Intimate Partner and Acquaintance Violence and Victim Blame: Implications for Professionals

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The present article represents a departure from applied crisis intervention and brief treatment-based papers in that it takes one step back and suggests, following several related literature reviews, that preexisting attitudes must be examined by all prior to intervention. The main point of the present article is that victims, perpetrators, and therapists involved in all forms of intimate partner violence must assess their existing blame distribution attitudes, beliefs, and consequent behaviors in order to ensure proper, empathic, and therapeutically effective treatment. Data are also presented on other professionals’ attitudes, such as those of legal, medical, and other allied health professionals in an effort to predict and prevent potentially negative outcomes for clients. Finally, assessment and intervention implications are discussed in light of the reported attitudinal and belief biases apparently present in most professional and lay public samples. [Brief Treatment and Crisis Intervention 1:153–168 (2001)]

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Researchers investigating attitudes toward domestic and other forms of interpersonal violence and victimization in both the social psychology and clinical research literatures have indicated that attitudes have an immense effect and can significantly influence behavior (Anderson, Cooper & Okamura, 1997; DeBono & Snyder, 1995; Petretic-Jackson, Witte, & Jackson, in press; Witte, Cavanah, & Jackson, 2001). Consequently, the present article differs somewhat from those that focus on specific applied crisis intervention and treatment strategies for various populations and individuals in that this paper takes one step back, to focus on the underlying attitudes and beliefs held by clinicians, clients, and other groups of individuals, both lay and professional, who interact with victims and perpetrators of interpersonal violence, in particular, domestic violence. We suggest that clinicians must be aware of these attitudes and
the salient factors that contribute to beliefs such as acceptance of violence or victim blame. An examination of personal beliefs with regard to domestic and other forms of violence should be resolved and worked through prior to undertaking intervention with individuals presenting with such concerns, and periodically reexamined given the known impact (e.g., vicarious trauma; Schauben & Frazier, 1995) of working with traumatized groups on clinicians. Examples of these attitudes and personal beliefs include victim and situational blaming, rather than focusing on victim problem-solving and treatment, and some basic and rather simplistic causal assumptions professionals also make, such as “victims did something to deserve or contribute to their victimization,” and “perpetrators can’t control their actions if they’re drunk or too stressed.” We also suggest that in addition to a focus on symptom alleviation, client beliefs and attitudes warrant both assessment and review throughout the course of intervention. Thus, while this paper presents a review of research on attitudes and attitude modification, the intent is to encourage the crisis intervention professional and brief treatment therapist to use this information to address clients’ and their own beliefs, attitudinal difficulties, and consequent behaviors prior to and during treatment involving domestic and other forms of violence (Petretic-Jackson et al., in press).

Violence Prevalence

Violence involving intimates or acquaintances is now recognized as a significant social problem in our country. The U.S. Department of Justice’s Bureau of Justice Statistics (2001) National Crime Victimization Survey results indicated that, during the period of 1993–1998, over 50% of violent crimes involved intimate partners or family members. Both researchers and clinicians have broadened their perspective, and find they must consider the impact of a significant number of types of violence; individuals report a negative impact, often including significant psychopathology, not just from rape and physical violence but from harassment, coercion, and stalking. Such intrusive acts occur with alarming frequency. For example, Baker, Burgess, & Smolyak (2001) recently found that over half of the males and approximately half of the females in a large urban sample of college students had been cyberstalked (a type of domestic intrusion using computers), which may give rise to symptoms similar to other types of partner personal boundary intrusion. While this in no way is meant to pathologize half the college students in the country, it does point out that boundary intrusions and the potentially new ways of intruding on a person’s life as technology (e.g., the Internet) evolves. In this sample, Baker and colleagues found that the vast majority of females had engaged in drinking within 3 hr of committing the computerized stalking (intrusive and usually noxious and insistent Internet contact). While this aforementioned behavioral correlate of alcohol and the occurrence of various forms of violence and intrusion has been well-established (Jackson, Petretic-Jackson, & Witte, in press), the above represents what we consider an extension of typical boundary violations that could lead to more aggressive forms of interactions and perpetration. Given that the major emphasis in this article will be victim and other blame, it is felt important to point out the variety of “violence” that can exist. More importantly, the point is that a significant proportion of crises and referrals for brief treatment will involve domestic, acquaintance, familial, or intimate partner abuse or coercion of a variety of different types. This fact makes the therapist’s awareness of attitudes toward domestic violence, particularly victim blame, and the research involving gender differences absolutely critical since, different sets of attitudes have been found to be therapeutic, neutral, or poten-
tially psychonoxious (Sandberg & Jackson, 1986). This paper will focus on a research program that has resulted in what we believe is the most clinically useful tool available to assess attitudes regarding domestic violence (Petretic-Jackson, Sandberg, & Jackson, 1994). While this Domestic Violence Blame Scale (DVBS) will be discussed in detail, this article will also present a number of other methods of assessing and dealing with attitudes toward partner violence.

