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*J Interpers Violence* 2007; 22; 26
DOI: 10.1177/0886260506294995

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Beliefs of Sri Lankan Medical Students About Wife Beating

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The article presents the results of a study on beliefs about wife beating conducted among 476 Sri Lankan medical students. Participants fill out a self-administered questionnaire, which examines six beliefs about wife beating. Most students tend to justify wife beating, to believe women benefit from wife beating, and to believe the wife bears more responsibility than the husband for violence against her. At the same time, most participants express willingness to help battered women. However, the vast majority oppose divorce as a solution to wife beating and are against punishing violent husbands. The results also reveal that a significant amount of the variance in each of the six beliefs are best explained by the students’ patriarchal approach toward women and marriage and by their exposure to violence in their families of origin. The implications of the results for future research and theory development on beliefs about wife beating are discussed.

**Keywords:** wife abuse; wife beating; beliefs about wife beating; students of medicine; Sri Lanka

Wife beating is a multifaceted and multidimensional problem. Its multidimensionality is reflected in many aspects, including its rates, risk factors and causes, consequences for victims and perpetrators, and consequences for the marital and family systems, as well as strategies for treatment.

**Authors’ Note:** Entry of the study data was partially supported by the Research Group on Mental Health and Well-Being in Childhood and Adolescence at the Hebrew University of Jerusalem Paul Baerwald School of Social Work and Social Welfare. The authors would like to thank Professor Rami Benbenishty, the head of the research group, for his support. Correspondence concerning this article should be addressed to Muhammad M. Haj-Yahia, PhD., the Paul Baerwald School of Social Work and Social Welfare, the Hebrew University of Jerusalem, Mt. Scopus, Jerusalem 91905, Israel; phone: 972-2-5882207; fax: 972-2-5823587; e-mail: mshajyah@mscc.huji.ac.il.
and coping. Notably, health is a central dimension of wife abuse, among many other dimensions, such as legal, social, psychological, cultural, and political dimensions that may be relevant to several aspects of the problem. Until recently, health professionals tended to deny or ignore the existence of violence against women, and even when they encountered battered women among their patients, they tended to refrain from viewing the problem as part of their domain of responsibility (Hamberger & Patel, 2004). However, in light of the increasing evidence of high rates of violence against women by their spouses during the past three decades, professionals have begun to relate to the phenomenon as a serious health problem. Physicians are often perceived as standing on the frontline for identification of and intervention with battered women and their children. They are often requested to accomplish some or all of the following tasks: conducting routine screening, identifying coping mechanisms, inquiring about child abuse, performing a safety assessment, developing a safety plan, validating the women’s experiences, documenting the abuse (including taking photographs of injuries), maintaining records, referring the women to specialists or outside resources, reporting to local law enforcement agencies, providing emergency numbers and shelter information, and formulating a follow-up plan that includes future visits by physicians and coordination with community resources (Gerbert, Moe et al., 2002).

Despite the increasing recognition of the problem among physicians and notwithstanding their commitment to be involved in dealing with wife abuse, numerous studies have shown that most physicians do not even engage in screening—one of the primary tasks expected of them. Only 13% of the women who identified themselves in a questionnaire as victims of spouse abuse indicated that they had been asked by health care professionals in emergency departments about their intimate partners’ violence against them (Abbott, Johnson, Koziol-McLain, & Lowenstein, 1995). Ferris’ (1994) study of Canadian family physicians (FPs) and general practitioners (GPs) revealed that less than one third (about 31%) of the respondents believed that they could effectively diagnose physical abuse, and even less (about 25%) believed that they could effectively diagnose emotional abuse. It was also revealed that almost all of the physicians (about 99%) believed that they are missing cases of abuse. Of those physicians, about 55% estimated that they are missing at least 30% of the cases they encounter. In a study conducted by Gerbert, Gansky et al. (2002), physicians reported that they had screened fewer new patients for domestic violence (19%) than for other risk behaviors, such as tobacco use (98%).
alcohol abuse (90%), or HIV/STD risks (47%). Similarly, only 13% of the physicians in that study reported that they ask regular or returning patients about domestic violence, compared with 82%, 61%, and 27% who reported that they ask regular or returning patients about tobacco, alcohol, and HIV/STD risks, respectively.

The physicians in Ferris’ (1994) study mentioned 21 reasons for failing to detect 100% of the cases of abused women. Of those reasons, the following were the most common: infrequent patient visits (about 64%), patient’s unresponsiveness to questions about domestic violence (63%), no patient initiative (61%), lack of time (48%), not trained (32%), unresponsiveness of the patient to referrals (29%), forget to ask (29%), and cultural barriers (24%). Physicians participating in a study by Sugg and Inui (1992) indicated that they consider exploring domestic violence in the clinical setting analogous to “opening a Pandora’s box.” The main issues and barriers they present for identifying battered women include (a) discomfort (e.g., close identification with the patients, the physician’s own experience with abuse), (b) fear of offending the patient (e.g., the physician’s discomfort with areas that are culturally defined as private, such as wife abuse, fear of “accusing” the alleged batterer), (c) powerlessness (e.g., frustration and feelings of inadequacy to intervene), (d) loss of control (e.g., control of the outcome and circumstances was in the hands of the patients, or the physicians felt that their intervention is useless), and (e) time constraints. Compared with their beliefs regarding tobacco use and HIV/STD risks, significantly fewer physicians in the study by Gerbert, Gansky et al. (2002) believed that their intervention efforts in domestic violence are likely to be successful. In addition, quite a few of the physicians who intervene in some cases of wife abuse reported that they often pay a financial price because they are “marginalized” by their colleagues and by the institutions that employ them (Cohen, De Vos, & Newberger, 1997).

