RAPE MYTH ACCEPTANCE IN INDIAN ADULTS: A DEMOGRAPHIC ANALYSIS

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Abstract

This study seeks to identify the demographic variables that are related to rape myth acceptance (RMA) among young adults in India. Adding to the scarce body of research on the subject of rape myth acceptance in India, this study draws on research that was conducted on a sample of 1000 adults, the majority of whom were women ($F_n = 660$, $M_n = 340$). Age, marital status, and a personal history of victimisation were found to be associated with the nature of rape myth acceptance (high and low RMA) among young adults. Gender, qualifications, and occupation were not linked to RMA. However, even with a smaller number of male participants in the study, a larger share of people with a high RMA was found among men than women. The highest rates above the average RMA were found among people in the 30–35 age group, people with an Mphil/PhD, people whose occupation was in the field of business, and participants who were married. A personal history of sexual victimisation was found to be associated with RMA, but most participants who had no personal history of victimisation had a higher RMA than those participants who had a history of being sexually victimized.

INTRODUCTION

Rape in India

Sexual assault against women is a significant problem in Indian society (*Bhattacharyya*, 2015). The number of rape cases in India has increased over time, in spite of the presence of legal sanctions (*Maity*, 2009). However, there is very little available research on rape in India (*Basu Roy – Ghosh Dastidar*, 2018). The literature on rape in India relies on newspaper articles, case studies, and other social media as its source. Over time, this has created a need to discover what factors contribute to rape in India.

India witnessed one of the most brutal cases of rape ever in December 2012, in what is commonly referred to as the 'Delhi Rape Case'. In 2019, another gang rape and murder of a veterinary doctor in Hyderabad surfaced, and this again rocked the entire nation (*Ganeshan*, 2019). Thus, the list of cases goes on, and the rape statistics in India continue to rise. Table 1 shows the rising number of reported rape cases and provides an indication of how large the number of unreported cases might be.

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Table 1 **The number of reported rape cases in India between 2010 and 2019**									
Year	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Cases	22,172	24,206	24,923	33,707	36,735	34,651	38,947	32,559	33,356	32,559

Source: Statista Research Department (2021).

Some important statistics related to rape in India must be discussed: 35.1% of the sample of women respondents in the third round of the National Family Health Survey (NFHS) in 2005–2006 (on which the UN Women 2011 figures for India are based) reported to researchers that they had experienced physical violence from an intimate partner; 35.4% of the women had experienced sexual or physical violence or both during their lifetime from someone (*Bhattacharya*, 2013). *Gupta* (2014) stated that every third Indian woman between the ages of 15 and 49 claimed to have experienced sexual or physical violence in their lifetime. According to data from the National Crime Records Bureau (NCRB) and NFHS in 2005, a mere 5.8% of the sexual abuse cases perpetrated by a man who was not the woman's husband were actually reported. As few as 1% of cases in which the culprit was the woman's husband were reported. Also alarming to note is the fact that there were 40 times more incidents in which the sexual violence was perpetrated by the woman's husband than incidents in which the perpetrator was not the woman's husband.

Experts often state that the patriarchal system in India is to be blamed for such a high number of rape cases. Wherever men view women as their personal property, the situation becomes too tough for women to live in (*Johnson*, 2005). Secondly, gender inequality has played a major role in the rising number of rape cases. A former Indian Prime Minister once stated that no nation can hold its head high if one-half of humanity (i.e. women) is discriminated against (*Sharma et al.*, 2014). Also, as long as sex is considered a taboo subject in India, sex education will be kept at bay. The absence of proper sex education in India can lead to conservatism and the emergence of rape culture (*Ismail et al.*, 2015). In addition to these factors, there are several cultural (*Hofstede*, 1998), institutional, and educational factors that also contribute to the high rate of rape in India.

