Original Article

Rape Myth Acceptance among Nurses Undergoing Baccalaureate Nursing Degree Programme in a Nigerian University

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Abstract

Background: Rape myths acceptance is prevalent among the general public most especially among practitioners such as the nurses and this influence their perceptions of rape.
Objectives: The study was aimed at assessing how nurses' Rape Myth Acceptance (RMA) and gender influence their attribution of responsibility to victims and perpetrators in different rape scenarios and their perceptions of degree of rape trauma.
Methodology: The study employed a cross-sectional design and was conducted among 130 nurses undergoing Baccalaureate degree programme in a University in Nigeria. An adapted and pre-tested structured questionnaire containing RMA Scales with four rape vignettes was used to collect data.
Results: The study revealed that, 49% of the nurses had low RMA while 51% had high RMA. It was also found that, irrespective of their rape myth acceptance, majority of them attributed more responsibility to victims and had similar perceptions of degree of rape trauma. A statistically significant association was found between nurses' RMA and attribution of responsibility to perpetrator in acquaintance rape only [$p = 0.004$; Cramer's $V = 0.27$]. A higher percentage of the nurses irrespective of their RMA also reported that rape is not traumatic to a prostitute. No statistically significant association was found between the nurses' gender and their attribution of responsibility and perceptions of degree of rape trauma ($p>0.05$).
Conclusion: This study concluded that rape myths acceptance is high among nurses in the study setting and those with high and low rape myths acceptance did not differ significantly in their attributions of responsibilities and perceptions of trauma experienced by the victims of rape.

Key Words: Degree of Rape Trauma; Perpetrator's responsibility; Perception; Rape Myth Acceptance; Victim's responsibility.

Introduction

Rape is a form of sexual violence that has been documented to occur in many countries of the world and it is a largely-ignored global epidemic. Globally, the United Nations has reported that rape occurs in many countries of the world with more than 250,000 cases of rape or attempted rape being reported every year (Eileraas, 2011). In addition, one in ten girls experiences rape or sexual assault around the world and 7% of women have been assaulted as documented by UNICEF and WHO (Equality Now, 2017).Rape has been defined differently from setting to setting and it has different connotations to different people depending on their gender, type of rape, perceived relationship to the victim and societal norms. According to the Federal Bureau of Investigation (2014, p.1), rape is defined as "penetration, no matter how slight, of the vagina or anus with any body part or object, or oral penetration by a sex organ of another person, without the consent of the victim. The stigmatization associated with rape is always reinforced by rape myths. Lonsway and Fitzgerald, (1994) as cited in Stoll, Lilley & Pinter, (2017) have drawn up a definition for rape myths as 'specific set of attitudes and beliefs that are generally false but are widely and persistently held and serve to deny and justify male sexual aggression against women or shift blame for sexual assault from perpetrators to victims''. Rape myths have negative effects on reporting the crime, how the trial is handled and how the public respond to the crime (Ojo, 2013). Male perpetrators have always used rape myths as excuses for sexual aggression while the society uses rape myths to dismiss or minimize incidence of rape. Although, there exist theoretical limitations of rate myths, various studies have shown that the concept of rape myths contributes in a significant way to the understanding of rape and its consequences to the victim (Hine & Murphy, 2019; Stoll *et al.*, 2017; Suarez & Gadalla, 2013) hence, the conceptualization of rape myths acceptance.

