PREDICTORS OF DOMESTIC VIOLENCE MYTH ACCEPTANCE IN FORENSIC MENTAL HEALTH SPECIALISTS

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PREDICTORS OF DOMESTIC VIOLENCE

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Women's stories of intimate partner abuse are told to counselors in the nonprofit agencies that provide counseling and social services to women and their children. Sadly, their experiences with the long term effects of psychological and physical violence have been compounded by their struggles with mental health and legal professionals. These courageous and remarkable women deserve to be heard, without judgment or suspicion. They risk so much when they reach out for help that their safety and their success in living abuse free depend on the quality of help they receive. It is my hope that the results of this study will illuminate the need for careful consideration of the potential impact of gender and sexism on clinical and forensic services for battered women.

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CHAPTER I

INTRODUCTION

Intimate partner violence and sexual assault are common and far reaching social problems that affect women and girls around the globe. Though decades of research on domestic violence has improved public policy and produced quantitative justification for federal funding, steady progress in reducing the cultural bias that supports violence against women has not yet been achieved. Stereotypes, sexism, and negative attitudes toward women remain persistent throughout the institutions and programs that are designed to offer assistance and safety to women survivors of domestic violence (Bancroft & Silverman, 2002; Buel, 1999; Busch & Valentine, 2000; Dye & Roth, 1990; Jackson, Witt, & Petretic-Jackson, 2001).

The personal and societal effects that result from domestic violence are often immune to system interventions and are believed to be some of the "most traumatic, life threatening and harmful in American society" today (Roberts, 2005). This is due, in part to what some social science researchers believe is the endorsement of cultural myths by mental health and other helping professionals who interact with victims and perpetrators of intimate partner violence and sexual assault (Burt, 1980; Peters, 2002). For decades, empirical research has provided evidence that attitudes and stereotypical beliefs have a powerful influence on behaviors of helping professionals, specifically mental health

workers, attorneys, and physicians. Unfortunately, a significant number of those professionals' have projected blame onto the victims of domestic abuse, while in turn, exonerating the abusive acts of the perpetrator (Anderson, Cooper, & Okmara, 1997; DeBono & Snyder, 1995; Petretic-Jackson, Witte, & Jackson, 2001). Consequently, dispassionate or hostile perceptions of victims and survivors continue to affect the safety and long term psychological and physical health of women who are physically, psychologically, and/or sexually abused by someone they know. Over the past 40 years national studies have revealed that violence against women is a common occurrence and that women are more likely to be assaulted, injured, raped, or murdered by an intimate partner than by any other type of offender (Jordon, Neitzel, Walker, & Logan, 2004). Every nine seconds a woman is battered. Roberts (2007) stressed the need for skilled professionals who are sensitive to the impact of domestic abuse on the psychological and physical health of women, to provide appropriate crisis intervention that is consistent with the model of coordinated community response to domestic violence.

One of the primary goals of the anti-domestic violence movement was and continues to be to reduce violence against women by raising community awareness, providing safety to survivors, and coordinating multidisciplinary responses to intimate partner violence (Stout & McPhail, 1998). However, some of the well intended solutions such as mandatory arrest policies, mandated treatment programs for victims and batterers, and court ordered forensic evaluations have often created unforeseen problems for the female victims of intimate partner violence (Bancroft & Silverman, 2002; Roberts, 2005). For example, as a result of mandatory arrest policy, women have been arrested in their homes in front of their children for defending themselves against the batterer,

subsequently appearing to law enforcement as the "predominant aggressors" instead of the victims of an assault (Bancroft & Silverman, 2002; Keilitz, Hannaford, & Efkeman, 1995). Subsequent to their arrest, the women may be charged with assault and battery, then prosecuted and ordered to attend batterers' counseling where their attendance is monitored by both the counseling agency and the district attorneys' office until the program is completed.

Similarly, battered women are often caught up in punitive, gender biased family court systems (Ptacek, 1999) and ordered by judges to undergo intrusive forensic mental health evaluations due to the persistence of batterers to gain custody of the children (Bancroft & Silverman, 2002; Stark, 2007). In forensic custody evaluations the mothers' parenting is observed, scrutinized, and evaluated, often by a variety of mental health professionals and social workers whose loyalty, understandably, is to the safety of the children first. However, these professionals are also likely to subscribe to domestic violence myths that blame the mother and exonerate the batterer, holding the mothers to a higher standard of accountability for being battered (Roberts, 2005). These myths, in turn, may very well serve as justification for the courts' recommendations for the batterer as the optimal parent (Roberts, 2001).

Perceptions of Violence Against Women

Physical and sexual assault by an intimate partner are identified by the Federal Bureau of Investigation as violent crimes, with sexual assault the most underreported of all violent crimes in the United States (Rand & Catalano, 2007). Like rape victims, victims of domestic violence fear that they will not be believed if they report violence by

an intimate, that they will be blamed by law enforcement for the assault, or that they will be arrested for using physical force in self defense against an abusive partner (Tjaden & Thoennes, 1998). In addition to their reluctance to report abuse to law enforcement, only 9% of domestic assault victims disclose information to their physicians about their abusive experiences (Plichta, 1996, Tjaden & Thoennes, 1998). This reluctance is often a result of the victims' fear that the abusive partner will be contacted or reported to the police by poorly trained professionals who are not current with legislation or confidentiality statutes with regard to domestic violence. These fears create increased opportunities for the re-victimization of women involved in the mental health and court systems, and speak to the reluctance of victims to report assaults by intimate partners (Dutton & Gollant, 1995; Jacobson, 1998; Bancroft & Silverman, 2002)

