaviour.

**Keywords:** beliefs, experiential learning, intimate partner violence (IPV), nursing education, nursing students.

**Introduction**

In a worldwide context, intimate partner violence (IPV) is recognised by the World Health Organisation (WHO) (1) as a serious epidemic problem (2). Violence is a universal social problem that affects individuals, families, and communities throughout the world (3). Violence occurs across age groups, with adolescents and adults as well as very old women being exposed to IPV (4). That violence is “ageing out” is an illusion; the same power and control tactics are used by perpetrators of IPV across the life span (5). Men’s violence against women has increased through the use of internet, and sexual offenders commit sex crimes against minors (6). The consequences of IPV are recognised as one of the main health problems affecting women (7). Several studies report that abused women are the main receivers of health care (8). Globally, IPV is a major contributor to premature deaths, injuries, and disabilities (9).

Myths about IPV are not a new phenomenon. Intimate partner violence is firmly rooted in patriarchal dominance, which has existed for millennia (2). In recent years, commonly accepted myths about IPV have been
identified and described by Eliasson (10). A myth can act like a barrier preventing nurses from intervening (11). McMahon (12) finds that a negative relationship exists between rape myth acceptance and the willingness to intervene as a bystander. There are certain myth constructions, including Violence occurs in certain groups; Women want violence, and thus, an abused woman consciously provokes her partner to batter her; Abused women ask for it; Women lie; Mentally ill men use violence; Alcohol is the cause of violence. For example, a research study found that some nurses believed that the causes of physical violence were alcohol and drugs, and that the abused woman was helpless and submissive, and that if the woman found the abuse offensive, she would certainly leave the man (11). A woman will disclose victimisation when met with trust and understanding. She will not voluntarily disclose her problem to someone she does not trust, because of the shame, self-blame, denial, and fear (13). Researchers have shown that women suffer physically and psychologically and have extreme difficulties leaving the dangerous man (14). Nevertheless, many women do eventually leave their perpetrators, proving that they are active victims (15). In many cases of IPV, the perpetrator's aim is to have complete control over the victim (16). The man has total power in a relationship in which the woman is threatened and isolated to powerlessness. Still, the woman is often met with suspicion by health workers while her partner is treated as the caring and empathic partner which increases the woman's feelings of shame and guilt, thus victimising her for the second time (2). Such an IPV perspective is related to the lack of knowledge and understanding.

Nurses as acknowledge themselves to be the most important link in the chain of care for abused women (17). Despite this role, it appears that nurses often believe that they will fail to identify an abused woman in a care situation, and that among the many female patients they meet in their everyday work, the abuse of some women is not recognised (11). In one study (18), nurses suggested that educational programmes on the topic might improve nursing care for the IPV victim; in another, 83% of the nurses included requested further training to be able to supply more appropriate care (11).

Education means bringing about change (19-21). One venue for changing myths and popular beliefs is training and hands-on experience when nursing students develop their attitudes, knowledge, and skills in caring for abused women (22). The result aimed for by learning is permanent change (23), a change manifested in behaviour such as (in this case) identification of abuse victims, empathic understanding and recording of the signs and symptoms. Health professionals need to recognise that no one “deserves” to be abused; therefore, the belief that the victim provokes abuse may prevent the nurses from supplying the optimal care.

This study was conducted on the premise that specialised training may increase the nursing students’ confidence and competency to encounter the IPV victims with supportive attitudes. Roark (3) emphasises that educational sessions are an effective way to develop nursing students’ attitudes, knowledge, and skills in encountering female IPV victims. The purpose of the study was to explore whether, and how, an educational programme on IPV
using an experiential learning method to convey knowledge about IPV to nursing students affects the students’ knowledge and attitudes. To provide a deeper understanding of the students attitudes towards the myths about IPV, a mixed methodology including both quantitative and qualitative method was used.