Prior to 1970, research on victimization was rare. With the women’s movement, interest in rape, child abuse, and domestic violence grew and research on these forms of violence gained momentum. Comparatively speaking, the child abuse and rape literatures grew more rapidly than did that on domestic violence. Research specifically focused on attitudes toward all forms of violence, as well as other types of victimization, has steadily grown in the last decade. While a significant body of research on rape attitudes exists, attested to by a recent meta-analytic review on this topic (Anderson et al., 1997) a smaller yet growing body of research has developed regarding domestic violence attitudes. In a relatively early study on this topic, Ewing and Aubrey (1987) examined whether a community sample (N = 216) held erroneous beliefs about battered women (e.g., beliefs that battered women are masochists who are somehow responsible for the battering they suffer and could avoid being battered by simply leaving their batterers). Results suggested that many community members held erroneous, stereotyped beliefs about battered women and that women were more likely than men to subscribe to these stereotypes. The impact of such demographic characteristics as gender, ethnicity, and age on domestic violence attitudes will be discussed in greater detail below.

Over the last several years the general media has also been employed in an attempt to increase the lay public’s awareness of the issue of domestic violence in some very positive ways. For example, public education campaigns are attempting to change attitudes and stereotypical beliefs about domestic violence. Along those lines, victim advocates are using media to disseminate social norm-change messages about domestic violence in both print and television awareness campaigns (Ghez, 2001). Further, other types of media presentations are based on a Zero Tolerance campaign. That is, public education media and poster campaigns are being presented to spread the message that perpetrators (mostly males) should always be held responsible for violence such as that expressed as rape, child sexual abuse, and domestic violence (Gillan & Samson, 2000). These campaigns also serve to educate the public about reporting issues, likely responses from the criminal justice and other professional communities, prevalence rates of various types of violence and their effects on victims and those acquainted with the victims.

While professionals in the health and mental health fields have achieved greater awareness of the problem of battering in the last decade, it has also been suggested that the responses of service providers to battered women may play a significant role in either ameliorating or compounding the problems faced by those seeking assistance. The research discussed below addresses the development and utilization of standardized measures of blame distribution regarding a specific form of battering, wife abuse. While domestic violence attitudes of various demographic groups is the primary focus, attitudes toward other forms of victimization are included due to the commonalities of response to victimization across types of violence/victimization. Individual perspectives (e.g., victim, perpetrator, or therapist) often influence how people view domestic violence and other forms of victimization. Attitudes toward the victim and perpetrator may vary by experience and corresponding beliefs. Attitudes toward domestic violence may consequently best be under-
stood in the context of the relevant belief structure of the individual. Past research has examined the demographic, cognitive, experiential, affective, and personality correlates of attitudes toward victimization (Anderson et al., 1997). Victim blame has been a construct of particular interest to researchers (Petretic-Jackson et al., in press).

Prior to discussing the DVBS (Petretic-Jackson et al., 1994) and other measures and methods of assessing blame, a brief review of the victimization blame literature that led to their development is provided. While many of the blame attribution articles and scales in this paper may appear dated, the reader should note that much more recent data collected in preparation for a monograph (Jackson & Petretic-Jackson, 2001) corroborates the earlier citations involving rape, incest, domestic violence, and violence in general (Jackson, Brown, Davis, & Pitman, 1998).

Throughout the following review, it is important to point out the particular kinds of attributions and assumptions that are particularly problematic among mental health professionals; for example, that victims are people who subconsciously seek battering relationships, there are no effective interventions for batterers, domestic violence is a “relationship problem,” etc. It is also felt important for all of us who are crisis intervention workers, that some of us may harbor hostile feelings toward both batterers and victims for a variety of reasons that have to do with such issues as our own personal histories and secondary post-traumatic stress disorder (PTSD). Attributions, attitudes, and beliefs may be, in large part, a function of unacknowledged anger, hostility, or other, less-than-adaptive characteristics in us.

Some of these aforementioned specific erroneous attributions presented in the previous two paragraphs and elsewhere in the article may lead to ineffective interventions. These beliefs must be assessed and acknowledged, if not resolved, by crisis intervention and all other professionals in order for progress to occur.