Inaccurate assumptions and suspicions by professionals with regard to domestic violence assessments can compromise the safety of women who are battered or psychologically abused by an intimate by impeding treatment that is appropriate, empathic, and therapeutically effective (Jackson, Witt, & Petretic-Jackson, 2001). The risk to victims is made evident by clinicians who fail to acknowledge their own biases, especially if they are prone to disregard serious threats made by the spouses of their female clients, or if they tend to view allegations of abuse as exaggerated attempts by the victims to solicit sympathy (Bancroft & Silverman, 2002). These findings support recommendations in the literature for clinicians whose work involves their interaction with victims or perpetrators of domestic violence to focus their interventions on problem-solving and safety planning; or making judgments and recommendations that are based

on adequate evidence from multiple sources instead of on preexisting beliefs or myths with regard to victim blame (Buel, 1999; Jacobson & Gottman, 1998).

Statement of the Problem

The problem of domestic violence is extensive, therefore, mental health professionals, specifically those who specialize in forensic psychology, will undoubtedly find victims or offenders among their clients (Jordan et al., 2004). Forensic mental health specialists interact in a variety of ways with victims and perpetrators of domestic violence during periods of litigation over divorce, child custody litigation, and criminal matters such as violations of protective orders, assault and battery, and domestic homicide. Research on specific attitudes and stereotypical beliefs of forensic psychologists whose work involves victims or perpetrators of domestic violence is not found in the literature; however, some studies have been conducted on the identification of victim blame, specifically, in licensed psychologists and social workers (Jackson, Witt, & Petretic-Jackson, 2001).

This study will examine correlates and determine predictors of domestic violence myth endorsement by forensic psychologists (N=138) by using four self-report scales (a) the Domestic Violence Myth Acceptance Scale (DVMAS) scale (Peters, 2003); (b) the Interpersonal Reactivity Index (IRI) (Davis, 1996); (c) the Ambivalent Sexism Inventory (Glick & Fiske, 1996); and (d) the Crowne-Marlow Social Desirability short form (Greenwald & Satow, 1970). Gender differences will be explored as potential predictors of domestic violence myth acceptance. A univariate analysis of variance

(ANOVA) will be used to test the Null hypotheses that the error variance of the dependent variable (DVMAS) is equal across groups (F/M gender).

Since the prevalence of domestic violence, gender stereotypes, and attitudes toward women are believed to contribute to a culture of violence that is hostile to victims and survivors (Brownmiller, 1975), it is necessary to begin with a review of the prevalence of domestic violence and the impact of attitudes and stereotypes on professional perceptions of violence against women.

Prevalence of Violence Against Women

"Violence against women that is endemic in every country around the world erodes women's physical and mental wellbeing, interferes with their productive engagement in society, destroys families, and unravels the very fabric of communities" (Ellsberg & Heise, 2004). From a global perspective, a multi-country study conducted by the World Health Organization (WHO) on domestic violence and women's health revealed that 70% of 24,000 women surveyed from seven countries (excluding the United States) had experienced physical and/or sexual violence by an intimate partner (World Health Organization, 2005). The study highlighted partner violence and concluded that women's health was negatively affected by domestic abuse, irrespective of where women lived, the prevalence of violence in their communities, their cultural background, or economic status. Ellsberg and Heise (2004) stressed that violence suffered by women throughout the world generates from the lack of power women experience in their relationships, and society. The authors point to the cultural and historical contributions to the abuse of women and girls in many areas throughout the world. Abuse of women and

girls is commonly demonstrated by the acts of human trafficking, honor killings, genital mutilation, and rape of women during violent national or civil conflicts. The tolerance of such acts assists in the continuation of violence against women at an international level.

In the United States, research shows that though the number of domestic assaults declined somewhat since the end of the 1990's, 4.4 million American women are still physically assaulted by their intimate partners each year (Tjaden & Thoennes, 2000). In 2001, more than half a million (588,490) female victims of violence reported being assaulted by an intimate partner, and in the same year 20% of violent crimes against women were attributed to intimate partner violence (Tjaden & Thoennes, 2000). In other select populations the rate or prevalence of domestic violence is greater than the rates reported for married and cohabitating women. A group of 152 battered women who killed their intimate partners did so after enduring physical abuse for eight years or longer. Prior to killing their partners, 65% of the 152 women had received direct death threats from the batterers who also specified the time, the method, and/or the place where the threats would be carried out. (Randall & Haskell, 1995; Williams & Hawkins, 1989).

A telephone survey by the National Violence Against Women (NVAW) organization was conducted on the prevalence and incidence of violence against women in the United States (Tjaden & Thoennes, 2000). The survey administered to women in households across the country revealed approximately 52% of women in the sample reported having been physically assaulted by an intimate, and close to 18% reported being victims of rape or attempted rape during their lifetime.

Tjaden and Thoennes (2000) also noted that the prevalence and severity of violence indicated significant differences between heterosexual women and men that

accounted for lifetime recipient rates of intimate physical violence being higher (25%) for women than for men (7.6%). Women reported more frequent assaults (6.9 assaults) than men who averaged 4.4 assaults; and more chronic and serious injuries were sustained by women (41.5%) versus men who reported injury from the most recent assault (19.9%). In a comprehensive study of police reports and crime statistics, intimate partner violence was found to account for 21% of violent crimes against women and 2% for men (Greenfield, Rand, Craven, Flaus, & Ringel, 1998). For specific populations delineated by divorce, separation, or homosexuality, the rates show a significant increase. For example, 70% of women in the process of divorcing reported that violence occurred while married; while 57% of women with cases involving human services for child protection reported physical assault during adulthood (Tyler, Howard, Espinoza, & Doakes, 1997).