**Method**

The mixed-method approach used quantitative and qualitative methods leading to triangulation of the findings (24). The aims of triangulation was to enrich the details of the findings that either method could generate alone. At the beginning of two different compulsory educational training classes on IPV, delivered at two different points in time with an 18-month interval between the courses (the first in 2010 and the second in 2012), the study used a survey to assess the knowledge of the nursing students. A second survey was administered at the end of each course. Focus group interviews with some of the students were carried out at the end of the second course. The IPV course was held every third semester at the university. The aim of the focus group interview was to search for in-depth meanings and to gain deeper insights. In the focus group interviews, the participants develop the topics through interactions in group discussions, sharing their experiences and their thoughts while triggering each other (25).

**Participants**

The study comprised two independent samples. The first sample (n = 22) included 19 women and three men at a nurse education programme in a university in Finland. All participants were the total-nursing students attending the nursing programme that year, except for five participants who were admitted through the Open University course administration. The Open University participants included practising professionals, from nursing students in a social education programme to a volunteer working in children’s support programmes. The second sample (n = 15) included 14 women and a man, all of them nursing students (the total number of nursing students attending the nursing programme that year). The nursing students were surveyed at the beginning of and again at the end of the courses. In the first sample, one student was excluded from the data analysis, and a second student was excluded from the second sample at the end of the course due to an incorrectly filled-out questionnaire. A few students (3) did not turn up at the last session and thus did not fill out the questionnaire the second time. In the first sample, the students ranged in age from 23 to 54 years, with a medium age of 34.6 years (standard deviation (SD) = 9.3) while in the second sample, the age range was 23–46 years, with a medium age of 32.6 years (SD = 7.9). Five of the students from the second sample participated in focus group interviews. These were conducted with two voluntary groups, the first comprising three female students and the second two female students (data not shown).
In the nursing education programme, a 7.5 European Credit Transfer System (ECTS) course in IPV was mandatory. Nursing student preparation for screening of an intervention with abused women was the practical issue to be addressed. A change of knowledge and attitudes was assessed. The training method was derived from Kolb’s (20) experiential learning model. The process of learning development was collaborative and creative, in the shape of workshops supported by follow-up expert advice and guidance between meetings. The course was given during a 5-week period, with self-directed learning and activities between the sessions.

The course was carried out at the educational centre over 7 days during a 5-week period. The author developed and led a university-based course entitled “Violence in intimate partner relationships” and included some external facilitators in the training. The training included the following topics: definition of the term “IPV” and the characteristics of IPV, description of the problem, the cycle of violence, women’s perspectives, as well as screening and assessment, documentation, referrals, and safety behaviours. Students were given a choice of topics for in-depth study of IPV (e.g. the leaving process of the battered woman, characteristics of the IPV perpetrators, violence against the elderly).

The students were requested to hand in two working papers. The first one asked them to define “IPV” and to explain men’s violence against women. The second one asked them to focus on a topic related to IPV and to include data from at least three, recently published scientific papers. Students completed their papers individually or in pairs and presented their findings in an oral presentation at the end of the course.

Design
The study design employed a pre- and post-training test comprising quantitative elements. The questionnaire consisted of “yes”/“no” answers (“don’t know” for sample two) questions (Table 1). The pilot testing of the students’ knowledge and attitudes towards myths and beliefs was assessed using the ten statements by Jacobson and Gottman (26), which are based on facts and myths about IPV. At the end of the course, the students from sample 2 were invited to participate in focus group interviews conducted to explore the students’ knowledge about and understanding of IPV after completing the course. The author (A.H.) moderated both focus group interviews. The first focus group (n=3) lasted 17 minutes, and the second (n=2) lasted approximately 43 minutes (25). Examples of interview questions included: “What do you think about women being passive in a violent relationship?”, “Can a prison sentence change the perpetrator’s behaviour?”. The focus group interviews were carried out at the university, audio-taped, and transcribed verbatim for analysis.

Ethical Considerations
At the beginning of the educational programme, the students were asked to voluntarily fill in the questionnaire as a pre-test. Information about the study was given to the nursing students by the author. The author requested their permission to analyse their questionnaire answers and to publish the results. All students gave their verbal consent. The university did
not have an ethical committee at that time. The research was carried out accordingly to the principles of the ethical guidelines of the Declaration of Helsinki.