Hamberger and Patel (2004) also highlight personal reasons for unwillingness to identify and intervene in cases of domestic violence (e.g., discomfort with the topic and negative beliefs about battered women) as well as reasons such as lack of training, the belief that the problem is none of their business, and lack of system support. Clearly, these studies and reviews indicate that among the main causes and barriers that prevent physicians and other health practitioners from intervening in cases of violence against women are their approach toward the problem and beliefs about it. Assuming that these beliefs about wife abuse are not acquired with professional education and experience but develop gradually from childhood
through adolescence and young adulthood, there is a need to identify such attitudes and beliefs among students during their academic studies. In recent years, research has been conducted on issues related to wife abuse among students in the health professions (e.g., Coleman & Stith, 1997; Janssen, Landolt, & Grunfeld, 2003). However, very few of them have examined the students’ attitudes toward wife abuse, and most of them have focused on the skills and training they receive to deal with the problem.

Colman and Stith (1997) conducted one of the few studies on beliefs about wife beating among students in the health care profession, focusing specifically on female nursing students. The results revealed that the more the nursing students maintained egalitarian sex-role attitudes, the greater their sympathy toward victims of domestic violence. Although Coleman and Stith used a model that examined the combined impact of feminist perspectives and social learning on students’ attitudes toward violence against women, only feminist perspectives were found to have a significant effect. As for social learning, students’ exposure to violence (i.e., witnessing and personally experiencing violence) did not correlate significantly with their attitudes toward the problem. Hence, besides the dearth of empirical evidence on health students’ beliefs about violence against women, it should also be noted that previous research focused on one or two beliefs (e.g., sympathy toward abused women), while ignoring other important beliefs (e.g., justifying wife beating, the belief that women are responsible for and benefit from beating). In addition, these studies do not provide a comprehensive theoretical explanation for such beliefs, and most important, they were conducted among students in Western societies, which are typically individualistic. Thus, there is a lack of similar studies among students in Eastern and collectivist social contexts, in which the status of women may be lower than in individualistic societies (Matsumoto, 1996).

In an attempt to fill this gap, this article presents a pioneer study on beliefs about wife beating among medical students from Sri Lanka, which is a typical collectivist society (Matsumoto, 1996). The study was based on an integrated and multidimensional conceptual framework, which combines factors derived from the feminist perspective with social learning theory, as well as intrapersonal (personality) factors, family environment, and some sociodemographic characteristics (e.g., Jasinski, 2001). Specifically, expectations of marriage (i.e., egalitarian vs. patriarchal) and attitudes toward women (i.e., liberal vs. traditional) represented the feminist perspective. As for social learning, we tested witnessing of interparental violence and experiencing violence by a parent. In addition, psychological symptoms were
examined as some types of intrapersonal and personality factors, and family functioning (i.e., affective and communication dimensions in the family) was tested as an indicator of the participants’ family environment. As indicated, the participants’ sociodemographic characteristics (gender, age, year of university studies, father’s and mother’s levels of education, and family’s socioeconomic status) were also tested in an attempt to examine their relevance to beliefs about wife beating. Accordingly, the study tested the extent to which this multidimensional perspective and conceptual framework explains six main beliefs about wife beating among Sri Lankan medical students: justifying wife beating, the belief that women benefit from beating, the belief that women are responsible for being beaten, beliefs about helping battered women, the belief that husbands are responsible for their violent behavior, and beliefs about punishing violent husbands.

Method

Sample

The study was conducted among 476 medical students at a major university in Sri Lanka: 50.6% of the students were women and 49.4% were men. Participants’ ages ranged from 19 to 34 ($M = 22.2$, $SD = 1.64$). The students’ distribution by year of study was as follows: about 64% were in their first year of university, about 4.5% were second-year students, about 14% were third-year students, and about 18% were fourth-year students (because the percentages were rounded, the total is slightly more than 100%). Owing to the small number of second-year participants, they were merged with the third-year students, and both years were treated as one group in the data analysis. Because of technical and bureaucratic constraints, fifth-year students did not participate in the study. As for religion, about 89% of the participants were Buddhist and 11% belonged to other religions (3% Hindu, 6% Christian, 1% Muslim, and 1% other religions). Regarding ethnicity, the majority of participants (94%) belonged to the Sinhala, and the remaining 6% belonged to other ethnic groups. Fathers’ and mothers’ ages ranged from 38 to 79 and 35 to 71, respectively ($M = 56.1$, $SD = 5.6$, and $M = 51.8$, $SD = 5.0$, respectively). With regard to the socioeconomic status of the participants’ families, about 1% defined their families as high class, 20% as upper middle class, about 67% as middle class, 10% as lower middle class, and about 2% as socioeconomically deprived.
Measures

A self-administered questionnaire based on the following items and scales was used to measure the different variables in the study.