As for the prevalence of domestic violence in racially, economically, and sexually diverse populations, the literature reveals that women who live in poverty, women of color, and women who are members of other minority groups are at significant risk for victimization (Belle, 1990; Wilson, 1997). Therefore, mental health professionals who provide services for women and men from ethnic minorities can better assist their clients if they are familiar with the minimal body of research available on intimate partner violence in diverse populations (Jordan, et al. 2004).

For example, the National Crime Victims Survey (NCVS) found that African American women experienced intimate partner violence at a rate 35% higher than Caucasian women (Rennison & Welchans, 2000). Greenfield (1998) found that femicide was the leading cause of death for African American women in the United States who

were age 15-45. Violence against Latina/Hispanic women is also particularly complex given the diverse cultures and countries in which they live. For example, Hispanic women in the United States represent thirty two countries of origin. A study of residents in a shelter for women escaping abuse found that Hispanic women married at a younger age, lived in more severe poverty, and had less education and larger families than non-Hispanic women. They also reported living with abuse for longer periods of time than women from other ethnic backgrounds (Jordon, et al., 2004).

In non-heterosexual relationships research is varied on physical violence. For example, research on the lesbian population finds rates ranging from 17% to 46% of lesbians reporting physical assaults by an intimate (West, 1998); while rates for gay males is "virtually unknown" (Peters, 2003, pg.3). One study of 34 gay male participants showed 44% of the men reported being "victimized" in a previous relationship by a male partner (West, 1998).

Cultural Myths and Victim Blame

Barbara Hart, a leading expert in the field of violence against women addresses some of the attitudes and beliefs held by the public and professionals with regard to battered women (Buel, 1999):

> ….battering is not something that happens to a woman because of her characteristics, her family background, her psychological profile, her family of origin, dysfunction, or her unconscious search for a certain type of man. Battering can happen to anyone who has the misfortune to become involved with a person who wants power and control enough to be violent to get it (p.187).

Myths are developed by cultures to make sense of unexplainable occurrences, such as violence against women and children, and in some ways, are intended to secure adherence to social values such family unity, monogamy, or religious affiliation (Kincheloe and Simpson, 1992). Cultural myths are also powerful means by which cultural consciousness is shaped and status quo maintained. In *Cultural Myths in the Making*, authors Tippins, Nichols, & Kemp (1999) described cultural myths as "networks of beliefs and values" (p.4) that contribute to the collective consciousness of a social group. These myths have positive importance in the sense that they support the values within a culture and legitimize those things that contribute to cultural identity such as belief systems and historical connections. However, the impact of cultural myth is not always positive since myths can also invalidate knowledge and beliefs, obscure meaning, and suppress common social practices (Tippins, Nichols and Kemp, 1999). A myth can be benign to one group while being oppressive to another, making it a generally accepted truth that myths have a powerful influence on the beliefs of a culture, irrespective of their positive or negative impact.

Rape Myth

One such myth is *rape myth* which was defined by Burt (1980) as "prejudicial, stereotyped, or false beliefs about rape, rape victims, and rapists"(p. 217). Research that contributed to Burt's development of the Rape Myth Acceptance Scale in 1980 provided the "first empirical foundation for a combination of social, psychological and feminist theoretical analysis of rape attitudes and their antecedents" (Burt, 1980, p. 229). Examples of rape myths include, "women are asking for it," "No really means yes," and

"women cry rape to get even with men" are just a few of the beliefs supported by rape myth that dismiss the accountability of the rapists and invalidate the experience of the victims. From her research, Burt (1980) concluded that rape was a product of a culture that tolerated dominance vs. submission and other forms of sexual stereotyping. When these sexual stereotypes were intertwined with pervasive attitudes toward women, sex roles, and rape, Burt (1980) surmised that a systematic change, not only in societal attitudes toward rape but in societal values, would be required to subvert the dominant cultural paradigm that served to subordinate women. Burt compared the negative attitudes toward rape in the 1980s to those that prevailed in the early 1960s (Burt, 1980). Given the prevalence of violence against women in the 21st century, it is not out of step to conclude that the current cultural orientation of violence against women in the United States resembles the cultural orientation of domestic abuse and sexual assault in the 1960s as well.

Domestic Violence Myth

In the same ways that rape myths influence perceptions of rape victims and rapists, domestic violence myths serve to justify domestic violence blame while representing misconceptions about the female victim/survivor and her perceived responsibility for the violence (Peters, 2003). Lonsway and Fitzgerald (1994) posited that *myth,* by itself, was a construct with three functions: that myths were widely held beliefs, that they served as justification for culturally based ideas, and that they explained somewhat unexplainable cultural phenomenon. In keeping with the perspectives of Burt, Lonsway, and Fitzgerald (1994), domestic violence myth is defined as widely held,

generally false stereotypical beliefs about domestic violence, victims of domestic violence, and the perpetrators of domestic violence that serve to justify men's aggression toward women.

As mentioned earlier, preexisting attitudes and stereotypical beliefs that contribute to societal acceptance of violence against women have been identified in various groups of professionals. These attitudes and beliefs are found throughout the literature on victim blame, rape myth, and gender role stereotyping (Dutton, 1998; Jackson, 1996; Jones, 1994; Walker, 1989). For example, "battered women are masochistic or crazy", "battered women are provocative and could leave if they really wanted to", or "batterers are violent in all of their interpersonal relationships" are a few of the myths that not only make inaccurate assumptions, they also represent systematic victim blame, support the lack of accountability for the offenders, and contribute to the disempowerment of survivors. (Walker, 1989; Jacobson & Gottman, 1998; Bancroft & Silverman, 2002).