Rape Attitudes

As mentioned previously, a moderate body of research has been amassed on attitudes toward rape (Anderson et al., 1997). While several theoretical models of male aggression have been constructed to explain male violence, with regard to blame attributions within the rape victimization literature, the initial investigator in this area, Brodsky (1976) hypothesized that the offender was not the only party blamed for the act. It was maintained that in the minds of the general public, societal attitudes, situational variables, and even the victim herself were also held partly accountable for the occurrence of rape. While the argument seemed cogent, no empirical support was offered at that time. Ward and Resick (1981) standardized and cross-validated a 20-item scale based on Brodsky’s conceptualization. The resulting scale, the Attribution of Rape Blame Scale (ARBS), was found to be factor analytically sound, and distributed the blame for the occurrence of rape across offender, societal, situational, and victim blame dimensions. In subsequent studies of mental health professionals (Resick & Jackson, 1981), rural and urban college women (Kenning & Jackson, 1984), Native Americans (Jackson & Plane, 1987), incarcerated sex offenders (Jackson & Eck, 1987), attorneys and judges (Morris & Jackson, 1989), and college student athletes (Jackson, 1991), a similar pattern of blame distribution was obtained. In all of these studies, the offender was blamed the most for the occurrence of rape. Societal variables, such as the amount of sex and violence in the media, were usually held second most accountable for rape. Situational variables, such as poorly lit areas, were held somewhat responsible for rape. The victim, while blamed the least, was not held
completely blameless. A more important set of findings in these studies involved gender effects. Consistently, in all studies that sampled both males and females, male respondents held the victim significantly more at fault for her own rape than did female respondents. Further, the offender was blamed significantly more by female than by male respondents for the occurrence of rape. This is a pattern that the reader will see persisting throughout this article, and one with serious implications for professionals (Jackson, 1996).

**Incest Attitudes**

A second series of victimization blame attribution studies adapted the rape blame scale for use with the crime of incest. The Jackson Incest Blame Scale (JIBS; Jackson & Ferguson, 1983) was developed to parallel the dimensions represented on the ARBS. Like the ARBS, the JIBS was a factor analytically sound, 20-item Likert scale. Blame for incest was distributed across offender, societal, situational, and victim factors. Findings from a series of studies involving mental health professionals (Jackson & Fischer, 1982), attorneys and judges (Jackson & Sandberg, 1985), metropolitan police officers (Prentice & Jackson, 1984), and incest victims (Ferguson & Jackson, 1986) replicated the original standardization results. In studies sampling both males and females, victims of incest were blamed significantly more by male respondents, and the offenders were blamed significantly more by female respondents.

**Domestic Violence Blame Attitudes in the General Sample**

In an effort to assess whether the established order and gender effects obtained with rape and incest blame would generalize to wife abuse, Petretic-Jackson et al. (1985) developed the DVBS. The DVBS is a 23-item Likert type scale that assesses attributional blame for wife abuse accorded to situational, societal, victim/wife, and offender/husband causes. The items are scored on a six-point, forced choice continuum from strongly disagree to strongly agree. Using a sample of Midwestern college students, Petretic-Jackson et al. found that, as with rape and incest, wife abuse was perceived by adults in the college population as having multiple causes. Sample DVBS items include: “The husband’s abuse of alcohol and drugs causes domestic violence” (Situational Blame); “Domestic violence can be mainly attributed to peculiarities in the husband’s personality” (Perpetrator Blame); “The amount of sex and violence in the media today strongly influences the husband to physically assault his wife” (Societal Blame); and, “Wives encourage domestic violence by using bad judgement, provoking the husband’s anger and so on” (Victim Blame). While victims were blamed least for their victimization, they were not perceived as blameless. However, in contrast to other forms of assault (e.g., incest, rape, child physical abuse), offenders in cases of wife abuse were not assigned the most blame for the abuse to their partners. Situational determinants, including a number of factors in the external environment, were believed to “stress the dyad” to the point of abuse. Included among the situational factors were the abuser’s use of drugs and/or alcohol. Societal attitudes regarding acceptable relationship violence and gender roles were thought to play a contributory role as well in the etiology of wife abuse. Thus, laymen were found to perceive wife abuse as a unique form of interpersonal violence. Assessment implications of this standardization and other professional-oriented results are presented in other writings, but obviously include the use of the DVBS on therapists and clients alike (Jackson et al., in press).
Victim Blame and Demographics

A number of factors have been identified to affect attitudes of victims and the attitudes of others regarding victims. These variables/factors related to victim blame include such demographic characteristics of the observer as gender, ethnicity, judgements about victim and perpetrator behavior, alcohol use, a personal history of violence, and status (such as athletes or celebrities).