Rape myths acceptance (RMA) is conceptualized by Burt (1980) as the amount of stereotypic ideas that people have about rape such as 'women falsely accuse men of rape', 'rape is not harmful', 'women want to enjoy rape', or 'women cause or deserve rape by inappropriate dressing or risky behavior'. Rape myths acceptance is prevalent among the general public most especially among practitioners such as the law enforcement agents, medical examiners, criminal justice professionals among others (Page, 2010). Out of the documented evidences are the findings among police officers (Hine and Murphy, 2019 & Venema, 2016) in which RMA predicts their perceptions of rape cases and suspect blame. The poor perceptions of the law enforcement agents had been linked to their low scores on the rape myths acceptance scale which has also contributed to their understanding of rape (Mennicke, *et al*, 2014). Among Mock Juros (Sommer, Reynolds & Kehn, 2016), and lesbian, gay, bisexual, and transgender (LGBT) (Schulze & Koon-Magnin, 2017), victim blame as a product of rape myths acceptance has also been documented. However, the study of Custers and McNallie, (2017) has been able to show that viewing of television sports was indirectly related to higher acceptance of rape myths while the study of Barnett, Sligar and Wang, (2016) and Hayes, Abbott and Cook, (2016) was able to link rape myths acceptance with religious affiliation and drinking respectively. The myriads of findings on RMA most especially in victim blame and perpetrator exoneration have shown that blaming the victim or attributing responsibility to either the victim or the perpetrator is a resultant effect of RMA. Different groups in different societies have shown that holding on to rape myths could significantly influence the way an individual view a victim and perpetrator of rape which consequently determines the judgment of rape cases. The study of Süssenbach *et al*, (2017) among students and staff of a University campus in Germany has shown that higher RMA predicts stronger anti-victim and pro-defendant judgments and this report was similar to the findings of Navarro and Tewksbury, (2017) in their study among athletes and non-athletes. Although, gender has been discovered to significantly determines victim blame and perpetrator exoneration (Hockett, *et al*, 2016; Hust *et al*, 2016; Angelone, Mitchell & Smith, 2016; LeMaire, Oswald & Russell, 2016; Ayala, Kotary & Hetz, 2018), some studies have also proven that gender is not a mediating factor between RMA and victim blame (Barn & Powers, 2018; Navarro & Tewksbury, 2017)

Attributing blame to either the victim or perpetrator in different rape scenarios has been

documented in the literature. As far back as 1994, the study of Kormos and Brooks among college students and prison inmates has been able to differentiate between victim blame when the perpetrator is a stranger or an acquaintance. The students in this study assigned equal blame to the victim regardless of whether the assailant was a stranger or an acquaintance, while the inmates in the study assigned more blame to the victim when the assailant was a stranger than an acquaintance. A more recent study conducted among nurses and non-nurses has shown that nurses generally attribute more blame to victim of acquaintance rape than stranger rape (Persson, Dhingra, & Grogan, 2018). Aside from the perpetrator being an acquaintance or a stranger, differences have also been observed in victim blame when the perpetrator is in a familiar relationship with the victim. More victim blame is predicted when the perpetrator is described as a husband than a boyfriend most especially when the perpetrator is a benevolent sexist or has a prior relationship with the victim (Bieneck & Krahé, 2011; Durán *et al*, 2010) Most interestingly is the report of a recent study that shows that women in marital and dating relationship who are raped are not likely to blame themselves compared to if the experience were to be with a non-partner perpetrator (Jaffe, Steel & DiLillo, 2017). Among health care professionals such as nurses, rape myths acceptance and victim blame attribution are very essential in their ability to carry out quality care to their rape clients. Unfortunately, studies among nurses in this regard are scarce even in developed countries. The study of Uji *et al*, (2007) among Japanese professionals indicates that nurses have significantly higher rape myths acceptance than any other professional group. Contrary to this result, a study among nursing students in the United States of America indicates that RMA is lower for nursing students in their last semester of college than in the pre-nursing group; and that last-semester nursing students held less victim-blaming attitudes toward rape victims than pre-nursing students (Strunk, 2017). Victim blaming by nurses has also been documented by Persson, Dhingra and Grogan (2018) in cases of acquaintance rape. Aside from the nurses' rape myths acceptance, it is also essential to determine the extent to which nurses perceive the degree of trauma experienced by rape victims as this influences the quality care provided for the victims. Different studies on rape trauma have only explored the post traumatic syndrome experienced by rape victims (Keefe *et al*, 2018; Lee &, Theus, 2012), rape trauma management (Donatilla, 2018) and rape trauma disclosure (Larson, 2018) but determining the extent to which rape has traumatic effect on different types of victim is scarce in the literature. In Nigeria, the ever increasing incidence of rape, especially of minors, have become a source of concern to the populace hence, has been termed to be epidemic (Achunike & Kitause, 2014). The exact prevalence of rape in Nigeria is not known because, many cases are not reported. The increasing rate of rape in Nigeria has been linked to many factors that are inherent in the Nigerian society and these include culture of silence, peer group pressure, acceptance of rape myths, among several others (Achunike & Kitause, 2014; Folayan, 2013). Unfortunately, scanty studies had been conducted on rape myths in Nigeria. The recent study by Fakunmoju, Abrefa-Gyan, and Maphosa, (2018) has only carried out confirmatory factor analysis and gender invariance of the revised Illinois Rape Myths Acceptance scale (IRMA) while another study of Fakunmoju, *et al*, (2016) used IRMA to determine convergent validity of new instruments that are designed to measure beliefs about violence against women and gender stereotypes and beliefs. Also, the study of Aborisade, (2014) which was conducted among female undergraduate students only determined the influence of RMA and situational factors in defining sex and labeling rape. There is lack of empirical evidences suggesting studies conducted among Nigerian nurses on rape myths acceptance. Generally, sexual violence studies among nurses in Nigeria are rare.Nurses as health care professionals are usually the first contact of victims of rape in the clinical settings. They also have the opportunity to come in contact with either the perpetrator or victim of rape in their day-to-day activities. Therefore, it is pertinent that nurses are informed about rape and its myths and are able to make appropriate judgments in rape cases which will consequently influence their care. Therefore, assessing the rape myths acceptance of nurses in Nigeria in relation to their blame attribution and perceptions of degree of rape trauma is essential for effective management of rape victims which this study has been able to achieve.