Just as rape myth limits the options of rape victims, domestic violence myth creates obstacles to evaluation, treatment, and intervention, increasing both the difficulty for victims to report and the ability for professionals to comprehend the true nature and impact of physical, psychological, and sexual assault by intimates (Petretic-Jackson, Witt, & Jackson, 2001). For example, if the characteristics of batterers and victims do not adhere to common stereotypes, allegations of abuse can appear suspect to professionals who assesses for domestic violence in victims or perpetrators. Minimization or denial of the victim's claims of abuse or acceptance of the batterer's denial that he has acted violently toward his spouse, are misperceptions by the professional that could impede empathic responses to the survivors' allegations.

Victim-Blame

Victim blame is a by product of domestic violence myth, while victim self-blame is a culmination of the preferred beliefs of a culture that place considerable pressure on female victims of domestic violence to take personal responsibility for their spouses' abusive behaviors (Buel, 1999 Petretic-Jackson, 1994; Rosewater, 1987; Walker, 1984). Victims of intimate partner violence are sensitive to professionals who minimize threats and deny the seriousness of their circumstances. Professionals who respond suspiciously to women's reports of abuse appear to the victims as colluding with or making excuses for the batterer. These oversights or misinterpretations about victims and survivors' circumstances can dissolve trust between the client and professional, leading to a breakdown in communication. As a result, inappropriate recommendations for legal remedies or clinical evaluations create further problems for their clients that require even more resources than are available to them (Bancroft & Silverman, 2002; Stout & McPhail, 1998, & Wilson, 1997).

Victims of domestic violence who are suspected of being instrumental in their own victimization have been accused by professionals and laypersons of being responsible for being battered or sexually assaulted by an intimate partner in the same ways rape victims have been blamed for the actions of the rapist (Peters, 2003). Domestic violence myth endorsement reinforces victim blaming by professionals, acting as a buttress for any self blame that the victim may be experiencing (Peters, 2003).

Law enforcement officers, clergy, prosecutors, social workers, and mental health professionals who subscribe to domestic violence myths and place blame on the victims

of violence and sexual assault often do so because they misunderstand the circumstances of battered or emotionally abused women as well as the coercive control and manipulations of batterers (Bancroft & Silverman, 2002). This misunderstanding of the nature of the risk to the victim could unintentionally influence unwanted results in domestic violence cases such as lost custody of the victim's children, serious physical injury to the victim and/or her children, or child abduction by the batterer. Therefore, it is especially critical for mental health professionals to examine and resolve their own personal beliefs about violence and other forms of abuse before accepting cases involving intimate partner violence.

Some of the factors that influence the perpetuation of victim blaming attitudes in particular groups of professionals, previously described, were found in their moral reasoning processes, gender stereotyping practices, and inadequate training on the dynamics of domestic violence (Buel, 1999). These same factors are substantiated in feminist research as primary influences in the societal support for violence against women that have politicized women's personal experiences with violence (Brownmiller, 1975).

Another serious consequence to women survivors of domestic violence who reach out to mental health communities, legal services, and child welfare intervention, either voluntarily or by court order, is one that experts refer to as a replication of the abusive partner's verbal and emotional abuse by counselors, caseworkers and advocates for children (Bancroft & Silverman 2002; Jacobson & Gottman, 1998; Jones, 1994). This type of replication is explained in the literature as verbal degradation and criticism by professionals toward victims (Buel, 1999); harsh judgment about the decisions of battered

women to stay or leave (Bancroft & Silverman, 2002); and even sexual harassment by professionals whose knowledge and authority are used to harm instead of help (Buel, 1999; Rosewater, 1987; & Walker, 1989).

Professional Responsibility

Civil and criminal aspects of domestic violence such as child custody litigation, violations of protective orders, assault and battery, or homicide of the batterer by the victim require mental health professionals to have specialized training, especially if they provide treatment or court ordered psychological evaluations for victims or perpetrators. Mental health professionals involved in these cases require specialization, not only in the complicated issues of domestic violence, but in their knowledge of state laws regarding domestic violence and the intersection of criminal and civil court systems with mental health services. This intersection of mental health and law presents challenges that are not common to general mental health practice.

Professional Challenges

Jordan, et al., (2004) cautioned professionals to be aware of pitfalls that untrained, inexperienced professionals can encounter in domestic violence cases. These pitfalls are likely to cause problems for mental health professionals who: (a) provide services outside their boundaries of competence, (b) fail to screen or conduct adequate assessments for DV, (c) deficiently respond or hyper react to victims' disclosures of DV, (d) waive privacy due to rules of court testimony, (e) use prejudicial labels and syndromes to support recommendations, (f) engage in dual roles with court testimony, (g) treat

offenders individually, or with the victims as a couple, and (h) engage in substance abuse intervention and Christian counseling without the awareness of the risks to victims.

Although it is understood that not all clinicians will have expertise in domestic violence, they are still expected to recognize signs of abuse in victims or abusive behavior in offenders so that they can make assessments and appropriate referrals. However, research shows that clinicians do not routinely screen for abuse in their clients which leaves detection up to guesswork or untimely discovery, again increasing the risk to victims (Walker, 1994; Jordan, et al., 2004; Saunders, Kilpatrick, & Resnick,1989). Adequate instruction on domestic violence dynamics, protocol, and service provision that would prepare a clinician to intervene in complicated cases such as these is not generally required in most graduate programs. Ideally, gaining clinical expertise in special populations calls for additional academic background and supervised practicum experience at the graduate level. Busch (2004) found that social workers received little to no instruction on domestic violence aside from an occasional elective course, and that they received minimal education or training on how to respond to battered women in crisis.