With regard to the actual extent and nature of intimate partner violence as a function of race and gender, the National Violence Against Women (NVAW) Survey (Tjaden & Thoennes, 2000) found that rates of intimate partner violence varied significantly among women of diverse racial backgrounds. Asian/Pacific Islander women reported lower rates than women from other racial and ethnic minority groups and African-American and Native American reported higher rates. However, differences were reduced when socioeconomic and other variables are controlled, suggesting the need for further research. The survey found little difference in Hispanic and non-Hispanic women’s reports of physical violence.

When attitudes are examined regarding ethnicity or race, several findings have been obtained. In an interesting set of findings in a sample of Chinese Americans, the majority did not approve of using physical violence toward partners or to solve problems. A quarter of the sample believed that victims caused the abuse, and approximately half indicated that they felt victims could easily leave an abusive relationship. Many participants felt that family matters were private issues (Yick, 2000).

When given a scenario of a domestic violence episode, women blamed the husband more for domestic violence, sympathized more with the wife, and rated the incident as more serious. African American participants sympathized more with African American victims. Participants blamed the African American husband less for the abuse than they did the analogous European American husband. Women and European Americans, when compared to men and African Americans, had more positive views of women and disapproved more strongly of wife battering (Locke & Richman, 1999).

Further, a separate sample of individuals expressed attitudes that batterers in interracial relationships should be considered more “guilty” than their counterpart batterers in same-race relationships (Harrison & Willis, 2000). Relatedly, findings from the National Violence Against Women (NVAW) Survey indicated that a significant risk factor for intimate partner violence for men was racial difference from their partner (Tjaden & Thoennes, 2000).

For the demographic variable of gender alone, this survey found that women are significantly more likely to report having experienced physical assault by an intimate partner than their male counterparts. Note that the majority of intimate-partner physical assaults are actually never reported to the police. Even fewer male victimizations are reported to the police than women’s (Tjaden & Thoennes, 2000). Clearly, there are a number of different demographic variables that interact in a manner that serve to cloud the perceptions and findings regarding various groups. Nevertheless, therapists should be aware of the plethora of issues, factors, and variables that may affect attitudes and correlated behaviors among their clients as well as themselves.

Prior Experience With Domestic Violence

While several studies offer contradictory results, one survey provided a parsimonious and corroborated outcome. That is, that while again mediated by other attitudes and demographics, a robust result indicated that experiencing violence while growing up is related to favorable at-
attitudes toward violence against spouses. (Markowitz, 2001). This is clearly something for both therapists and clients to consider. Prior personal experiences with violence may, according to this research, predispose all involved to possess greater victim blame, biases toward keeping the couple together in spite of continuing dangerousness, etc. It may be important for crisis intervention workers and therapists working in the area of violence to also examine their own experiences and consult with another professional regarding their own potential biases as well as how to be aware of client biases in this arena.

Athletes and Other High-Risk Groups

While NCAA Division I male student-athletes report analogous rates of perpetration and female student-athletes report significantly less victimization than their nonathlete student counterparts (Jackson, 1991), there appear to be differing patterns of blame for this group and, by extension, other high-profile “celebrities” when blame is concerned. In a recent study, male and female college students differed in blame attributions when athletes were concerned. Using varying scenarios, females blamed the athlete-batterer more than did male respondents. Judgments about athletic and nonathletic batterers became increasingly similar as harm to the victim increased (Craig, 2000).

Alcohol Consumption

When assessing the correlation between alcohol and violence, researchers have found that alcohol intoxication does not appear to be accepted as an excuse for domestic violence. Respondents presented with a vignette involving a domestic violence scenario in a study by Lane and Knowles (2000) assigned a perpetrator almost full responsibility in all conditions (high and low severity of injury to victim and presence and absence of alcohol intoxication on the part of the perpetrator). More significantly, recommendations for punishment were harsher for cases involving perpetrator alcohol intoxication and victim injuries. Punishment recommendations were more lenient from respondents who showed a high level of acceptance of interpersonal violence. Psychological interventions were highly recommended as an adjunct to conventional punishments.

Harrison and Willis (2000) investigated the relationship between judgments when victim alcohol use and race were considered in a sample of predominantly white, middle-class college students. When domestic violence victims were reported to drink alcohol, they were ascribed more blame and derogation than victims who did not drink. Among victims who were reported to drink alcohol before an assault, more responsibility for the assault was attributed to Black victims than White victims.