**Background information.** The questionnaire consisted of several items relating to the participants’ sociodemographic background, such as age, gender, year of study at the university, religion, ethnic affiliation, fathers’ and mothers’ ages and years of schooling, number of siblings, and family’s socioeconomic status as perceived by the participant.

**Beliefs about wife beating.** A revised version of the Inventory of Beliefs About Wife Beating, developed by Saunders, Lynch, Grayson, and Linz (1987), was used in this study to measure the following five beliefs about wife beating: (a) justifying wife beating (JWB, 15 items), (b) battered wives benefit from beating (WBB, 4 items), (c) helping battered wives (HBW, 7 items), (d) husbands are responsible for their violent behavior (HRV, 3 items), and (e) punishing violence husband (PVH, 1 item). Saunders et al. (1987) report that all of the five variables have acceptable internal reliability. In the current study, the Cronbach’s alpha values were .86 for the JWB scale, .77 for WBB, .84 for HBW, and .79 for HRV. Because PVH was measured by one item, it was not possible to calculate a Cronbach’s alpha value. A sixth belief i.e. battered wives are responsible for their beating (WRB, six items) was measured by a short version of Haj-Yahia’s (2003) scale. The Cronbach’s alpha value for the version of that scale used in this study was .87. Responses to all of the items related to the six beliefs were based on a 7-point scale ranging from 1 = strongly agree to 7 = strongly disagree. All six beliefs were considered the main dependent variables of the study.

**Attitudes toward women.** A short version of the Spence and Helmreich (1978) Attitudes Towards Women Scale (ATWS) was used in this study to measure types of attitudes toward women among Sri Lankan medical students (i.e., traditional-patriarchal vs. liberal-egalitarian). Spence and Helmreich found a correlation of .91 between this measure and the original version of the ATWS. The Cronbach’s alpha value of that scale, as used in the present study, was .87. Responses on the items of this measure were based on a 4-point Likert-type scale ranging from 1 = strongly agree to 4 = strongly disagree.

**Marital role expectations.** A short 14-item version of Dunn and DeBonis’s (1979) Marriage Role Expectations Inventory (MREI) was used
to measure Sri Lankan medical students’ marital role expectations (i.e., companionship-egalitarian vs. traditional-patriarchal expectations). Dunn and DeBonis reported a Spearman-Brown reliability coefficient of .975 for the measure on a split-half correlation analysis. The Cronbach’s alpha value for the short version of the MREI used in this study was .85. Responses to these items were based on a 5-point Likert-type scale ranging from 1 = strongly agree to 5 = strongly disagree.

Exposure to family violence. Two forms of two subscales—Verbal Aggression and Physical Violence—comprising 16 items from Straus’ (1979) Conflict Tactics Scales (CTS) were used to measure participants’ exposure to family violence during childhood and adolescence. One form was used to measure witnessing interparental violence, and another was used to measure parental violence against participants during that period. The CTS is widely used in family violence research and is considered to have reliable and valid subscales of different patterns of the problem. Responses to the items were based on an 8-point scale ranging from 0 = never to 7 = daily. In this study, the Cronbach’s alpha values for measures of witnessing interparental verbal aggression and physical violence were .81 and .84, respectively, and for measures of participants’ experiencing verbal aggression and physical violence by parents were .78 and .76, respectively.

Psychological symptoms. A short 30-item of Briere and Runtz’s (1989) Trauma Symptom Checklist (TSC-33) was used to measure four psychological symptoms—dissociation, anxiety, depression, and sleep disturbance—among Sri Lankan medical students. Briere and Runtz provide a detailed report on the psychometric properties of the TSC-33 and the methodological procedures they used to develop the measure. The Cronbach’s alpha values for the four symptoms measured in this study were .78 for dissociation, .73 for anxiety, .72 for depression, and .63 for sleep disturbance. In addition, the Cronbach’s alpha value for the combined score on all 30 items measured in this study was .91. Because of the very high multicollinearity among all four symptoms, one score for all 30 items was derived to measure one overall symptom, that is, the trauma symptom. Responses on these items were based on a 4-point scale ranging from 0 = never to 3 = very often.

Family functioning. A short 20-item version of Roelofse and Middleton’s (1985) Family Functioning in Adolescence Questionnaire was used to
measure Sri Lankan medical students’ current perceptions of the functioning of their families during their childhood and adolescence, with special emphasis on affective and communication dimensions in the family. The complete version of the scale measures overall family health plus structural, affective, communication, behavior control, value transmission, and external systems dimensions of family functioning. Roelofse and Middleton report that this measure has high reliability and validity. The Cronbach’s alpha value of the short version of the measure used in this study was .84. Responses to those items were based on a 4-point scale ranging from 1 = almost always true to 4 = hardly ever true.

Procedures

After obtaining ethical clearance for the study from the Ethical Clearance Committee of the Faculty of Medicine, University of Colombo, students at that facility were informed that we were conducting a study on personal and family issues, and they were invited to participate in it. About 2 weeks in advance, students were informed by their batch/year representatives of the date, time, and place that the instrument package would be administered. Participants who were present on the specified date were assured that all of the information they provide would be kept confidential. Students were instructed to refrain from providing any information that would disclose their identity. It was also emphasized to students that the survey is not a required part of their university curriculum and that completion of the instrument package automatically reflected their consent to take part in the study. They were informed that they could withdraw from the study at any time, and the contact details of the second author were provided to those who might wish to consult her in regard to any issues pertaining to the study or in case they experienced any discomfort as a result of their participation in the study. The students were asked to complete the instrument package during lecture time. All 476 of the participants who attended that meeting returned the completed questionnaires (i.e., a 100% response rate).