Without graduate preparation, the professional is vulnerable to problems that can arise when practicing outside of their area of competence such as not knowing how to intervene safely, or not knowing how to conduct a safety plan with a victim who reports that she is returning to the batterer. A strict adherence to codes of ethics is strongly recommended, and Jordan, et al., (2004) urge all mental health professions to consider the ethical guidelines for psychologists. These guidelines include admonishment for professionals who do not practice competently, reminding them that the risks of harm to

clients or patients increase considerably when practicing in an area for which they have inadequate training. An individual interest in an area of mental health does not qualify one to practice in it. Such is the case for domestic violence intervention and treatment.

Forensic Mental Health Specialists

Forensic mental health specialists whose work involves victims or offenders of domestic violence face special challenges due in part to the complicated nature of these cases. The term *forensic* indicates a relationship between a single profession such as medicine, psychology, or anthropology with the legal system (Goldstein & Weiner, 2003). A number of definitions for forensic psychology and psychiatry exist; however, the most accepted definitions for forensic psychology are currently found in the "Specialty Guidelines for Forensic Psychologists" (Committee on Ethical Guidelines for Forensic Psychologists, 1991):

> "all forms of professional conduct when acting with definable foreknowledge, as a psychological expert on explicitly psychological issues in direct assistance to the courts, parties to legal proceedings, correctional and forensic mental health facilities, and administrative, judicial, and legislative agencies acting in a judicial capacity" (pg. 657).

In cases where domestic abuse of a female spouse is evident, the forensic mental health professionals may have at their disposal a history of police reports on domestic disturbances, documents such as protective orders and violations of protective orders, misdemeanor or felony convictions, child welfare reports, medical records, and counseling interventions to include in their comprehensive evaluations. But if the

victim/survivor has been too frightened to call the police, or not allowed by her husband to seek counseling or help from the outside, there will be no documented evidence of a history of abuse of any kind from which to make an informed assessment of the individuals. In light of the absence of adequate evidence, the professional must rely on standardized psychological testing to reveal underlying personality traits or disorders of alleged victims and offenders. The results of commonly administered standardized tests will reveal adult psychopathology but will not reveal whether a wife is a victim of intimate partner violence or if a husband is a perpetrator of violence against his wife (Walker, 1989).

Forensic specialists' involvement in domestic violence cases is controversial (Applebaum, 1997); therefore, their full understanding of beliefs and attitudes toward domestic violence is critical in their evaluations or treatment of victims and perpetrators. A review of the intersection of mental health and the law in chapter two is necessary to understand the special roles of forensic mental health practitioners who interact with female victims and male perpetrators of domestic violence. As for forensic mental health practitioners specifically, the identification of preexisting attitudes and beliefs held by professionals with regard to domestic violence myth acceptance are as critical to the safety of victims as they are to the accurate assessment of perpetrators who seek services from forensic mental health specialists.

Definition of Terms

Rape Myth. Burt (1980) defined rape myth as "prejudicial, stereotyped, or false beliefs about rape, rape victims, and rapists" (p. 217).

Domestic Violence Myth. For the purpose of this study, Lonsway and Fitzgerald (1994) explained that *myth,* by itself, was a construct with three functions: that myths were widely held beliefs, that they served as justification for culturally based ideas, and that they explained somewhat unexplainable cultural phenomenon. In keeping with the authors' explanation, domestic violence myth is defined as widely held but generally false stereotypical beliefs about domestic violence, victims of domestic violence, and the perpetrators of domestic violence that serve to justify men's aggression toward women.

Domestic Violence. Definitions for domestic violence are varied, therefore, for the purpose of this study and due to the use of the Domestic Violence Myth Acceptance Scale (Peters, 2003) the following definition is used: domestic violence involves the perpetration of physical, sexual, or psychological acts of aggression by an adult male to exert power and control over a current or prior adult female intimate partner. In this study the term *domestic violence* is used interchangeably with the term *intimate partner violence* and the intimate partners' genders are designated as described above for the victim and offender involved in heterosexual relationships.

Victim of Domestic Violence. For the purpose of this study, victims of domestic violence are adult women who have been physically or sexually assaulted, and/or psychologically abused by a current or previous husband or male significant other. Although the 'victim' label can be found in the literature as a controversial label for women who have been abused, the term used in this study in no way represents a clinical diagnosis of abused women or a negative reference to their position or circumstances. Victim is a term used in this study that is not intended to designate *who* these women are nor is it meant as a negative label for women who have been battered. The term victim is

intended to give the reader an indication of what their experience has been and how that experience has shaped their view of the world.

Batterer. Bancroft and Silverman have their own working definition of batterer that integrates well with the terms in this study (2002):

> A batterer is a person who exercises a pattern of coercive control in a partner relationship, punctuated by one or more acts of intimidating physical violence, sexual assault, or credible threat of physical violence. This pattern of control and intimidation may be predominately psychological, economic, or sexual in nature or may rely primarily on the use of physical violence (p. 3).

This definition considers the variability evident in the abusive styles of batterers and does not require the presence of aggressive physical beatings. However, the authors emphasize that a serious threat of harm such as dangerous driving, raising fists in a threatening manner, or cutting telephone or utility lines, is behavior enough to qualify as a batterer by their definition. For the purpose of this study, the terms perpetrator, offender, and batterer are used interchangeably and refer to an adult male who physically, sexually, or psychologically abuses a current or previous adult female intimate partner.