Problem Statement

Rape has been a serious issue of concern in Nigeria, as many professionals, most especially nurses are being encouraged to devise means of reducing the menace and also manage victims appropriately. Anecdotal evidences showed that, majority of Nigerians are engrossed in rape myths acceptance which has negatively influenced their responses to rape incidences. This consequently has contributed to the perpetuation of rape in the Nigerian society. Studies on nurses' rape myths acceptance in Nigeria are rare as there are very few sexual violence researchers in the country and the few available are rarely working among nurses. Rape concept and management are taught to nursing students in Nigeria as a topic in Community Health Nursing course at the Baccalaureate level. Little or nothing is taught about rape at the diploma levels. With increased incidences of rape in Nigeria, victims usually have contacts with nurses who are positioned to care for them at the acute or primary care settings. It is assumed that nurses should have received on-the-job training on rape prevention and management by the nature of their job and this would have positively influenced their perceptions about rape and its myths and consequently their attribution of responsibility in rape cases. However, as at the time of conducting this study, there was no evidence of on-the-job training for Nigerian nurses on rape prevention and management. Also, studies among Nigerian nurses that explore their rape myths acceptance are rare. This study was therefore conceptualized to determine the link between RMA of nurses and their attribution of responsibility to victims and perpetrators of rape in different rape scenarios. It also assessed the nurses' perceptions of degree of trauma experienced by different categories of female rape victims (virgin, widow, prostitute, married and divorced women).

Research Objectives and Hypotheses

The following objectives and hypotheses were developed for this study.

Objective 1: To determine the influence of nurses' Rape Myth Acceptance (RMA) on attribution of responsibilities to victims and perpetrators in cases of acquaintance rape (AR), stranger rape (SR), marital rape (MR) and date rape (DR).

H_1 There is a significant difference between nurses with high rape myths acceptance (HRMA) and low rape myths acceptance (LRMA) and their attribution of responsibility to either victim or perpetrator in cases of acquaintance rape (AR), stranger rape (SR), marital rape (MR) and date rape (DR)

Objective 2: To determine the influence of rape myths acceptance (RMA) on nurses' perceptions of degree of trauma experienced by different categories (virgin, widowed, divorced, married, prostitute) of female rape victims

H_2. There is a significant difference between nurses' level of rape myths acceptance and their perceptions of degree of rape trauma experienced by different categories (virgin, prostitute, married, divorced, widowed) of female rape victims

Objective 3: To determine the influence of gender of nurses on their attribution of responsibilities to victim and perpetrator of rape and their perceptions of degree of trauma experienced by different categories of female rape victims

H_3. There is a significant difference between male and female nurses and in their attribution of responsibilities to victim and perpetrator of rape and their perceptions of degree of rape trauma experienced by different categories of female rape victims.