Rape and rape myths

Knowledge of rape myths is crucial for understanding rape. *Burt* (1980: 1) has defined rape myths as 'prejudicial, stereotyped, or false beliefs about rape, rape victims, and rapists'. Rape myth acceptance is about sharing in widely held beliefs that lead people to support or reject the occurrence of sexual violence, and that ultimately justify a perpetrator's acts and lead to the victim being blamed (*Newins et al.*, 2018). *Lonsway* and *Fitzgerald* (1994) stress the cultural factors behind rape myth acceptance (RMA). Men justify rape myths to deny that there has been any sexual violence or involvement in a crime, whereas women do it to evade personal vulnerability (harassment, damage to their reputation, etc.) after the incident has occurred. In some instances, even women may strongly endorse rape myths, which is also a part of the gender-based hypothesis of the present study. For example, if a woman believes that dressing in a provocative way leads to rape, she can make herself feel safer by deciding to 'always dress decently'. Different stereotypical rape scripts, such as 'only girls with a bad character get raped' or 'women who are substance abusers get raped', can function like rape myths (*Peterson – Muehlenhard*, 2004), irrespective of gender. Prevalent rape myths are known to play a major role in sustaining rape culture (*Barnett et al.*, 2018). *Scully* and *Marolla* (1984) have argued that rape myths predict rape. Also, RMA is associated with a personal history of being sexually abused. An abused person is more likely to have rape-supportive attitudes than a person who has never had such an experience. A person who has been sexually abused can commit various crimes against other people in the future. Also included in these crimes are sexual offences (*Widom – Ames*, 1994).

Studies on rape myth acceptance in India are scarce. A recent study among Indian students showed that anti-social attitudes, sexist attitudes, and low self-control contribute to high RMA among students (*Qureshi et al.*, 2021). India shows a higher tendency

to disbelieve rape claims, compared to the USA and Japan (*Stephens et al*., 2016). Among Indian medical students, a study revealed that nearly one-fifth of their sample show a high level of RMA, among both men and women (*Chudasama et al*., 2013). But very few studies focus on demographic variables, which may be linked with RMA.

Thus, determining the nature of the rape myth attitudes that people endorse is important for understanding how rape myths relate to the crime of rape. Hence, it is essential to determine the demographic factors related to RMA and how they are associated with different variables. This is the premise underlying the objectives of the current study designed to gather more knowledge about RMA in India.

Objectives
1) To discover the nature of RMA among Indian adults in different demographic strata.
2) To determine how the demographic variables are associated with the nature of RMA, experienced by the Indian adults

METHODS
Sample
The sample consisted of 1,000 young Indian adults. Among them, 660 were females and the other 340 were males. The participants ranged in age from 18 to 35 years and the mean age was approximately 25. Taking into account the age structure in India, 10.76% of Indians fall between the ages of 18 and 23 (as reported in knoema.com[3]). In the present sample, 50.2% of the participants belonged to the 18–23 age group and the rest (49.8%) fell into either the 24–29 age group or the 30–35 age group. The Indian age structure indicates that around 15% of the population are between 25 and 35 years of age (*Basu*, 2007). These differences between the representative sample and the population result from the fact that population data (in percentages) include age groups under the age of 18 and above the age of 35, as well. Also, not all the detailed age divisions in the current sample were available in the census data. Hence, they could not be compared accurately.

The participants had diverse educational qualifications and different occupations. All were currently working and residing in India at the time of the study. Both married and unmarried people were included in the study. One crucial criterion for inclusion in the study was that participants had to be conversant in the English language. A random sampling technique was used to derive the sample for this study.

Materials used
A basic information form was drawn up and administered to collect general demographic information from the participants. The updated Illinois Rape Myth Acceptance Scale (*McMahon – Farmer*, 2011) was administered to assess rape myth acceptance among the participants. This scale utilises a 5-point Likert-type scale, where the scores range from 1 (strongly agree) to 5 (strongly disagree). Higher scores in the test indicate a greater rejection of rape myths. There are four subscales in the test: i) It wasn't really rape, ii) He didn't mean to (includes both normal items and intoxication items), iii) She lied, and iv) She asked for it. The Cronbach's alphas of the subscales ranged from 0.64 to 0.80. The overall Cronbach's alpha for the entire test was found to highly reliable (α=0.87). The scale is especially fit for this study because it was validated in an Indian context. The test was found to possess satisfactory reliability (α=0.86), validity, and other psychometric properties when it was administered to an Indian sample (*Das – Bhattacharjee*, 2021).

Procedure
Ethical norms of research were adhered to in the data collection. Consent, rapport-building, and prior knowledge of being involved in research are important ethical standards that were upheld in this study. After the process of data collection, the data were properly categorised and tabulated. The frequencies were carefully computed for each of the demographic strata (variable). The data from the IRMAS (Illinois Rape Myth Acceptance Scale) provided the four subscale scores, which were then totalled to get the full scale score. In this study, we utilised the total or full scale

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3) https://knoema.com/atlas/India/topics/Demographics/Age/Population-aged-18-23-years (retrieved on 15 January 2022).

score, which depicts the overall nature of the rape myth acceptance, endorsed by the participants. Following the central score of the updated IRMAS scale, the participants were categorised into 'low RMA' and 'high RMA' groups. Individuals who scored below the average score of 66 were categorised as 'High RMA' and those who scored above it were categorised as 'Low RMA'. This is because higher scores in the IRMAS scale is associated with a higher rejection of rape myth acceptance (*McMahon – Farmer*, 2011).