Victim Blame. In this study victim blame refers to holding one accountable or assigning responsibility to a female victim of intimate partner violence, self blame by a victim of intimate partner violence, or excuses made by a male offender who externalizes blame for domestic violence on the victim.

Empathy. For the purpose of this study, Davis' (1996) multidimensional, cognitive-affective approach to measuring constructs of empathy is applied. Four distinct but related constructs: (1) *perspective taking*, (2) *empathic concern*, (3) *personal distress*,

and (4) *fantasy* provide measures of "dispositional tendencies" (Davis, 1996, p.55) in the Interpersonal Reactivity Index (IRI). The four constructs of empathy in Davis' model are identifiable by the tendencies of an individual to adopt the psychological perspective of others, to experience compassion for others who are less fortunate, to feel uncomfortable with the distress of others, and to use imagination to project oneself into situations that are fictitious. It is an assumption of this study that empathic mental health professionals are less likely to endorse domestic violence myths.

Sexism. Sexism is commonly considered a stereotype that has been linked in several studies (Chapleau, Oswald, & Russell, 2007; Glick, Diebold, Bailey, Warner, & Zhu, 1997; Vicki, Abrams, & Masser, 2004) to prejudice, attitudes toward sexual assault, and rape myth acceptance. Specifically, the ambivalent sexism measure used in this study is divided into two constructs, benevolent and hostile sexism toward women (Glick & Fiske, 1996). These two constructs are the hypothesized predictors of domestic violence myth acceptance in this study. Like empathy, sexism requires a multidimensional approach due to its multiple constructs that range from benevolent attitudes toward women to hostility towards women in personal and institutional spheres.

Purpose of Study

The purpose of this study is four fold: (a) to make a contribution to the existing body of literature in the field of violence against women by identifying potential predictors of domestic violence myth endorsement by forensic mental health specialists; (b) to test the hypothesis that domestic violence myth acceptance by forensic mental health practitioners is predicted by gender, empathic disposition, and hostile or

benevolent sexism; (c) to examine the relationship between domestic violence myth endorsement, and empathic concern, personal distress, perspective taking, fantasy, benevolent sexism, and hostile sexism; and (d) to determine if forensic mental health practitioners are susceptible to attitudes that blame victims for intimate partner violence and to what extent their attitudes represent predictable variables for domestic violence myth endorsement.

Research Questions and Hypotheses

Research Questions

The research questions for this study include: (a) Does a relationship exist between gender (female, male)of forensic mental health practitioners and dispositional empathy, ambivalent sexism, & domestic violence myth acceptance? (b) Is dispositional empathy a significant predictor of domestic violence myth acceptance in female forensic mental health practitioners? (c) Is dispositional empathy a significant predictor of domestic violence myth acceptance in male forensic mental health practitioners? (d) Is ambivalent sexism a significant predictor of domestic violence myth acceptance in female forensic mental health practitioners? (e) Is ambivalent sexism a significant predictor of domestic violence myth acceptance in male forensic mental health practitioners?

Research Hypotheses

The following hypotheses will be formulated as the foundation of this study:

Hypothesis One. It is hypothesized that gender differences will be evident in domestic violence myth endorsement as measured by the DVMAS (Peters, 2003).

Hypothesis Two. It is hypothesized that the DVMAS will correlate significantly with one or more subscales in the Interpersonal Reactivity Index (Davis, 1996) in the female sample.

Hypothesis Three. It is hypothesized that the DVMAS will correlate significantly with one or more subscales of the Interpersonal Reactivity Index (Davis, 1996) in the male sample.

Hypothesis Four. It is hypothesized that the DVMAS will correlate significantly with hostile or benevolent sexism, subscales of the Ambivalent Sexism Inventory (Glick, 1996) in the female sample.

Hypothesis Five. It is hypothesized that the DVMAS will correlate significantly with hostile or benevolent sexism, subscales of the Ambivalent Sexism Inventory (Glick, 1996) in the male sample.

Hypothesis Six. It is hypothesized that the DVMAS will correlate significantly with social desirability in the female sample.

Hypothesis Seven. It is hypothesized that the DVMAS will correlate significantly with social desirability in the male sample.

Hypothesis Eight. It is hypothesized that demographic variables such as age, education, and years of practice correlate significantly with domestic violence myth acceptance in female forensic mental health specialists.

Hypothesis Nine. It is hypothesized that demographic variables such as age, education, and years of practice correlate significantly with domestic violence myth acceptance in male forensic mental health specialists.

Hypothesis Ten. It is hypothesized that dispositional empathy in one or more subscales of the IRI significantly predict domestic violence myth acceptance in female forensic mental health specialists.

Hypothesis Eleven. It is hypothesized that dispositional empathy in one or more of the subscales of the IRI significantly predicts domestic violence myth acceptance in male forensic mental health specialists.

Hypothesis Twelve. It is hypothesized that ambivalent sexism in 1 or more of the of the ASI subscales (hostile and benevolent sexism) significantly predicts domestic violence myth acceptance in female forensic mental health specialists.

Hypothesis Thirteen. It is hypothesized that ambivalent sexism in one or more of the of the ASI subscales (hostile and benevolent sexism) significantly predicts domestic violence myth acceptance in male forensic mental health specialists.