**Data Analysis**

Both quantitative and qualitative data have been included in this study (27). Furthermore, the researcher’s familiarity with the research settings increases the study’s credibility according to Lincoln and Guba (28). Descriptive and statistical data analyses were conducted. The data gathered from the questionnaire were analysed using SPSS for Windows, version 19.0 (SPSS Inc. Chicago IL USA). Statistical methods (Percentile and Wilcoxon’s signed-rank test for two related samples) were used to compare the results of the pre-test with the results of the late post-test. The answer “don’t know” from sample two was treated as a missing variable to enable the correlation between sample one and two. The data gathered from the focus group interviews were analysed using thematic analysis to generate common themes into larger categories (26). The analysis process was determined by the purpose of the study, and the analyses considered the critical quality of systematic, verifiable, sequential, and continuous aspects (26). The analysis strategy has been documented step by step, and results have been verified by re-reading the data after the final description of the analysis. Sequential aspects were addressed by providing written focus group questions, with the moderator probing and asking for clarification. Analysis of the interviews was performed while gathering new data.

**Results**

The results showed that most of the students had no or few misconceptions about IPV. Table 1 (sample 1) and Table 2 (sample 2) show the mean baseline scores of the respondents for their responses to the ten statements. The survey findings indicate that there was a slight, significant increase in knowledge from the beginning to the end of the course. Differences were examined with the Wilcoxon signed-rank test, and significant differences were found for statement six for sample 1 (Table 1) \( (p = 0.008) \) which indicates a positive, directional change: namely that there is little evidence that psychotherapy is more effective than prison in stopping batterers from using violence, and for sample 2 (Table 2) statement nine \( (p = 0.08) \) which indicates that battering cannot be prevented through actions taken by the victim. A comparison between pre-test and post-test responses to statements one, two and eight indicated no differences (Table 1) and (Table 2). The students’ responses showed that they had 100% knowledge about the statements already at the time of the pre-test. Post-test responses to statements four, five, seven, nine (except for sample 2) and 10 indicate a positive, directional change in their knowledge which, however, did not reach any levels of significance (Table 1) and (Table 2). Responses to statement three in sample 1, which stated that battering is never caused by drugs or alcohol, showed a negative directional change which did not, however, reach any significance \( (p = 0.32) \). Overall, the Wilcoxon’s signed-rank test (asymptotic significance, two-tailed) in sample 1 showed no significance \( (0.317) \) whereas sample 2 showed a significance of 0.011 (not shown).
Focus group findings

The study yielded three main categories of violence against women and their children from the students’ points of view: (1) “guilty or not guilty”, (2) “a complex story”, (3) “from uncertainty to security”.

Guilty or not guilty

The students said that a man’s violence is not a result of the woman’s response, nor is it affected by how active or passive this response may be. The woman bears no guilt. Although fear may stop her from leaving and make her passive, her staying in the violent relationship may be a survival strategy. For a woman in a violent relationship, leaving can be difficult and often dangerous (the students emphasised the risk of being killed). A woman often stays in a violent relationship because of society’s normalisation of men’s violence towards women. Moreover, their decision to stay in the relationship may be motivated by considera-

### Table 1. The mean percentage of successful change, according to the categories of questions and the statistical significance of changes in sample 1.