Statistical Analysis

Three types of statistical analyses were conducted to address the research questions. First, descriptive statistics were calculated for each of the items that examined beliefs about wife beating. However, because of
space limitations, only examples of the results of this analysis (mainly percentages, means, and standard deviations) are presented in the text. Second, correlations were calculated among several sociodemographic characteristics of the study, the main independent variables as delineated earlier, and the beliefs about wife beating (the main dependent variables—see Table 1). Third, regression and multiple regression analyses were conducted for each of the six beliefs about wife beating, where two blocks of predictors were formed. The first block included participants’ sociodemographic characteristics (i.e., gender, age, year of study at the university, and parents’ level of education). Because of the very high multicollinearity between father’s and mother’s levels of education ($r = .78$, $p < .001$), one variable, parents’ level of education, was derived by adding up the two levels of education. This block was the first to be entered into the regression formula to control for sociodemographic variables. In this way, it was possible to measure the extent to which the variance in each of the beliefs about wife beating could be attributed to the main independent variables of the study (i.e., the second block of predictors), over and above the variance that can be explained by their sociodemographic characteristics. The second block comprised four variables: participants’ patriarchal approach toward women, exposure to family violence, trauma symptoms, and family functioning. The first variable, patriarchal approach, is the result of adding up the participants’ scores on two independent variables, that is, their attitudes toward women and their marital role expectations, which was derived because of the high multicollinearity between these two variables ($r = .67$, $p < .001$). The second predictor (i.e., participants’ exposure to family violence) was derived by adding the participants’ scores on witnessing interparental violence and experiencing violence from parents. One score was produced because of the high multicollinearity among these two patterns of family violence ($r = .51$, $p < .001$). The results of these analyses for justifying wife beating, the belief that women benefit from beating, and the belief that women are responsible for being beaten are presented in Table 2. The results for the other three beliefs—helping battered women, husbands are responsible for their violence, and punishing violent husbands—are presented in Table 3. We are aware that one factor can be produced from all of these beliefs about women, which could be called “sympathy with battered women” (Saunders et al., 1987). However, because of the dearth of such research in Sri Lanka, we thought that if each belief were not referred to separately, this would detract from the richness of the results.
Results

Justifying Wife Beating

The results revealed that between 7.2% and 33.4% of the participants expressed some level of agreement (i.e., strongly agreed, agreed, or somewhat agreed) that in some cases or on some occasions wife beating is justified. For example, 33.4% and 25.1% of the participants expressed some level of agreement that “a sexually unfaithful wife deserves to be beaten” ($M = 4.62$, $SD = 2.54$) and “a woman who constantly disobeys her husband and doesn’t listen to him is asking to be beaten” ($M = 5.28$, $SD = 3.00$), respectively. Although 71.3% of the participants expressed some level of agreement that “even when a wife’s behavior challenges her husband’s manhood, he is not justified in beating her” ($M = 1.69$, $SD = 1.79$), 24.3% and 23.2% of the participants still expressed some level of agreement that “it would do some wives good to be beaten by their husbands” ($M = 5.07$, $SD = 1.85$) and that “occasional violence by a husband toward his wife can help maintain the marriage” ($M = 5.28$, $SD = 1.84$), respectively.

Although participants’ age and year of study at the university did not correlate significantly with the extent that they justified wife beating, male participants were significantly more likely than their female counterparts to justify wife beating ($r = -0.21$, $p < .001$). In addition, the results revealed that the lower the participants’ fathers’ and mothers’ levels of education and the lower the socioeconomic status of their families, the greater their tendency to justify wife beating ($r = -0.12$, $p < .05$, $r = -0.17$, $p < .01$, and $r = -0.14$, $p = .01$, respectively). The results also revealed that the more the Sri Lankan medical students held traditional attitudes toward women and the more patriarchal and nonegalitarian their expectations of marriage, the greater their tendency to justify wife beating ($r = 0.41$, $p < .001$, and $r = 0.54$, $p < .001$, respectively). The results did not reveal significant correlations between the participants’ trauma symptoms and the functioning of their families on one hand and their tendency to justify wife beating on the other. However, the more they witnessed and experienced family violence during childhood and adolescence, the greater their tendency to justify wife beating ($r = 0.32$, $p < .001$, and $r = 0.26$, $p < .001$, respectively, see Table 1).

The results of regression and multiple regression analysis revealed that 44.4% of the variance in the participants’ tendency to justify wife beating can be attributed to both blocks of predictors, whereas gender (males more than females), a patriarchal approach toward women, and exposure to family violence were the most significant predictors explaining this belief ($\hat{\beta} = .214$, $p < .004$, $\hat{\beta} = .563$, $p < .00001$, and $\hat{\beta} = .466$, $p < .00001$, respectively—see Table 2).
Women Benefit From Beating

Between 14% and 24% of the Sri Lankan medical students expressed some level of agreement that women benefit from beating. For example, 14% and 24% of the students expressed some agreement that “most wives secretly desire to be beaten by their husbands” ($M = 5.30, SD = 1.65$) and “wives try to get their husbands to beat them in order to get sympathy from others” ($M = 5.00, SD = 1.66$), respectively. However, 75.5% of the participants expressed some level of agreement that “women feel pain and no pleasure when they are beaten up by their husbands” ($M = 2.49, SD = 1.71$).