Methodology

Design and Setting: This study utilized a cross-sectional descriptive explanatory design and was conducted in a Department of Nursing of a University in South-West Nigeria. The department trains nursing students at undergraduate and graduate levels and the undergraduate programme is in two modes of delivery (Full time and Part-time).

Sample and sampling: The nursing students undergoing the part-time Baccalaureate programme were those selected for this study. The students in this programme were those who had undergone 3-year diploma basic nursing training in approved Schools of Nursing in Nigeria. Some of them have other postbasic nursing qualifications such as Midwifery, Public Health Nursing, among others. The baccalaureate programme is a five-year programme leading to the award of Bachelor of Nursing Science degree. Being a part-time programme, the students in this programme are

working class nurses and they usually have their lectures on week-ends but carry out their clinical postings at approved clinical sites in the respective States where they are working. The participants were chosen for the study because the programme captures different categories of nurses by their diploma certificates and work settings which are scattered across the country. As at the time of conducting this study, there were a total of 565 students in the programme. A hundred and thirty of them were recruited using convenience sampling technique. Students were visited in their classes before the commencement of their lectures and those that were met in their classes were selected for the study. Since the nurses had diploma certificates and have been practicing for some time, their level of education in the baccalaureate programme was not considered for the selection.

Instrument: The instrument used for data collection was an adapted, structured questionnaire containing three sections. Section I contains questions that explored the nurses' demographic characteristics. Section II contains Rape Myths Acceptance Scale developed by Butt (1980) while Section III contains four rape vignettes adapted from the vignettes used by Frese, Moya and Megías, (2004). The rape myths acceptance scale was adapted by replacing items 15-19 on the scale with a prostitute; a virgin; a married woman; a divorced woman; and a widow. The Rape Myth Acceptance Scale (Burt, 1980) was used to measure acceptance of rape myths by the nurses. The scale consisted19 items, with the first 11 being a 7-point Likert-type scale ranging from Strongly Agree (1) to Strongly Disagree (7). The next 2 questions were 5-point Likert scale questions of Almost all (1) to Almost none (5) while the last 6 questions were 5-point Likert scale of Never (1) to Always (5). Adaptation of the vignette was done by adding a fourth rape vignette (date rape) to the three vignettes (acquaintance, marital and stranger rapes) used in the study of Frese *et al*, (2004). The four vignettes were short rape scenarios depicting AR, MR, SR, and DR (Table 1).

Table 1: Rape Scenarios

SN	
1	Acquaintance Rape Imagine that a young woman who is drunk and dressed in a short skirt and skimpy blouse leaves a party accompanied by a man whom she does not know very much about and this man forces her to have intercourse with him.
2	Marital Rape Imagine a young woman who does not want to have sexual intercourse with her husband, who comes home drunk, is forced by him to have sex.
3	Stranger Rape Imagine that a young woman is threatened with a knife and forced to have sexual intercourse with an unknown man in the corner of a narrow path as she goes home at night.
4	Date Rape Imagine a young lady who went to visit her boyfriend who then drugged her and had sexual intercourse with her.

The nurses were instructed to read the scenarios and then assign responsibility to the male perpetrator and the female victim for each of the scenarios by selecting any of these options; no responsibility, very little responsibility, little responsibility and lots of responsibility. They were also instructed to determine the degree of rape trauma experienced by the female victim if she were to be a widow, virgin, prostitute, married woman or divorced woman by selecting any of these options; definitely not traumatic, may be not traumatic, may be traumatic, and definitely traumatic.