<table>
<thead>
<tr>
<th>Category of questions/statements</th>
<th>MPAA* in pre-test ± SD</th>
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<th>Number pre-/post-tests</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Men are also battered</td>
<td>2.00±0.00</td>
<td>2.00±0.00</td>
<td>20</td>
<td>1.00</td>
</tr>
<tr>
<td>2. All batters are alike</td>
<td>1.95±0.22</td>
<td>1.95±0.22</td>
<td>20</td>
<td>1.00</td>
</tr>
<tr>
<td>3. Battering is never caused by drugs or alcohol</td>
<td>1.89±0.32</td>
<td>1.79±0.42</td>
<td>20</td>
<td>0.32</td>
</tr>
<tr>
<td>4. Batterers can’t control their anger</td>
<td>1.42±0.50</td>
<td>1.50±0.51</td>
<td>20</td>
<td>0.66</td>
</tr>
<tr>
<td>5. Battering often stops on its own</td>
<td>1.86±0.37</td>
<td>1.95±0.22</td>
<td>20</td>
<td>0.18</td>
</tr>
<tr>
<td>6. Psychotherapy is a more effective “treatment” than prison</td>
<td>1.05±0.22</td>
<td>1.47±0.51</td>
<td>20</td>
<td>0.008</td>
</tr>
<tr>
<td>7. Women often provoke men to batter them</td>
<td>2.00±0.00</td>
<td>1.95±0.23</td>
<td>20</td>
<td>0.32</td>
</tr>
<tr>
<td>8. Women who stay in abusive relationships must be crazy</td>
<td>2.00±0.00</td>
<td>2.00±0.00</td>
<td>20</td>
<td>1.00</td>
</tr>
<tr>
<td>9. Battered women could stop the battering by changing their behaviour</td>
<td>1.89±0.32</td>
<td>2.00±0.00</td>
<td>20</td>
<td>0.16</td>
</tr>
<tr>
<td>10. There is ONE answer to the question “Why do men batter women?”</td>
<td>1.95±0.22</td>
<td>2.00±0.00</td>
<td>20</td>
<td>0.32</td>
</tr>
</tbody>
</table>

MPAA* = Mean Percentage of Accurate Answers; SD = Standard Deviation.
tions of what is best for her children. Other reasons mentioned by the students for staying in a violent relationship were the woman's low self-dependency, growing up in a violent home herself, feeling guilty and blaming herself, and her hope that the man will change. The students expressed frustration and indig- nation towards gender roles and expectations. They commented that men's violence against women is an insult to womanhood.

The students held the perpetrators responsible for their violent behaviour. Men's controlled violence in IPV relationships and also their uncontrolled violence when drunk were described as follows by a participant: “A man who is sober has more control and maybe digs at you about things like you’re worthless … […] if a man drinks … then it is more about what comes to mind, and the violence is different.” In violent relationships, sober men often use controlled violence, according to course participants. They said that supporting these

Table 2. The mean percentage of successful change, according to the categories of questions and the statistical significance of changes in sample 2.

<table>
<thead>
<tr>
<th>Category of questions/statements</th>
<th>MPAA* in pre-test ± SD</th>
<th>MPAA* in pre-test ± SD</th>
<th>Number pre-/post-tests</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Men are also battered</td>
<td>2.00±0.00</td>
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<td>15</td>
<td>1.00</td>
</tr>
<tr>
<td>2. All batters are alike</td>
<td>2.00±0.00</td>
<td>2.00±0.00</td>
<td>15</td>
<td>1.00</td>
</tr>
<tr>
<td>3. Battering is never caused by drugs or alcohol</td>
<td>1.93±0.27</td>
<td>1.87±0.35</td>
<td>15</td>
<td>1.00</td>
</tr>
<tr>
<td>4. Batterers can't control their anger</td>
<td>1.67±0.50</td>
<td>1.53±0.52</td>
<td>15</td>
<td>1.00</td>
</tr>
<tr>
<td>5. Battering often stops on its own</td>
<td>2.00±0.00</td>
<td>2.00±0.00</td>
<td>15</td>
<td>1.00</td>
</tr>
<tr>
<td>6. Psychotherapy is a more effective “treatment” than prison</td>
<td>1.00±0.00</td>
<td>1.00±0.00</td>
<td>15</td>
<td>1.00</td>
</tr>
<tr>
<td>7. Women often provoke men to batter them</td>
<td>2.00±0.00</td>
<td>1.87±0.35</td>
<td>15</td>
<td>0.16</td>
</tr>
<tr>
<td>8. Women who stay in abusive relationships must be crazy</td>
<td>2.00±0.00</td>
<td>2.00±0.00</td>
<td>15</td>
<td>1.00</td>
</tr>
<tr>
<td>9. Battered women could stop the battering by changing their behaviour</td>
<td>1.79±0.43</td>
<td>2.00±0.00</td>
<td>15</td>
<td>0.08</td>
</tr>
<tr>
<td>10. There is ONE answer to the question “Why do men batter women?”</td>
<td>1.93±0.27</td>
<td>2.00±0.00</td>
<td>15</td>
<td>0.32</td>
</tr>
</tbody>
</table>