Domestic Violence Blame in Victims and Perpetrators

Several studies have been conducted recently assessing both domestic violence victims’ and perpetrators’ distribution of blame using the DVBS. Rogers (1998), using a sample of 97 battered women in women’s shelters administered the DVBS and other measures. Significant correlations between DVBS factor means and histories of both prior exposure to violence and substance abuse were found. Implications from this study were similar to others reported in this article as it was stressed that several intuitive demographic variables must be assessed prior to treatment in order to determine likely resistance to attitude and consequent esteem and behavior change. Administration of the DVBS prior to posttreatment was also recommended in order to determine if more socially sanctioned attitudes were modified as a result of treatment and
These traditional goals include increasing rated perpetrator blame and decreasing rated blame for the other DVBS factors, especially victim blame.

LaBine (2000) utilized battered women from 10 support group facilities in the upper Midwest to determine how one’s sex role might be correlated with DVBS factor scores in this population. She used a nonclinical sample as a control group and found that sex-role orientation was associated with DVBS scores in both groups. Traditional sex-role stereotype adherents were more likely to blame victims for the occurrence of domestic violence than individuals holding more egalitarian sex-role beliefs. For the nonclinical sample, the classic and aforementioned gender effects were also found. The author’s main recommendation was to parse domestic violence victims into pre-, during, and posttreatment groups to examine whether blame changes as a function of treatment.

Witte, Callahan, LaBine, and Jackson (2001), as part of a larger and combined perpetrator/victim project, analyzed data from slightly over 100 court-mandated domestic violence perpetrators in two different states’ treatment centers. Not totally surprisingly, when compared to other mean factor score distributions for the DVBS, these perpetrators obtained the lowest perpetrator blame scores of any prior sample, as well as the highest victim blame scores. What was more troubling was the fact that the factor score elevations were in no way affected by length of treatment. In other words, domestic violence perpetrators continued to maintain diminished responsibility-taking and increased diffusion of blame for their actions in spite of treatment. The fact that length of treatment did not affect attitudes is distressing in that it may point to several explanations, all worthy of future research. It is possible that, while therapy may have an effect on this population, attitudes are not prone to change. If, however, as suggested by these initial findings, perpetrators rely substantially on denial as a defense mechanism, then success in treatment may be highly dependent on increasing perpetrator blame. Ultimately, battering may represent an ingrained pattern of control and coercion that is highly resistant to clinical intervention.

In addition to the DVBS, researchers have used other measures or methods to assess attitudes in offender and victim samples. Burns (2001) used the Relationship Attribution Measure to assess locus, stability, globality, intent, motivation, and blame in a sample of violent and nonviolent Australian men. Adult males in three groups, a physically violent group in counseling, a nonviolent group in counseling, and a nonviolent community group were sampled. Significant differences were found between physically violent and nonviolent men on each of the attributional dimensions. Physically violent men were more likely to attribute the negative behavior of their partners to unchangeable, intentional causes than unintentional or blameworthy causes.

Victim blame is an important dimension to measure when assessing batterers’ readiness to change in treatment. Levesque, Gelles, and Velicer (2000) attempted to increase the efficacy of batterer treatment by using a stage-based approach to client treatment matching with a sample of 258 batterers in treatment. Levesque et al. developed the University of Rhode Island Change Assessment-Domestic Violence (URICA-DV), a multidimensional stage measure designed to assess readiness to change based on the Trans-theoretical Model of Change. Participants in the most advanced stage clusters (decision-making or participation) engaged in less partner blame, were more likely to use strategies to end violence in the previous year, and valued the positive aspects of changing their behavior while minimizing the negative aspects of changing behavior than men in treatment who could be categorized as being at earlier stages of change (e.g., reluctant or immotive).
Victim blame is a strategy that supplements exertions of physical dominance by violent men to control their partners. Anderson and Umber-son (2001) recruited 33 violent males through a diversion program and conducted in-depth inter-views. Batterers reported that they were able to control their partners through interpretive efforts (victim blaming, with the partner de-scribed as responsible for the violence in their relationships, as well as presentation of them-selves as nonviolent, capable, and rational) as well as physical acts. Typical excuses that bat-terers expressed were that their female partners were responsible for the violence and that they as men were victims of a biased criminal system.

Domestic Violence Blame in Professional Samples

After the initial development of the DVBS using a general sample, we wondered if professionals would hold similar perceptions, and, if so, what the implications for intervention would be. The DVBS was subsequently administered to re-gional and national samples of various health and mental health professionals in a series of studies to determine salient respondent charac-teristics that might influence attributional bi-as in treatment. One purpose of several of these studies was to investigate the attitudes held by medical and mental health professionals concerning the perceived causes of various types of violence and to determine the impact of such professionals’ beliefs upon the nature and quality of professional services offered to both victims and offenders.