The Chi-square test and Phi correlation were then conducted to determine the association and correlation between RMA and the different demographic variables. For the variables with more than two levels (resulting in a greater than 2x2 table), the contingency correlation coefficient was computed, which replaced the Phi correlation. All the statistical analyses were done in IBM SPSS v25. The interpretations, discussions, and conclusions here are based on the findings.

RESULTS

Table 2 **Frequencies of the demographic variables and their associations with RMA**

Age	18–23	24–29	30–35	Total	χ^2	C
Low RMA	457	389	51	897		
	91.0%	90.0%	77.1%	89.7%	12.06**	0.356**
High RMA	45	43	15	103		
	9.0%	10.0%	22.9%	10.3%		

Gender	Female		Male		Total	χ^2	Φ
Low RMA	598		299		897		
	90.6%		87.8%		89.7%	1.73	.043
High RMA	62		41		103		
	9.4%		12.2%		10.3%		

Educational qualifications	12th	Graduate	PG	M.Phil. & PhD	Others	Total	χ^2	C
Low RMA	132	369	344	28	24	897		
	89.7%	89.9%	88.8%	88.2%	100.0%	89.7%	3.24	.102
High RMA	15	41	43	4	0	103		
	10.3%	10.1%	11.2%	11.8%	0.0%	10.3%		

Occupation	Student	Self-Employed	Service	Business	Total	χ^2	C
Low RMA	641	67	167	22	897		
	90.0%	87.5%	90.8%	80.0%	89.7%	4.26	.134
High RMA	71	9	17	6	103		
	10.0%	12.5%	9.2%	20.0%	10.3%		

Marital status	Unmarried		Married		Total	χ^2	Φ
Low RMA	839		58		897		
	90.3%		81.6%		89.7%	5.31*	.07*
High RMA	90		13		103		
	9.7%		18.4%		10.3%		

History of victimisation	Present		Absent		Total	χ^2	Φ
Low RMA	442		455		897		
	95.5%		84.6%		89.7%	31.00**	.18**
High RMA	21		82		103		
	4.5%		15.4%		10.3%		

*p< .05 **p< .001 χ^2 = Chi Square, Φ = Phi Correlation, C = Contingency Correlation
All percentages are computed across the columns.

As Table 2 shows, 897 (89.7%) respondents had a low rape myth acceptance and hence were categorised into the 'Low RMA' category. There were 103 (10.3%) respondents who were categorised into the 'High RMA' category. This shows that most Indians tend to reject myths associated with rape. *Qureshi et al.* (2021) has argued that there may be a lower rape myth acceptance among the Indian people than people residing in western countries like the United States.

We will now analyse the demographic variables associated with a high or low RMA. In terms of age, we find that the majority (91%) of respondents in the 18–23 age group had low RMA scores. The same is true for the other two age groups. The largest share of people with a high RMA (22.9%) was found in the 30–35 age group. The inferential statistics indicate that there is a significant association between age groups and the nature of RMA (χ^2=12.06; C=.356; $p<$ .001). Whether people experience low or high RMA depends on the age group they belong to.

Among both sexes, the majority of respondents belong to the low RMA category, as 91% of females and 88% of males experience a low RMA. A larger share of people with a 'high RMA' were found among men than women. The association and correlation tests showed that gender is not linked to RMA (χ^2 = 1.73; Φ = .043; $p>$ .05). The gender of the participants does not distinguish between people who have a high and a low RMA.