MPAA* = Mean Percentage of Accurate Answers; SD = Standard Deviation.
men through men’s groups can make a difference and change his behaviour. A prison sentence may not help the man if the prison lacks a strategy to change his behaviour.

A complex story

In relation to the lectures on child abuse, the students described suspected victims of abuse, children, whom they had encountered privately. Helping victimised children was seen as an even more complex issue. Success in helping them depended on the parents’ reaction and willingness to participate, the authorities’ knowledge, and also on certainty as to whether the child is being abused or not. The students described two different cases in which small boys were fond of showing their penises to each other, and in one of the cases, one of the boys had asked his friend to taste his penis. Another scenario was that of a 6-year-old girl who had begun soiling her underwear. The student commented, “How shall I interpret this? I wondered why [she had] this reaction.” The students expressed ambiguity about whether, and how, to interact with a child if they were not entirely certain that he or she was being victimised.

The students discussed the complexities when children are involved in violence.

From uncertainty to confidence

The students said that they had gained new, deeper insights in areas that had previously been unclear to them. They did mention that they thought the topic should be taught at the beginning of nursing education programmes. Some had met victimised women during their clinical practice and had not known how to interact with them which could have been avoided by earlier presentation of the topic.

Knowledge provided confidence when encountering victimised patients, and having guidelines made the encounters easier. Nurses ought to provide advocacy for women and should acknowledge the victimised woman, enquiring in depth about her wounds and the situation, and, if suspecting partner violence, informing her about the available help and support, such as shelters and the police.

As one student put it, “The worst thing to say is: Why don’t you just leave him! Instead, the nurse should be present and listen and believe in her.” The students furthermore said that nurses ought to be aware of the leaving process which often means leaving and returning and leaving again. One student said,

The encounter in the caring service is important […]. People stay, unable to act, and they are scared to death because you don’t know … [they] hope she won’t say that she has been victimised. How do we deal with that? But if you have … you have a plan of action … it becomes so much easier, and then decide how to act, one step at the time.

Another student said, “My point of view has changed a bit after this course, especially concerning how to understand the woman’s life … the phase the woman is in, and this course has given me the tools and knowledge to understand.”

Discussion

The findings show differences in nursing students’ knowledge about and attitudes towards IPV pre- v. post-training. The findings show
an association between most of the questions prior to and after the training sessions. In the focus groups interviews, the students expressed their knowledge about IPV and emphasised the importance of changing attitudes, for example that the men should be held responsible for using violence, not the women. According to Jacobson and Gottman (26), the students emphasised that a perpetrator sentenced to prison without therapy wouldn’t help the person to become less violent. Overall, the study shows that most of the students did not believe most of the common myths about IPV. However, there has been little change in general attitudes towards IPV among communities (29) despite the severity of the problem worldwide (1,3). Compared with an earlier study (11) in which some nurses believed in common myths, this study shows a welcome, attitudinal change among the nursing students. Students’ understanding attitudes towards IPV may have been due to knowledge obtained from daily newspapers and other media. Another source of knowledge, skills, and attitudes relating to the issue for nursing students is the practical experience gathered during clinical practice, according to Donohoe (30). While in clinical practice, the students will almost certainly come into contact with abused women since abused women use the health care system for all kinds of health problems (31). Nevertheless, to meet the needs of the students, and therefore be successful in teaching, letting their prior knowledge guide the course content must be the top priority. This study shows that some students have appropriate knowledge about IPV and about most of the common myths about IPV. The study also shows that students’ uncertainty about issues relating to IPV can be addressed, as the post-test findings show.