Physicians

Physicians and other health professionals would appear to be a viable point of first contact for many battered women. Results of the NVAW Survey (Tjaden & Thoennes, 2000) indicated that a substantial number of women who re-reported that they were injured during their most recent physical assault had received some form of medical care (28.1%). Some received more than one type of service, and some received a specific type of service more than once (e.g., 3.2 physician visits, 4.4 dental visits, 21.1 physical therapy visits, 5 overnights in the hospital, and 1.9 emergency room visits).

To study the attributions of wife abuse in health professionals, both practicing physicians and medical students were administered the DVBS. In a study of 145 Midwestern physicians, Tarver and Jackson (1992) found a rank order-ing of factors identical to the college standardi-zation sample. A significant gender e-ffect was obtained, with male physicians blaming female victims to a greater extent than did female physicians. Male and female physicians also differed in referral practices to mental health practi-tioners, with male physicians making fewer mental health referrals. Additionally, physicians with higher victim blame scores were less likely to suggest mental health interventions or to de-velop a protection plan to assure the victim’s safety. Work setting or personal experience with violence did not affect blame scores. It appears that attitudes regarding blame in physicians affect utilization of the mental health network. Such findings have implications for modifi-ca-tion of the educational and training programs of physicians.

While Tarver and Jackson (1992) sampled physicians in practice, Noonan (1989) sampled 230 physicians in training at three medical schools, in part to identify whether current training programs had incorporated knowledge about domestic violence. If such training was implemented, did it have a positive impact on attitudes? Noonan’s findings mirror those of Tarver and Jackson, and suggest that recent physician training has not incorporated ade-quate training about wife abuse. While medi-cal students’ victim-blame scores were lower...
than those of the physicians in Tarver and Jackson's study, this may be attributed in part to sampling differences. Interestingly enough, medical school respondents identified their training with respect to the problem of wife abuse to be inadequate. Those students who reported having obtained such training in other settings (e.g., not medical) had lower victim blame scores.

Several recent studies also have assessed domestic violence attitudes of physicians. Maiuri et al. (2000) developed a scale to measure attitudes, beliefs, and self-reported behaviors related to health-care provider identification and management of domestic violence. Maiuri et al. conducted a multiphase study that ultimately yielded a 56-item measure. The final version of the measure consisted of six behavioral and attitudinal factors (perceived self-efficacy, system support, victim blame, professional role resistance/fear of offending patient, victim/provider safety, and frequency of domestic violence inquiry) that could be used to assess provider characteristics and training needs as well as evaluation of training and policy interventions.

Garimella, Plichta, Houseman, and Garzon (2000) sampled physicians in four medical specialty areas (emergency medicine, obstetrics-gynecology, psychiatry, and family practice) to assess belief about victims of spouse abuse and identify factors associated with positive and negative beliefs about service provision. Virtually all physicians (95%) believed it was part of their role to assist victims of domestic violence. However, 30% held victim-blaming attitudes toward victims of spousal abuse. Even more disappointing was that 70% did not believe they had the resources available to them to assist victims of domestic violence. Being female, younger, in an OB-GYN specialty, and in practice fewer years were characteristics associated with holding supportive beliefs. Most negative beliefs were about resource availability.

**Mental Health Practitioners**

While it appears that training programs in the mental health professions have been more successful at incorporating such information into their training programs, there appears to be considerable variability in practitioners’ attitudes as a function of gender, theoretical orientation, and other therapist characteristics. For example, results of an initial survey of licensed psychologists in three Midwestern states indicated that practicing psychologists obtained the same overall blame scores as the college standardization and physician samples (Sandberg & Jackson, 1986). Male psychologists, like male physicians, had higher victim blame scores than female practitioners. It also appeared that the practitioner sample as a whole conceptualized cases of wife abuse from a systemic approach (Sandberg & Jackson, 1986). The more a wife was blamed, the more often systemic treatment was advocated. The more societal factors were blamed, the more individual treatment approaches were endorsed.

Subsequently, White and Petretic-Jackson (1992) surveyed a stratified random national sample of 437 licensed psychologists listed in the National Register of Health Service Providers in Psychology. They used a modification of the DVBS, the Modified Domestic Violence Blame Scale (MDVBS), a 48-item scale developed from the original item pool of the DVBS. A fifth independent blame dimension, relationship blame, was added to the scale. This decision was based on the salience of items that assessed husband-wife interactions within the DVBS situational factor and the finding that many psychologists in the Sandberg and Jackson (1986) study indicated a preference for a couples approach to conceptualizing and treating wife abuse. While this conceptualization and approach to treatment is not advocated by the present authors, given the likelihood of adherents to such a model among practitioners, this dimension was
judged worthy of further study. The preference among some therapists to approach domestic violence as a relationship issue led the authors to including this dimension in a modified version of the DVBS. However, the present authors are concerned that viewing violence as a “relationship issue” has the potential to “revictimize” the victim through holding him/her less than completely blameless. Further, this approach may, in its worst case, serve to enter into collusion with the perpetrator to allow the violence to continue. As with physicians, differences in conceptualizing abuse as a “couple” versus an “individual” problem influenced a clinician’s utilization of other support services for the battering victim (e.g., legal remedies, shelter, etc.).