Figure 1 **High RMA across all the demographic variables**
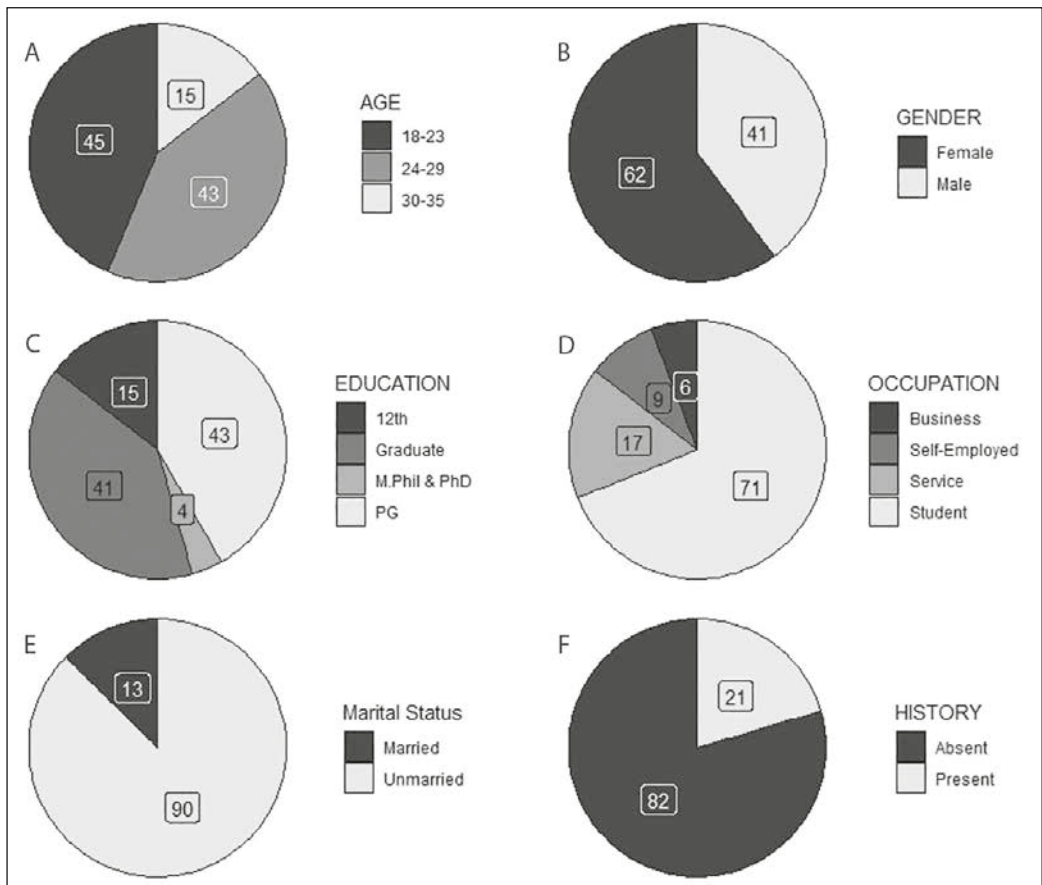
Note: Numerals indicate the frequencies of High RMA in the different categories.

Across all the categories of educational qualifications, the majority of respondents in each category had low RMA. The highest within group percentage of a 'high RMA' was found among people with MPhil or doctoral degrees. The other lower qualifications are seen to lag behind in terms of 'high RMA' rates. However, no significant association or correlation between RMA and people's qualifications (χ^2 =3.24; C= .102; p> .05) was found.

In terms of the occupation of respondents, all four categories show a high rate (percentage) of low RMA. The business sector showed the highest within group percentage of 'high RMA' (20%). The inferential statistics show no significant association or correlation between RMA and the occupation of the respondents, which suggests that the respondents' low or high RMA is not linked to their occupation (χ^2 = 4.26; C= .134; p>0.05).

Among both the married and unmarried participants most of the respondents had a low RMA. Only 9.7% of the unmarried group and 18.4% of the married group had a high RMA. Thus, the married group had a larger share of people with a 'high RMA'. Also, a significant association and correlation was found to exist between RMA and marital status (χ^2 = 5.31; Φ= 0.07; p<0.05). This implies that the marital status of the participants is linked to whether they have a high or low RMA.

Finally, a history of victimisation shows a highly significant association and correlation with RMA (χ^2 = 31; Φ= 0.18; p< .001). Among participants who report a history of sexual victimisation, the majority (96%) have a low RMA. Although the number of respondents with a 'low RMA' and no history of being sexually victimised is higher than the number of those with a 'low RMA' and a history of victimisation, the number of respondents in the 'high RMA' category was also higher among those with no history. Despite these findings, the association was found to be significant, which suggests that a personal history of victimisation is linked to the nature of RMA a person endorses.

Thus, both of the study's objectives were fulfilled. The following figure provides a better illustration of the percentages of high RMA across the variables.