Males showed a greater tendency than females to believe that women benefit from beating ($r = .26, p < .001$). Additionally, the lower the fathers’ and mothers’ levels of education, the more likely the participants were to believe that women benefit from beating ($r = -.11, p < .05$, and $r = -.13, p < .05$, respectively). Furthermore, the results revealed that the more traditional the participants’ attitudes toward women and the more patriarchal and nonegalitarian their expectations of marriage, the greater their tendency to believe that women benefit from their husbands’ violence against them ($r = .21, p < .001$, and $r = .27, p < .001$, respectively). In addition, the results revealed that the more the participants witnessed interparental violence and experienced violence by their parents, the more likely they were to believe that women benefit from beating ($r = .16, p < .01$, and $r = .19, p < .01$, respectively—see Table 1).

The results revealed that 25.2% of the variance in the participants’ belief that women benefit from beating can be significantly explained by their gender (males more than females), by their patriarchal approach toward women, and by their exposure to violence in their families of origin ($\beta = .242, p < .001$, $\beta = .182, p < .0001$, and $\beta = .152, p < .001$, respectively). Nevertheless, participants’ age, year of study, parents’ levels of education, families’ socioeconomic status, trauma symptoms, and family functioning did not contribute significantly toward explaining the variance in this belief (see Table 2).

Women Are Responsible for Their Beating

Between 8.2% and 63.1% of the participants expressed some level of agreement that battered women are responsible for their beating. For example, 63.1% of the participants expressed some level of agreement with the statement that “wives could avoid being battered by their husbands if they knew when to stop talking” ($M = 3.50, SD = 1.74$). Furthermore, 15.4% and 19.6% of the participants perceived battered wives as responsible
### Table 1

Zero-Order Correlations Among All Dependent and Independent Variables (N = 476)

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Note: GEN = Gender (male = 1, female = 0); YOS = year of study at the university; FLE = father's level of education; MLE = mother's level of education; SES = family's socioeconomic status; ATW = attitudes toward women; MRE = marital role expectations; WFV = witnessing family violence; EFW = experiencing family violence; TSC = trauma symptoms; FFU = family functioning; JWB = justifying wife beating; WRB = women are responsible for beating; HRV = husbands are responsible for their violence; WBB = wives benefit from beating; HBW = helping battered wives; PVH = punishing violent husbands.

*p < .05. **p < .01. ***p < .001.
The results indicated that male participants were more likely than their female counterparts to perceive battered women as responsible for their beating ($r = .20$, $p < .001$), and the lower the mothers’ levels of education, the more likely the participants were to believe that women are responsible for being beaten ($r = -.12$, $p < .05$, see Table 1). The results also revealed that the more the participants held traditional attitudes toward women and the more nonegalitarian their expectations of marriage, the greater their tendency to hold women responsible for being beaten ($r = .36$, $p < .001$, and $r = .47$, $p < .001$, respectively). Additionally, the more the participants witnessed interparental violence and the more they experienced violence by their parents, the greater their tendency to believe that battered women are responsible for violence against them ($r = .33$, $p < .001$, and $r = .24$, $p < .001$, respectively). The results also revealed that 41% of the variance in this belief can be significantly explained by the participants’ gender (males...
more than females), by their patriarchal approach, and by exposure to family violence (β = .174, p < .02, β = .564, p < .0001, and β = .380, p < .001, respectively). The results indicate that the participants’ trauma symptoms and family functioning did not contribute toward explaining significant amounts of the variance in their belief about women’s responsibility for violence against them (see Table 2).

### Helping Battered Women

Although 31.8% of the participants expressed some level of agreement with the statement that “if I should hear a woman being attacked by her husband, it would be best that I do nothing” (M = 3.37, SD = 1.76), a substantial percentage of the participants tended to believe that wife abuse is a social problem and should be considered as such by social agencies and the law. For example, 71.7% and 86.1% of the participants expressed some level of agreement that “wife beating should be given high priority as a social problem by government agencies” (M = 1.85, SD = 1.61) and “social

### Table 3
Regression and Multiple Regression Analyses on Helping Battered Women, Husbands Are Responsible for Their Violence, and Punishing Violent Husbands (N = 476)

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<th>Punishing Violent Husbands</th>
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Note: GEN = Gender (male = 1, female = 0); AGE = age; YOS = year of study at the university; PLE = parents’ level of education; SES = family’s socioeconomic status; PAW = patriarchal approach toward women; FVE = exposure to family violence; TSC = trauma symptoms; FFU = family functioning.
agencies should do more to help battered women” ($M = 1.26$, $SD = 1.27$), respectively. To cite other examples, 40.5% and 78.8% of the participants expressed some level of agreement that “if I heard a woman being attacked by her husband I would call the police” ($M = 2.84$, $SD = 1.65$) and “the police and the courts should intervene to help battered women as long as their husbands refuse to receive treatment” ($M = 1.44$, $SD = 1.43$), respectively. However, it should also be noted that the vast majority of participants opposed divorce as a solution for treating violence against women: Only 10% agreed that “if a wife is beaten by her husband, she should divorce him immediately” ($M = 4.52$, $SD = 1.47$).