Statistical Model

Subsequent to psychometric tests for reliability, a bivariate correlational analysis will be performed to determine relationships between gender, the independent variables, and domestic violence myth endorsement in the total sample by gender. A univariate analysis of variance (ANOVA) will be conducted with Levene's Test to assess the equality of variance in 2 samples: female and male respondents. For the purpose of this analysis, the *p* value must be greater than .05 to test the null hypothesis that population variances are equal, failing to reject the null hypothesis. Two correlational analyses by gender, and two separate regressions, by gender will then be conducted to determine differences between survey responses by gender (females and males) on the DVMAS

(criterion), and independent variables IRI, ASI, and demographic variables of interest. The analyses will determine differences in outcome on all measures with regard to gender and the relationship of gender to benevolent and hostile sexism, dispositional empathy, and domestic violence myth endorsement.

Summary

Violence against women remains an enormous social problem in the United States and across the globe that has not gone away in spite of four decades of serious, concentrated recognition and intervention by policy makers, antidomestic violence advocates, and multidisciplinary responses to domestic violence. The perception that domestic violence appears immune to system interventions is due in part to what some social science researchers believe to be the culturally entrenched attitudes and stereotypical beliefs that negatively influence behaviors of helping professionals who interact with victims and perpetrators of intimate partner violence (Anderson, Cooper & Okmara, 1997; DeBono & Snyder, 1995; Petretic-Jackson, Witte, & Jackson, 2001). It is widely accepted in the anti-domestic violence community that cultural myths play a critical role in the support of violence against women, the blame of the victim, and the exoneration of the batterer. Stereotypes and attitudes such as these are supported by cultural myths and are found in the institutions and programs that are designed to offer assistance and safety to victims/survivors and their children. An objective of this study is to show that stereotypes and attitudes about women and sexism contribute to a culture of domestic violence myth acceptance that is currently hostile to victims of intimate partner violence. The understanding of that contribution to the overall value we place on victims

of domestic violence and the degree to which we hold batterers accountable is critical to facilitate the social change required to dispel domestic violence myths and reduce victim-blame.

CHAPTER II

REVIEW OF THE LITERATURE

Feminist Theoretical Framework

The focus of this review of the literature is to inform the discourse on domestic violence myth endorsement by forensic mental health professionals whose practice includes professional contact with female victims and/or male perpetrators of intimate partner violence. Feminist psychological theory provides the contextual framework for the examination of domestic violence myth acceptance, its purpose, and the contributing factors. Since violence against women has an extensive documented history rooted in patriarchy, the attitudes and beliefs about victims and the impact of those beliefs on women and their roles in a patriarchal society will be reviewed. Feminist psychological theory is suitable for this study of the examination of domestic violence myth acceptance since feminist analysis addresses the structural elements of gender and power, the social and institutional role of family, the validation of women's experiences, and theoretical development in line with women's experience (Bograd, 1986; Pressman, Cameron, and Rothery, 1989). These constructs are important to societal views of violence and women since it is exactly those societal beliefs and attitudes that support ongoing violence against women (Brownmiller, 1975, & Burt, 1980).

Although an extensive body of literature exists on violence against women, there is minimal literature on domestic violence myth. This review will begin with a brief examination of the prevalence of domestic violence, a review of the pervasive victim-blaming attitudes by professionals, and a look at the literature on rape myth. Finally this review will discuss the relevance of the existing literature for forensic mental health specialists who interact with victims and/or perpetrators of domestic violence.

Forensic mental health practitioners interact with victims and perpetrators in a variety of ways during periods of litigation over divorce, child custody, and criminal matters such as violations of protective orders, assault and battery, and domestic homicide. Therefore, the primary purpose of this review is to lay a foundation on which to test the hypothesis that domestic violence myth acceptance by forensic mental health specialists correlate with their attitudes toward women, their level of dispositional empathy, and their hostile or benevolent sexism toward women. The literature will also show that the significance of gender in attitudes toward women is embedded in the traditional gender role expectations of women and men and is related to domestic violence blame and myth acceptance in professional and public spheres.

The use of liberal feminist critique as a component of the theoretical framework will provide a critical analysis of violence against women that designates the context for examining the consequences to victims who experience victim blaming attitudes and stereotypes. Therefore, this review will begin with an exploration of the impact of patriarchy on women's historical and social relevance in ancient and contemporary societies.

Historical Context of Women and Patriarchy

The history of *documented* violence against women began in the patriarchal societies of thousands of years ago. In *The Creation of Patriarchy*, Lerner (1986) explored the origins of patriarchy, a social system in which men are regarded as the absolute authority within the family and society, and in which power and possessions are passed on from father to son. Lerner (1986) surmised that there was no single explanation for the establishment of patriarchal societies, although the effects of patriarchy on the lives of women and girls is extensive. The subordination of women was also evident in the institutionalization of patriarchy within the family unit where men in the majority of families and societies were regarded as sole authority. It was in the family that power and property were bound by the societal influences of patriarchy and it was the economics, religion, and politics of the ruling class that contributed to women's subordination. Lerner (1986) explained that subservient status was not always the case for women. For example, archeologists discovered evidence that women in Paleolithic, Neolithic, and Bronze Ages were once respected and revered as the source of life and lineage while their abilities to conceive and give birth were granted divine associations (Martin, 1981). However, Lerner (1986) emphasized that as societies became more complex, the division of labor was not based solely on gender distinctions but on hierarchical authority of men with power over other men, in addition to the subordinate status held by all women.

Archaic states of Israel and Mesopotamia were patriarchal societies where legislation of the subjugation of women and slaves was common place. These practices were found in ancient Babylonian and Mosaic laws in the second millennium B.C.E. that document the selling of women to men who purchased them for their wives.