Only a few statements elicited responses from students indicating misconceptions about IPV. Notably, some of the students negatively changed their attitudes towards the perpetrators’ use of drugs and alcohol during IPV; despite this, focus group participants were emphatic that alcohol is not the cause of violence. Therefore, it may help to consider the length of training as well as the students’ motivations to learn (22). Further barriers to change may include students’ past experience of success and failure, personal values, special aptitudes, and students’ tempers, and intellectual capacities (23,32). Other possible factors may be connected to the ability of teachers to provide role models, teaching and learning methods, learning aids, and the learning context. The students’ responses to the question of child abuse indicate that efforts need to be increased since they showed frustration and uncertainty about how to handle child abuse. As this study shows, nursing students’ confidence and competency may be improved through a training programme focused mainly on students’ needs.

There are some limitations to the study. For example, the main facilitator (A.H.) was the same person as the researcher of this study which could have caused bias. A teacher’s desire is that the students ought to reach the goals and objectives, and therefore, reports only the expected or wanted outcomes. For this reason, the researcher has been aware of this possible bias or shortcoming and tried to prevent distorted reporting. Likewise, I expected all the students to show changed understandings towards myths and beliefs about
IPV, mainly as a result of the teaching method’s effectiveness which was used. However, the study didn’t reveal this. One reason could have been the overwhelming content covered in just a few days. In addition, the number of students’ was small; participants from only two classes taking one university educational programme in the health sciences were included in the study. Students attending health educational programmes can probably be assumed to be more attracted to gender issues and therefore more aware of issues related to women and gender equity. In contrast to Currier and Carlson (22), who found men scoring higher than women on rape-supportive attitudes, this study included only a few men, and their responses are unknown, due to the anonymity of the responses. Another limitation is statement 3, “Battering is never caused by drugs or alcohol,” which can be answered positively, because often the perpetrator acts violently without drug or alcohol use.

Ascertaining appropriate training starts with a well-planned training method. A method of choice, rather than a traditional, top-down learning method, is a humanistic learning theory (23). Secondly, a well-planned curriculum emphasises change. As the students emphasised, only when nurses can establish a safe and confidential relationship, ask about partner violence, support the patient, help her explore options, support and shelter, offer follow-ups, and professionally document observations and intervene in collaboration with other supportive systems, can the problem of IPV be properly addressed. Improved educational methods can offer innovative ways to supply knowledge and teach skills that can make a difference. Nurses who are able, through training, to understand most difficult, complex, and challenging problems about abused women and their children will be better equipped to deliver patient-centred care to those patients.

The findings suggest the need for further studies of educational efforts to increase knowledge and improve attitudes relating to the topic of IPV. More knowledge and a longer training programme may change the training outcome, and further studies are needed to develop the optimal training for optimal outcome. Additionally, studies on longer-term effects of educational programmes on attitudinal changes are needed (33). If educators do not find models for tackling difficult issues in learning situations, the health service will continue to provide inadequate support for vulnerable, abused women and their children. Educators’ familiarity with learning theories promises to promote a more conducive and transformative learning milieu. The present data also suggest that the questionnaire by Jacobson and Gottman (26) should be further developed. Furthermore, questions exploring associations between educational perspectives and IPV as well as professional health workers’ personalities remain to be identified.

**Conclusions**

In this article, I discuss the training of nursing students in dealing with IPV cases. Nurses are in fact the health providers who most often provide health care to victimised women, and therefore, there should be no restriction on IPV and related topics. As long as IPV is a major source of morbidity and mortality for women, nurse
educators ought to consider the complexity of the problem of violence in today's society. The study indicates that providing nursing students with training in dealing with IPV cases provides them with useful knowledge which may change attitudes, resulting in nurses' providing a more knowledgeable and understanding care for vulnerable and battered women and their children. However, health educators need to gain more insight into the choice of pedagogic methods related to the educational programmes in the field.

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