The results revealed that female participants were more likely than their male counterparts to support helping battered women ($r = -.18$, $p < .01$), and the higher the participants’ fathers’ and mothers’ levels of education, the greater their tendency to support helping battered women ($r = .15$, $p < .01$, and $r = .17$, $p < .01$, respectively). Moreover, the results revealed that the higher the socioeconomic status of the participants’ families, the greater their tendency to support helping battered women ($r = .12$, $p < .05$). However, it was also found that the more the participants held traditional attitudes toward women and the more they maintained nonegalitarian expectations of marriage, the less they tended to support helping battered women ($r = -.33$, $p < .001$, and $r = -.34$, $p < .001$, respectively). In addition, the results revealed that the more the participants witnessed interparental violence and the more they experienced violence from their parents, the less they tended to support helping battered women ($r = -.14$, $p < .05$, and $r = -.16$, $p < .05$, respectively—see Table 1).

The results also revealed that 36.2% of the variance in the participants’ willingness to support helping battered women can be significantly explained by their gender (females more than males), by their parents’ level of education, by their patriarchal approach toward women, and by their exposure to family violence ($\beta = -.266$, $p < .0001$, $\beta = .203$, $p < .01$, $\beta = -.404$, $p < .0001$, and $\beta = -.097$, $p < .0001$, respectively). Accordingly, neither age, year of study at the university, family’s socioeconomic status, trauma symptoms, nor family functioning contributed toward explaining a significant amount of the variance in the students’ beliefs about helping battered women (see Table 3).

**Husbands Are Responsible for Their Violence**

Between 33.3% and 48.2% of the participants tended to believe that abusive husbands are responsible for their violent behavior. For example,
48.2% of the participants expressed some level of agreement with the statement that “husbands who batter are responsible for abuse because they intended to do it” \((M = 2.62, SD = 1.68)\). Females showed a greater tendency than males to perceive husbands as being responsible for wife abuse \((r = -0.19, p < .001)\), and the higher the socioeconomic status of the participants’ families, the greater their tendency to hold husbands responsible for violent behavior against wives \((r = 0.13, p < .01)\). However, the more the participants held negative attitudes toward women and the more nonegalitarian their expectations of marriage, the less they tended to believe that husbands are responsible for wife abuse \((r = -0.21, p < .01, \text{ and } r = -0.27, p < .001, \text{ respectively})\). We also found that the more the participants witnessed interparental violence and the more they experienced violence in their families of origin, the less they tended to hold husbands responsible for wife abuse \((r = -0.18, p < .01, \text{ and } r = -0.15, p < .01, \text{ respectively})\)—see Table 1.

The results revealed that 22.6% of the variance in the participants’ belief that husbands are responsible for their violence can be significantly attributed to gender (females more than males), age, patriarchal approach, and exposure to violence in the family of origin \((\beta = -0.226, p < .01, \beta = -0.208, p < .01, \beta = -0.249, p < .001, \text{ and } \beta = -0.086, p < .001, \text{ respectively})\). Hence, year of study at the university, parents’ level of education, socioeconomic status, trauma symptoms, and family functioning did not significantly explain the participants’ beliefs about the husbands’ responsibility for wife abuse (see Table 3).

**Punishing Violent Husbands**

Only 8.7% of the participants agreed that “the best way to deal with wife beating is to arrest the husband” \((M = 4.47, SD = 1.39)\). Females were significantly more likely than males to support punishing violent husbands by arresting them \((r = -0.11, p < .05)\). However, none of the other predictors of the study correlated significantly with this belief (see Table 1). The results revealed that 7.8% of the variance in the participants’ belief about punishing violent husbands can be explained by all of the predictors of the study, where participants’ gender (females more than males) and parents’ level of education were found to be the most significant variables that contributed toward explaining that amount of the variance \((\beta = -0.198, p < .01, \text{ and } \beta = 0.117, p < .05, \text{ respectively})\)—see Table 3.

Besides these results, it should be noted that significant correlations were found between most of the dependent variables. For example, the greater the participants’ tendency to justify wife beating, the more they...
believed that women are responsible for being beaten ($r = .68, p < .001$), the less they believed that husbands are responsible for their violence ($r = -.36, p < .001$), the less they tended to support helping battered women ($r = -.34, p < .001$), and the less they supported punishing violent husbands ($r = -.11, p < .05$). To cite other examples, the more the participants believed that women are responsible for being beaten, the more they believed that women benefit from beating ($r = .46, p < .001$), the less they tended to support helping battered women ($r = -.32, p < .001$), and the less they supported punishing violent husbands ($r = -.15, p < .01$—for more examples, see Table 1).