Psychometric properties of the instrument: The Rape Myth Acceptance Scale internal consistency across several studies has been found to be p>0.86 (Peterson, 2014) while that of Frese *et al*, (2004) was 0.73. In this study, the internal consistency of the instrument was determined using Cronbach's Alpha and 0.7 was obtained for RMA Scale, 0.5 for attribution of responsibility and 0.7 for perception of degree of trauma. The overall Cronbach's Alpha for the instrument was 0.7.

Research Ethics: Approval for the study was obtained from the department where the study was conducted while informed consent of the nurses was also obtained. They were assured of the confidentiality of information received from them and the questionnaires were kept in a safe locker in one of the investigators' office.

Data Collection and Analysis: The questionnaires were administered in English to the nurses in their various classes before the commencement of their lectures and were retrieved back immediately. The data were analyzed using Statistical Package for Social Sciences (SPSS) version 22 (IBM Corp, 2013). The RMA scores for the 19 items were summed up and the total obtainable score was 117. Exploring the RMA data, the mean RMA score was 75.2 ± (11.3); CI =73.1-77.3; minimum and maximum scores being 50 and 104. The median score which was 74 was used as the cut-off point for RMA. Those with scores higher than the median score were termed to have Low Rape Myths Acceptance (LRMA) while those with scores of 74 and below were termed to have High Rape Myths Acceptance (HRMA). The attribution of responsibility scales was collapsed into two, thus; 'lots of responsibility', 'little responsibility' and 'very little responsibility' were grouped as 'Responsible' while 'no responsibility' was termed 'Not responsible'. The traumatic scale was also collapsed into two, thus; 'definitely traumatic' and 'may be traumatic' were grouped as 'Traumatic' while 'definitely not traumatic' and 'may be not traumatic' were grouped as 'Not Traumatic'. We further conducted a Chi-square test for the dependent (RMA) and independent variables (attribution of responsibility and perceptions of degree of trauma) to determine the differences between nurses with HRMA and LRMA in relation to the independent variables. We also tried to determine if there is any significant difference between nurses' gender and RMA (HRMA and LRMA) but we found none (x^2 = 0.95; df = 1; p = 0.33; Cramer's V = 0.09). We then went ahead to cross tabulate gender (male and female nurses) with attribution of responsibility and perceptions of degree of trauma. For every Chi-square test done, a Cramer's V value was obtained to ascertain the effect size of the independent variables on the dependent variables. Statistical significance level was taken to be p≤0.05.

Results

Out of a total of 130 questionnaires administered, only 116 were completely filled and returned giving a response rate of 89.2%. Findings showed that many (87%) of the nurses were middle age adults with minimum and maximum ages of 18 and 53 years (CI: 30.5; 33.11). The highest number (46%) of the nurses had between 1 and 5 years of experience as a nurse while the mean year experience was 8.5±0.6, (CI: 7.3-9.7) with minimum and maximum years of 1 and 31 years respectively. Reports of their work description showed that majority were working in the hospital settings (85%). Other characteristics of the nurses are stated in Table 2.

The nurses who had Low Rape Myth Acceptance (LRMA) were 49% (n = 57) while 51% (n = 59) had High Rape Myth Acceptance (HRMA). The descriptive findings showed that irrespective of the RMA of the nurses, majority of them indicated that victims were responsible for rape in all the rape scenarios. No statistically significant difference was observed between nurses with HRMA and LRMA in their attribution of responsibilities to either the victim or perpetrator in three of the four rape scenarios except for perpetrator in acquaintance rape (P = 0.004). The Cramer's V of 0.27 for perpetrator in acquaintance rape indicated that only 0.5% variation in their RMA explains their attribution of responsibility to perpetrator. Hence, hypothesis 1 is only true for acquaintance rape (Table 3). Also, majority of the nurses irrespective of their rape myths acceptance perceived that rape is not traumatic to a prostitute but traumatic to other rape victims. A statistically significant difference was observed between those with HRMA and LRMA for perceptions of degree of trauma for a prostitute as a victim (P= 0.02) but, Cramer's value of 0.21 indicated 4.4% variation in

the nurses' RMA explains their perceptions of the degree of trauma experienced by a prostitute hence, hypothesis 2 is only true for a prostitute (Table 4). Analysis of gender showed that there is no statistically significant difference between male and female nurses in their attribution of responsibility and perceptions of degree of trauma ($p>0.05$). However, descriptive analysis indicated that majority of the nurses irrespective of their gender reported that victims are responsible for rape in all the rape scenarios and also perceived that rape is not traumatic to a prostitute (Tables 5 and 6).