Analyses yielded five independent attribution dimensions: relationship blame, societal blame, situational blame, wife blame, and internal dispositional blame for both husband and wife. Husband blame items were found to be interrelated with wife blame items (e.g., self-defeating personality, passive, dependent traits). The resulting factor, consisting of items describing characterological attributes of both the husband and wife, was labeled the internal disposition (e.g., personality) blame dimension. Personality features of both the husband and wife were blamed most, followed by relationship blame, situational blame, and societal blame.

Therapist gender, therapeutic orientation, and marital status were found to significantly influence the degree and type of attributional blame. Female therapists blamed societal causes and husband/wife internal dispositional causes significantly more than did male therapists. Male therapists attributed blame to the wife significantly more than did female therapists. In comparison to psychodynamic, cognitive-behavioral, and feminist therapists, systems therapists blamed relationship causes significantly more. These findings suggest that potential gender-related beliefs and theoretical biases systematically influence psychologists’ attributions about wife abuse. Furthermore, married or previously married subjects attributed a significantly higher degree of blame to relationship causes than did single subjects. Thus, therapists’ personal experiences within a marital relationship may also influence blame attribution for wife abuse to favor “couple” causal factors.

Wandrei and Rupert (2000) surveyed practicing psychologists’ conceptualizations (e.g., causal attributions and expectations) of domestic violence using written scenarios. The perpetrator was held by participants to be most responsible. Although the victim was perceived as less responsible, greater responsibility was attributed to her in scenarios in which she had a pervious history of being abused. Severity of violence had inconsistent effects on expectations of the psychologists. Participants expected worse outcomes for the victims of more severe violence, but did not expect therapeutic interventions to be any less effective in ameliorating these outcomes. These findings suggest that several dilemmas exist for therapists treating partner violence.

Foshee and Linder (1997) examined the influence of three situational factors—level of provocation by the victim, frequency of violence, and visibility of sustained injury—on service providers’ motivation to help adolescent victims of partner violence. Provocation influenced motivation to help female victims, whereas frequency of the violence influenced motivation to help males for this sample of social workers. Perception of seriousness and attribution of blame did not mediate the relationship between situational variables and motivation to help.

**Alcohol and Drug Counselors**

As Roberts (1984) has noted, traditional mental health professionals (e.g., psychiatrists, social workers, and psychologists) may possess limited knowledge about the attitudes of paraprofessional and volunteer workers who staff commu-
nity intervention programs for battered women. Similarly, they may lack information about the attitudes of alcohol and chemical dependency workers who, in the course of their addictions counseling, often encounter both husbands and wives involved in battering situations. Using the DVBS, Parsons, Yutrzenka, and Jackson (1987) found that the patterns of attribution of blame in these groups were similar to those found with other health and mental health professional samples. Parsons et al. found that victims were blamed least and situational factors were blamed most by their sample of mental health professionals and trained volunteers working in mental health centers, drug and alcohol treatment programs, and women’s shelters. Female staff in these settings rated victims as less blameworthy, while male staff blamed situational factors to a greater extent. Interestingly, chemical dependency workers blamed both offenders and societal factors more than did workers in traditional mental health centers. Furthermore, no differences emerged between staff who treated only female clients and those who worked with both male and female clients involved in wife-abuse situations. This finding suggests that staff in mental health, shelter, and chemical dependency settings who shared an individual treatment orientation preference also shared a philosophy that endorses personal responsibility on the part of offenders for their problematic behaviors.

Police and Criminal Justice Officers

Findings from the NVAW Survey (Tjaden & Thoennes, 2000) indicated that most intimate partner violence is not reported to the police, with approximately one-fourth of women reporting they had contacted the police. The majority who did not report their victimization to the police indicated a belief that the police either could or would not do anything on their behalf. This view suggests that many victims of domestic violence do not consider the criminal justice system a viable alternative for resolution of their intimate violence.