**Discussion**

A considerable percentage of Sri Lankan medical students participating in this study tended to justify wife beating and believed that women benefit from violence against them. In addition, many of the students tended to place the main responsibility for wife beating on the woman herself and not as much on the husband, although some of the students did believe that both partners share responsibility for violence against the wife. These beliefs are consistent with the patriarchal approach, which views the wife as the source of evil, anarchy, and trickery or deception (Moghadam, 1992). This approach also considers the wife to be inferior to patriarchs in the private and public spheres and expects her to submit to them (Jasinski, 2001). It is not surprising that a substantial share of the Sri Lankan medical students in this study tended to justify wife beating when the wife is perceived as “sexually unfaithful,” “refuses to have sex with her husband,” “doesn’t respect him and his family,” and “constantly disobeys her husband.” Accordingly, it is not surprising that significant amounts of the variance in these beliefs can be explained by the participants’ patriarchal approach toward women and marriage.

Although the students’ tendency to acknowledge the pain experienced by battered women may reflect a sincere recognition of the harsh consequences of violence, it also reflects the prevailing negative and patriarchal perception of women as weak and as “needing to be treated tenderly.” This view may derive from the perspective of patriarchal societies regarding the feminine characteristics of “communion,” that is, personality traits of concern, tenderness, sensitivity, warmth, and connection (Moghadam, 1992). These results are also consistent with patriarchal expectations of husbands to be “real men” (i.e., to be dominant, “to defend their honor,” and even at
times to use violence against their wives in response to attempts to undermine their masculinity and dominant status). Moreover, the understanding approach toward violent husbands conforms to the sexist belief that women are “provocative and cause their husbands to beat them.” Men, by contrast, are perceived as responsible for seeing that the family functions in a way that furthers their perceptions of the “family’s best interests,” and patriarchs in the family are expected to set the moral standards for the behavior of other family members, including the wife (Moghadam, 1992).

The participants’ tendency to help battered women reflects fundamental values such as social solidarity, interdependence, and mutual support, which prevail in traditional societies such as Sri Lanka (Abraham, 2000). In addition, high percentages of participants supported the involvement of welfare services and were in favor of taking legal measures to help battered women. However, a relatively low percentage of them indicated that they would actually be willing to call the police themselves to help battered women, and fewer still approved of divorce as a solution to wife beating. Although the current study did not examine why the students tended to avoid taking initiative to help battered wives, the findings indicate that the more traditional their attitudes toward women and the more patriarchal their expectations of marriage, the less they tended to support HBW. The low tendency to approve of divorce reflects the traditional, patriarchal values that prevail in societies such as that of Sri Lanka, where the family is viewed as a fundamental and sacred institution that should be preserved and sustained, even if the well-being of some family members is harmed (Abraham, 2000; Moghadam, 1992). Also, in Sri Lanka, divorce is considered a social stigma, especially for women and for children of divorced parents. In particular, unemployed women generally prefer to stay on in an abusive marriage because they may have no source of income in the event of divorce and also because they may be socially marginalized as divorcees.

The very low tendency to support punishment of violent husbands also reflected the prevailing patriarchal ideology in Sri Lanka. Punishment of husbands may be perceived as weakening and undermining their control of family life and their dominance of the family domain. Support for punishment of violent men may also be perceived as opposing violence on one hand and as empowering the wife and inciting her to rebel against her husband and society on the other hand.

Although two major predictors that derive from patriarchal ideology (i.e., traditional attitudes toward women and nonegalitarian expectations of marriage) were addressed in this study, there are numerous additional variables such as sex-role stereotypes, sexual conservatism, religiosity, and...
familial patriarchal beliefs that have yet to be examined in relation to students’ beliefs about wife beating. Furthermore, future research on Sri Lankan medical students’ beliefs about wife beating might also explore the structural element of patriarchy as reflected in the low status women generally hold relative to men in the family and in economic, educational, political, and religious institutions in Sri Lanka and the extent to which this element affects the students’ approach toward abused wives, abusive husbands, and children in those families.

The findings also indicated that a considerable share of the variance in the Sri Lankan medical students’ beliefs about wife beating can be attributed to their witnessing interparental violence and experiencing violence in their families of origin. These results are consistent with social learning theory, which argues that violent behaviors, supportive attitudes toward violence, and lenient beliefs about violence are learned and transmitted from one generation to the next (Jasinski, 2001; O’Leary, 1988). According to this theory, when people are exposed to behavior through observation and/or personal experience, they imitate it and learn that society relates to it as appropriate and acceptable. In keeping with this theory, it can be assumed that the students who tended to have a lenient attitude toward wife abuse adopted those beliefs as a result of intergenerational transmission of violence during their childhood and adolescence. The students were evidently affected by their family’s socialization process, which encouraged tolerance toward violence in general and wife abuse in particular (O’Leary, 1988). According to this perspective, it is highly probable that students who experienced and/or witnessed violence in their families of origin learned that violence is an acceptable and appropriate means of resolving conflicts or attaining what they want. In this connection, Bandura (1978) maintained that violence can be learned from three primary sources: family, culture and subculture, and the media.