Table 2: Demographic Characteristics (n = 116)

	Frequency	Percentage
Age group		
18-19 (adolescent)	1	1
20-40 (young adult)	101	87
41-53 (middle age adult)	14	12
Mean = 31.8±0.7		
Gender		
Male	28	24
Female	88	76
Marital Status		
Single	51	44
Married	64	55
Divorced	1	1
Qualifications		
RN	48	41
RM	32	28
Others	36	31
Work setting		
Hospital setting	98	85
Community	15	13
NGO	1	1
Private business	2	2
Years of experience		
1-5	53	46
6-10	35	30
11-15	12	10
Above 15 years	16	14
Mean = 8.5±0.6		

Table 3: Nurses' Rape Myth Acceptance by their attribution of responsibility to victim and perpetrator of rape (n = 116)

		Responsible	Not responsible	X^2	P	Cramer's V
		n (%)	n (%)			
Acquaintance Rape						
Victim	HRM	43(73)	16(27)	3.02	0.08	0.16
	LRM	49(86)	8(14)			
Perpetrator	HRM	47(80)	12(20)	8.41	0.004	0.27
	LRM	31(54)	26(46)			
Marital Rape						
Victim	HRM	31(53)	28(48)	3.06	0.08	0.16
	LRM	39(68)	18(32)			
Perpetrator	HRM	35(59)	24(41)	1.22	0.27	0.10
	LRM	28(49)	29(51)			
Stranger Rape						
Victim	HRM	38(64)	21(36)	0.11	0.74	0.03
	LRM	35(61)	22(39)			
Perpetrator	HRM	28(48)	31(53)	1.34	0.25	0.11
	LRM	21(37)	36(63)			
Date Rape						
Victim	HRM	45(76)	14(24)	0.10	0.75	0.03
	LRM	42(74)	15(26)			
Perpetrator	HRM	23(39)	36(61)	1.08	0.30	0.01
	LRM	17(30)	40(70)			

Table 4: Nurses' Rape myth acceptance by their perceptions of degree of rape trauma experienced by different categories of female rape victims (n = 116)

		Not Traumatic	Traumatic	X^2	P	Cramer's V
		n (%)	n (%)			
Virgin	HRM	4(7)	55(93)	1.76	0.18	0.12
	LRM	1(2)	56(98)			
Married	HRM	12(20)	47(80)	3.10	0.08	0.16
	LRM	5(9)	52(91)			
Divorced	HRM	14(24)	45(76)	0.68	0.41	0.08
	LRM	10(18)	47(83)			
Prostitute	HRM	50(85)	9(15)	5.18	0.02	0.21
	LRM	38(67)	19(33)			
Widow	HRM	11(19)	48(81)	2.38	0.12	0.14
	LRM	5(9)	52(91)			

Table 5: Attribution of responsibility to victim and perpetrator of rape according to the gender of the nurses (male = 28, female = 88)

		Responsible	Not responsible	X^2	P	Cramer's V
		n (%)	n (%)			
Acquaintance Rape						
Victim	Male	22(79)	6(21)	0.01	0.91	0.01
	Female	70(80)	18(21)			
Perpetrator	Male	19(68)	9(32)	0.006	0.94	0.007
	Female	59(67)	29(33)			
Marital Rape						
Victim	Male	18(64)	10(41)	0.24	0.63	0.05
	Female	52(59)	36(41)			
Perpetrator	Male	16(57)	12(43)	0.12	0.73	0.03
	Female	47(53)	41(47)			
Stranger Rape						
Victim	Male	17(61)	11(39)	0.08	0.78	0.03
	Female	56(64)	32(36)			
Perpetrator	Male	11(39)	17(61)	0.13	0.72	0.03
	Female	38(43)	50(57)			
Date Rape						
Victim	Male	19(68)	9(32)	1.00	0.32	0.09
	Female	68(77)	20(23)			
Perpetrator	Male	9(32)	19(68)	0.09	0.77	0.03
	Female	31(35)	57(65)			