DISCUSSION

Early studies pointed to the role of age in the acceptance of rape myths, and the findings of this study concur with this. Younger people were found in this study to have a lower rape myth acceptance (*Burt*, 1980; *Hudson – Rickets*, 1980). In a study conducted in 2005, older people were found to be more accepting of rape myths (*Kassing et al.*, 2005). In the current study, the age group of '30 to 35 years' had the highest number of people with a high RMA. This may be due to generational differences, the types of family culture they were exposed to, the societal and cultural norms that existed when they were growing up, and other factors that contributed to the difference between the three age groups shown in the study.

In contrast to the present findings, past studies identified a significant association between gender and RMA. This study found, however, that although gender was not linked to RMA, high levels of RMA were more common among men than women. *Davis* and *McCartney* (2003) stated that men are the ones who tend to blame the victim the most. Women do not blame the victim or the situation and they also tend to deny that victims could easily avoid sexual assault (*Kopper*, 1996).

Qualification and occupation were not found to be associated with RMA in the present study. In line with the present findings, a study in Nigeria showed that rape perpetration is not associated with educational qualification (*Laima et al.*, 2020). *Kassing et al.* (2005) showed that education is a notable determinant of RMA, which is consistent with the findings of this study. People with lower levels of education were found to be more accepting of rape myths. In another study, it was found that people with post-secondary education do not significantly differ from people who have a lower level of education when it comes to having rape supportive attitudes (*Powers et al.*, 2015). This is at odds with the common notion that education liberates people and broadens their outlook in life, thus playing a significant role in their attitudes towards rape myths.

The role of occupation in RMA is a much less researched topic (*Klemmack – Klemmack*, 1976). People with a higher occupational status are less likely to blame a rapist than people with a lower occupational status (*Sealy – Corninsh*, 1973). A person's job status was also found to have an effect on whether the

rapist was blamed for rape (*Deitz – Byrnes*, 1971). Similar results were found in a study that employed the 'successful employee vs student' design, using the power differential concept (*Yamawaki et al*., 2007). However, in this study, a larger share of people in the occupation of business were found to have a high RMA than were found among students and people in other occupations. This may be owing to the cultural differences of successful people (e.g. in business) in India.

Very few studies have been able to determine the association/relationship between RMA and marital status. In this study, a significant association was found between the two. A larger share of people with a 'high RMA' were found among married respondents (18%) than among their unmarried counterparts (10%). Married people are more conservative in nature (*van der Toorn et al*., 2017) and this can lead to greater acceptance of rape myths. Unmarried people are more in touch with multiple potential partners and are more often going out on dates or meeting new people than married people are, and this can result in a lower RMA among unmarried people.

A personal history of victimisation on the part of respondents was found to be associated with the RMA they endorse. There is said to be a link between the experience of sexual abuse and committing a sexual offence (*Jespersen et al*., 2009). People who have been a victim of sexual abuse after the age of 12 are at a greater risk of being a sexual offender in later life (*Ogloff et al*., 2012). The 'sexually abused-sexual abuser' hypothesis focuses on the association between a personal history of abuse and the perpetration of sexual offences. It lays the foundation for the likelihood that a sexually abused person can abuse and victimise other people later in life (*Leach et al*., 2016). Since RMA is known to be a predictor of the act of rape (*Scully – Marolla*, 1984), this explains why a personal history of sexual abuse and RMA are related. However, a unique finding in this study was that a personal history of sexual victimisation did not lead to a high RMA among the respondents. The share of people with a 'high RMA' was larger among the respondents with no personal history of victimisation. This can be explained by the personal dispositions and other factors relating to the people in the 'negative past history of victimisation' group. And the aforesaid dispositions among these people led to this group having a higher RMA than the 'positive past history of victimisation' group.

CONCLUSION

To conclude, it can be stated that demographic patterns of rape myth acceptance among Indian adults were identified in this study. The study also revealed and discussed how different demographic variables are related to RMA among young adults. It was found that age, marital status, and a history of sexual victimisation were associated with the nature of RMA respondents endorsed. However, gender, educational qualifications, and occupation were found to have no significant association with RMA.

The study determined what demographic factors are linked to RMA. Since the sample in this study is fairly large, the results can be effectively generalised to apply to the Indian population. This study also provides a significant theoretical framework for similar research on other countries or cultures. The findings of the study can help to identify the demographic characteristics of people that make them most likely to support the crimes of rape and to blame the female victims. The reasons why the variables in this study are significantly associated with RMA among young adults in India should be the subject of future related research. Other studies in this area should attempt to predict RMA using other demographic variables correlated to the ones used in this study. Various sex education plans and gender-based sensitisation will help to reduce the acceptance of rape myths among people.

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