With regard to domestic violence attitudes, Petretic-Jackson administered the DVBS to a large sample of law enforcement officers in both rural and urban communities in the Midwest (Petretic-Jackson, 2001). While community size was not an important factor associated with blame distribution, professional experience in responding to domestic violence calls and general attitudes about women and violence were associated with greater victim blame. A minority of officers reported formal training experiences, although such training was associated with most positive victim attitudes and less blame. Younger officers endorsed less victim blame. Other research using interview methodology to assess attitudes of law enforcement personnel has suggested that the occupational culture of the police leads to patriarchal beliefs that blame the victim and breed images of women as manipulative (Rigakos, 1995). A small sample (N = 23) of police and justice officers were interviewed about their attitudes regarding various types of protective orders. Findings suggested that protective orders are not treated seriously by the police or court officers.

In general, while mental health professionals were guilty of the above mentioned gender and blame distribution effects, they at least presented themselves better than other health care professionals and the law enforcement officers. We recognize that this represents damning with faint praise, or perhaps holding mental health professionals to be less guilty than others. This is clearly a significant and very problematic set of findings. Victim-blaming and other attitudinal biases, as well as gender effects appear to have been present (to some extent among all professional groups likely to encounter victims) for a substantial minority of other professionals as indicated by the results of the studies reported above. These findings, taken with the
identified lack of adequate training concerning wife abuse, suggest the need for educational efforts regarding victim treatment directed at both students enrolled in professional training programs and practicing professionals (Tarver & Jackson, 1992).

Knowledgeable mental health professionals can play an important role in the education of physicians and other health personnel concerning mental health referrals. Examination of personal biases and implications for differential case management in terms of client safety must be addressed by mental health professionals. A strong systemic bias in conceptualizing wife abuse may result in the neglect of necessary individual intervention and other services. This, of course, relates to our original philosophical premise that violence in intimate relationships must be viewed as a problem in and of itself, rather than merely a symptom of a dysfunctional dyad.

Prescriptively, this means that crisis intervention professionals should be well aware of the literature involving violence, the likelihood of their own biases, and perhaps, secondary victimization and PTSD, and the clear imperative for consultation or supervision when the attitudes arise, and the need for consultative support and guidance for this work in general (Petretic-Jackson et al., in press). If the professional is unaware of, or ignores these biases they may become guilty of interventions, which by their systemic nature, could result in revictimization, possible collusion with the perpetrator to allow the violence to continue, and reports to law enforcement that could minimize or distort judges’ sentencing preferences if criminal charges are pending. Further, the above findings argue for several brief treatment approaches that are empirically derived and somewhat more objective, if not manualized. These approaches serve to lessen the possibility that aberrant attitudes can creep into the therapeutic process. For example, a useful treatment package for clients who have resolved many assault-related problems yet continue to exhibit severe fear responses involves stress inoculation training (SIT). A cognitively and behaviorally based anxiety management approach, SIT is designed to assist the client in actively coping when the client’s fear and anxiety cues can be clearly specified (Petretic-Jackson et al., in press).

**Summary**

Although we suspect that for some readers some of the above exploratory and empirical studies may seem interesting but not directly applicable to clinical practice, we are determined to drive home the point that attitudes involving interpersonal violence are critical to all involved. The question is no longer whether or not attitudes cause specific behaviors; we are indeed now invested in determining how specific attitudes and beliefs relate to consequent behavior (Anderson et al., 1997). A therapist interviewing a battered woman in crisis, and questioning (albeit subtly and, perhaps subconsciously) whether her actions brought on the violence (“Is it possible that she might have been setting herself up for this?”), may clearly do more harm by his/her attitudes than help. The focus on any number of counter-factual, nonproductive attitudes, and faulty causal assumptions has been presented throughout this paper. It seems clear, given the above research, that crisis intervention professionals and therapists might inadvertently engage in such mistakes as victim blame and erroneous relationship attribution, depending on their background, training, lifestyle, experiences, etc. These attitudes may also influence his/her report and subsequent recommendations for or against restraining orders, treatment, etc. (Sandberg & Jackson, 1986). The present article summarized over two decades of work dealing with multidimensional distribution of blame for various types of violence. Even
a cursory review of the literature, the obtained consistent gender effects, the differential blame rankings (including victim blame) for different types of violence, and the fact that the lay public and all types of professionals alike hold similar attitudes, should cause the reader serious pause. As was stated at the outset of this article, it is critical to assess, resolve, or at least address these attitudes for all concerned lest they lead to psychonoxious or, at best, less than effective results in dealing with the various forms of violence covered in this paper. As there are a number of extant well-established, empirically supported treatments for most of the reported forms of violence, it seems to us that the main point of the article—that treatment means nothing without appropriate, therapeutic, and empathic attitudes—is well taken. This is especially true given the disturbing nature of the majority of reported attitudinal studies on multidimensional violence blame and its potential consequences.

References