Table 6: Nurses' Perceptions of degree of rape trauma by their Gender (male = 28; female = 88)

		Not traumatic	Traumatic	x^2	p	Cramer's V
		n (%)	n (%)			
Virgin	Male	3(11)	25(89)	3.67	0.06	0.18
	Female	2(2)	86(98)			
Married	Male	5(18)	23(82)	0.30	0.58	0.05
	Female	12(14)	76(86)			
Divorced	Male	6(21)	22(79)	0.01	0.91	0.01
	Female	18(21)	70(80)			
Prostitute	Male	20(71)	8(29)	0.40	0.53	0.06
	Female	68(77)	20(23)			
Widow	Male	4(14)	24(86)	0.008	0.93	0.008
	Female	12(14)	76(86)			

Discussion

Rape myths acceptance has been explored in many societies and it is still found to be prevalent (Hine & Murphy, 2019; Custers & McNallie, 2017; Barnett, Sligar &, Wang, 2016). The findings from this study does not exonerate the nurses from rape myths acceptance as more than half of them were found to have high rape myths acceptance. The result also confirms the report of Folayan, (2013) that rape myths acceptance is prevalent in the Nigerian society and has contributed to frequent occurrences of rape cases. Rape myths acceptance is a societal issue that is embedded in the beliefs and norms of every society most importantly in Africa. Even in marriage, it is believed that rape cannot occur between husband and wife under any circumstance as long as the woman has signed a marriage contract with the man who has the right to demand for sex from her without refusal (Tavrow *et al*, 2013).

The results from this study also indicated that the level of rape myths acceptance of nurses do not exonerate them from blaming victims and defending perpetrators as no significant difference was found between nurses that had LRMA and HRMA in their attribution of responsibilities in different rape cases except in the attribution of responsibility to perpetrator in acquaintance rape. Even for acquaintance rape, only 0.5% in the RMA accounted for the difference. The nurses who had LRMA can be said to have an understanding of rape myths but in actual sense, they held on to rape myths as reflected in their attribution of responsibilities. Critically looking at the result of the attribution of responsibility, higher percentage of nurses with LRMA and HRMA attributed responsibility to victims in all the rape cases. Even in acquaintance rape where a significant difference existed between those who had LRMA and HRMA, the percentage of those who attributed responsibility to victim among those who had LRMA is more than those who attributed no responsibility (Table 3). The findings from this study did not support the report of previous studies (Ayala, 2018; Reynolds, 2017; Süssenbach *et al*, 2017; Ojo, 2013; Grubb & Turner, 2012; Basow & Minieri, 2011; Hammond *et al*., 2011) that increased rape myths acceptance is associated with victim blame. For this set of professionals in this study, it can be inferred that having low rape myths acceptance does not guarantee their not attributing responsibility to victims in marital, stranger, date and acquaintance rapes. Recently, Gurnham (2016, pg 277) had argued that "using rape myths acceptance as a conceptual framework for understanding whether a particular response constitutes victim-blame may be as likely to mislead as to guide, and that a broad review of psychological and sociological research actually suggests that seeking to exclude certain beliefs as unacceptable may be both unwarranted and unhelpful". With this report of Gurnham, (2016, pg 277) and the findings from this study, it becomes imperative to carry out more studies to identify if individuals with LRMA do not actually blame rape victim and exonerate the perpetrator.