As shown, this study focused on the relevance of students’ exposure to family violence and their beliefs about wife beating. However, we did not examine the extent to which these beliefs are learned from the other two sources: culture and subculture and the media. Future research should therefore examine the extent to which ethnic and religious affiliation (as major cultural sources) and training for the medical profession (as the participants’ main subculture) are related to their beliefs about wife beating. Most of the medical students participating in this study were Buddhists, and their ethnic affiliation was Sinhala. Because very few of the participants belonged to other religious or ethnic groups, there was no way to conduct a statistically valid comparison of beliefs about wife beating among students from different
religious and ethnic groups in Sri Lanka. We therefore recommend conducting future studies on this topic among representative samples that are large enough to enable comparison of the extent to which the students’ religious and ethnic affiliation affect their beliefs about wife beating. In a similar vein, future studies can examine the extent to which the nature of the students’ exposure to violent and nonviolent behavior in those cultures is related to learning negative or positive beliefs about wife beating. We also recommend examining the extent to which those beliefs derive from aspects of the participants’ culture and subculture that affect the way they work with battered women and the way they perform the professional tasks described above. Notably, year of study in the university can be considered a step in the process of socialization to their subcultural affiliation. In this study, the vast majority of participants were first-year students, whereas a few were third- and fourth-year students and hardly any were in their second year of medical studies. Although no significant differences were found in beliefs about wife beating among first- and fourth-year medical students, there is no doubt that further studies should be conducted among larger samples of students from all 4 years of the medical school program and the practicum period. This would enable more valid comparisons between students in different years of study in an attempt to examine the impact of the curricular content and their professional socialization on their beliefs about wife beating. In addition, future research can examine the extent to which the students are exposed to the third source of learning, namely the media. It would be worthwhile to consider the impact of different types of media on attitudes toward battered wives and violent husbands.

Our findings provided partial but significant evidence that the beliefs of medical students about wife beating are more significantly explained by an integrative perspective that combines various theories from the social sciences than by any one theory. Two of the four theories (the patriarchal perspective and social learning theory) significantly explained most of the variance in each of the six beliefs about wife beating that were examined in this study. However, the other two theories—family systems theory (with special interest in family functioning) and personality and intrapersonal theory (with special interest in trauma symptoms) —did not contribute significantly toward explaining the difference in these beliefs over and above the variance explained by those two theories. Nonetheless, the medical students’ beliefs about wife beating deserve to be examined from a holistic, integrative, and ecological perspective. Consistent with this perspective, future studies can include other theories such as social exchange theory, family stress theory, symbolic interactionist theories, and frustration-aggression
theory, as well as other theories for testing beliefs about wife beating among medical students and practicing physicians. Social exchange theory can be used as a framework for examining the costs and benefits that medical students and physicians weigh when they consider whether to intervene in cases of wife beating. The symbolic interactionist theory can be used as a framework for examining how they perceive themselves personally and professionally as well as how they believe that society perceives them, how they perceive society’s expectations of them, how they expect to be perceived and treated by society, and how all of those perceptions affect their decisions about intervening in cases of wife abuse. Stress and frustration theories can provide a framework for examining the sources and types of stress and frustration that medical students and physicians encounter. Based on that framework, it is possible to examine the extent to which such stress and frustration affect the personal and professional functioning of physicians and medical students with cases of domestic violence.

Even though this study has yielded extensive data on the topic, some limitations need to be taken into account. First, the study was conducted among a convenience sample of medical students at one university in Sri Lanka rather than among a random sample of all medical students in the country. Second, despite the reliability of the CTS as a measure for examining exposure to family violence, several problems need to be addressed. Above all, it was used to examine the students’ exposure to violence in their families before the age of 18 (where that entire age span was considered as one block), without considering the extent of exposure to the problem in different years of their childhood and adolescence. In addition, the CTS was not used to measure the context in which the students were exposed to violence, nor were the students asked how they interpreted that violence during their childhood and adolescence, as compared with their present interpretations. Thus, the measure did not examine the relevance of the historical interpretations of family violence to the students’ beliefs about wife abuse in the past and present. Concomitantly, it is likely that the students forgot or repressed some of the violence that they were exposed to as children and provided only partial reports. This may have had an impact on the strength of the relationship between their exposure to violence and their beliefs. Future research on the topic can take these limitations into account, for example, by inquiring about the contexts in which the students were exposed to violence as well as by asking the students about their past and present interpretations of the violence to which they were exposed. Third, because this study examined issues that are highly sensitive in traditional societies, such as that of Sri Lanka, it is highly probable that social
desirability considerations affected the students’ responses. Hence, future studies on the topic in Sri Lanka and in other traditional societies should include a measure to examine social desirability, which would neutralize or control for the potential impact of those tendencies on participants’ responses.

The implications of the findings for education and training of medical students are noteworthy. Above all, the medical curriculum should incorporate topics that emphasize to the students that there is no justification for violence against women and that enhance the students’ awareness of the suffering that battered women experience. The students need to be made aware that battered women are not responsible for violence against them. In addition, the medical curriculum should increase the willingness of students to help battered women, while heightening their sensitivity to physiological, emotional, cognitive, behavioral, and marital symptoms of wife abuse. The students should be equipped with skills for communicating with abused wives and their perpetrator husbands, which will enable them to provide more appropriate assistance to these women to break the cycle of violence.

Finally, medical training programs need to invest in enhancing students’ awareness of their sexist and patriarchal beliefs in an attempt to counteract negative perceptions of women and nonegalitarian expectations of marriage. Universities must offer individual and group counseling services to medical students to help them overcome the severe consequences of their exposure to violence in their families of origin. It is assumed that by breaking the cycle of violence in the students’ lives, they will be more willing to identify with victims of violence and understand their suffering. Hopefully, this will help the students become more involved in identifying battered women and provide appropriate assistance.

References


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