Furthermore, the trend that was observed in the attribution of responsibility was also observed for the perceptions of degree of trauma in this study. Majority of the nurses with HRMA and LRMA perceived that rape is traumatic to a virgin, married woman, divorced woman and a widow but not traumatic to a prostitute. It would have been expected that all the nurses or majority of them with LRMA will perceive that rape is traumatic to a prostitute but, a higher percentage of them, just like those with HRMA reported that it is not traumatic to a prostitute. Although, a significant difference occurred in their perception (Table 2) but only 4.4% of their RMA explains the difference. The findings confirmed again that RMA might not necessarily be associated with the perceptions of degree of trauma experienced by female rape victims. However, the perceptions that rape is not traumatic to a prostitute but traumatic to other types of women is an erroneous impression of these nurses. It is expected that nurses should view the degree of trauma experienced by different categories of victims as same because rape will have the same effect on every category of woman that is raped. Nurses as health care professionals should express unbiased mind towards different rape victims in the discharge of their duties so as to

ensure the delivery of quality care to all victims of rape.

In many studies, gender has been found to influence RMA, attribution of responsibility or victim blame (Hockett *et al*, 2016; Hust *et al*, 2016; Angelone *et al*, 2016). Contrary to previous studies, gender in this study was not associated with the nurse' RMA, attribution of responsibility and perceptions of degree of rape trauma. This finding is consistent with the report of Barn and Powers, (2018) in their study as they found no association between gender and RMA among Indian and UK students. This is expected for nurses because, nurses as health care professionals should deliver care without gender bias. This value has been inculcated into them during their professional training in which they are taught to give quality care irrespective of gender, race or culture. As health care professionals, it is expected that nurses view rape as a serious health problem and should not allow gender to influence or cloud their perceptions of rape and acceptance of rape myths.

Conclusion

This study concluded that rape myths acceptance is high among nurses in the study setting. The nurses who had LRMA and those with HRMA did not differ significantly in their attribution of responsibility to victims and perpetrators in different rape scenarios as well as their perceptions of degree of rape trauma experienced by different female rape victims.

Strenght and Limitation

The study has strength in its ability to show that nurses' level of rape myths acceptance (high or low) might not necessarily cause differences in their attribution of responsibility to victims or perpetrators in different rape scenarios. Also, they might not differ in their perceptions of degree of rape trauma experienced by different female rape victims. This study was carried out among working class nurses who were baccalaureate nursing students in a part-time programme in a Nigerian University. Therefore, generalizing the findings of this study to the entire Nurses in Nigeria is limited. Also, perpetrator in this study is a male gender while victim is a female gender. The authors appreciate the fact that female gender could also be a perpetrator while male gender could be a victim. Therefore, interpreting the result of this study is only limited to female gender as a victim and male gender as a perpetrator.

Implication of the Study to Nursing Education and Practice

The findings in this study have implications for both nursing practice and education. Nurses are trained not to allow their beliefs and values to influence the care they provide to their clients, but this study showed that many nurses are still holding on to rape myths. In order for nurses to be able to provide unprejudiced and quality care in practice especially to victims of rape, they must draw a clear cut line between their values and beliefs about rape and the care rendered to clients. Also, the concept of rape and its management should be included in the curricula of schools of nursing and baccalaureate programme as a module to be taught within a larger course on violence. Emphasis should be laid on the teaching of value clarification, ethics and advocacy in foundation of nursing practice to ensure that nurses are well equipped to provide dispassionate and quality health care to recipient of care especially rape victims. Aside from the educational teaching of rape, rape as a concept should be developed as a module and delivered as a continuing educational programme for practicing nurses.

This study has revealed the need to train nurses on rape concept and management and improve their perceptions of rape myths. However, it should be understood that reducing RMA among nurses requires special rape-focused training that is culturally relevant to their curriculum content because RMA is a product of societal beliefs and norms which might take a while to correct in the community.

Recommendations

This study has been able to show that rape myths acceptance might not necessarily be linked to attribution of responsibility and perceptions of degree of rape trauma. Therefore, more studies are required to explore these variables and identify the differences that may exist between individuals with HRMA and LRMA in their views of different rape scenarios and perceptions of rape trauma. This is necessary because, many past studies have shown

that victim blame and perpetrator exoneration is to a large extent, a product of rape myths acceptance.

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