Brownmiller (1975) posited that the practice of exchanging wives for money was considered a more civilized proposition than *capturing* brides since women were civilly bought and sold as prostitutes or as wives for "50 pieces of silver" (p. 18) thus, enabling their families to prosper monetarily and raise their status in society. Bride capture, also known as protective mating, occurred when a man staked his claim on a woman by raping her, giving him a claim to her body as his property. Bride capture was generally recognized in ancient authoritarian societies as the most acceptable means of obtaining a wife, and was practiced as recently as the fifteenth century in England. In *Against Our Will: Men, Women, and Rape* (1975) Brownmiller explained women's fear of rape as a critical factor in women's subjugation by men and contributed to women's "historic dependence and domestication by protective mating" (p.16). Since men were responsible for preserving property and protecting lineage, men also believed they were entitled to exercise control over their wives' behaviors, even if it meant killing their wives in order to control them (Wilson, 1997).

From the mid 13th through the 18th centuries women were abused, tortured, and murdered in a "femicidal mania of the witch craze" that spread through Europe and into the American colonies (Wilson, 1997, p. 260). The exact number of women killed in executions that usually involved live burnings at the stake is unknown but has been estimated to be from two hundred thousand to ten million. Among those accused of practicing witchcraft were midwives, single women and older widowed women who lived alone. A great number suffered from mental illness or physical deformities; many had allegedly committed acts of prostitution, sodomy, or adultery; others had miscarried from natural causes, or as a result of domestic assault (Wilson, 1997).

With a diminished number of midwives to practice healing arts, men replaced women as the healers and became the 'midwives' who, in the seventeen and eighteen hundreds, became known as *gynecologists.* Through the 19th century, women were banned from formal medicine since medical practice required university training and licensure which, for the most part, were inaccessible by women. The patriarchal culture was once again threatened by the idea of women gaining power, so labels of *mentally disturbed* or *hysterical* stuck to women who were fervently fighting to gain admission to the universities, own property, and win the right to vote in local, state, or national elections. Clitoridectomy, hysterectomy, and lobotomy became the medical 'cures' for hysteria which, Herman (1992) argued, was more likely psychological trauma stemming from sexual assault and domestic violence. After the Viet Nam War, trauma was recognized as a diagnosable mental disorder by the American Psychiatric Association. At that time, however, mental health practitioners were still unaware that the most common traumatic disorders were not experienced by men in war, but by "women in civilian life" (Herman, 1992, p. 28). The mental health professionals who subscribed (albeit unconsciously) to myths about women, psychology, and women's prescribed roles in society were more likely to have projected their bias or ignorance onto their female clients who stood to suffer the most from uniformed diagnoses and inappropriate treatment.

Politics of Feminism and Violence Against Women

The momentum of a political movement in the 1960's rekindled public awareness of sexual assault, civil rights, and women's emancipation and opened society's eyes and

minds ten years later to the very real and very secret social problem of domestic violence. Domestic violence, like rape, became a political and social issue. Grassroots coalitions organized crisis hotlines, and battered women's shelters, and were responsible for the initial changes in the response of the criminal justice system to violence against women and children. The body of research on domestic violence grew ten fold in the last forty years, and yet, the prevalence of violence against women is still disputed, under reported, and in many instances even denied as a problem (Springer & Roberts, 2007)

The circumstances of the child abuse prevention movement are similar to those of the movement to protect adult women from domestic violence (Berns, 2001). These two movements contrast in very distinct ways evident in the child abuse congressional hearings of the 1980s regarding the motivation for parental abuse of children. In the hearings on violence against women, however, the expert witnesses testified as to "why women were willing to be beaten" (Pleck, 1987, p. 197, cited in Berns, 2001). Neither the dynamics of battering nor the personality characteristics of batterers were processed or analyzed by expert witnesses, or legislators during the hearings. Berns (2001) identified four strategies that maintained patriarchy (a) to present women as the abusive gender (b) to hold victims accountable for their own victimization; (c) to challenge a social tolerance for violence of women and not for the violence of men; and (d) to blame antidomestic violence advocates who assist victims of intimate partner violence.

In *Degendering the Problem and Gendering the Blame*, a study on ongoing media influence on the societal acceptance of domestic violence, Berns (2001) used the term 'patriarchal resistance' to explain the practice of "obscuring men's violence while placing the burden of blame on women" (2001, p. 262). The practice of resistance discourse,

suggested Berns, was built on the political nature of violence against women. Berns offered three implications that framed what she described as the backlash discourse (a) the social acceptance of intimate violence as a normalized occurrence in the daily lives of women (b) steady attempts to deflect from the real problem of men's responsibility for violence against women while ignoring the socio-cultural factors that maintain the status quo; and (3) the popular focus on women as the new aggressors and domestic violence perpetrators in contemporary society. This focus, Berns insisted, lacked genuine concern for the true victims of domestic violence, and was only intended to present women as equally violent as men.

Like Herman (1992) and Wilson (1997), Berns (2001) agreed that the institution of patriarchy in the United States was threatened during the revolt of the 1960's and 1970's because patriarchy was identified by feminists in the movement as being the foundational support for violence against women. Feminist activists voiced their intolerance for patriarchal practices that diminished women's safety and blamed women for the violence. Thus, the efforts to challenge men and their behavior were diverted to a solitary devotion to the victims and what they needed to survive (Berns, 2001).

Impact of Cultural Stereotypes on Mental Health Providers

Cultural stereotypes have influenced the delivery of mental health services, often to the detriment of women seeking those services. "Sexist biases in conventional clinical theory and in our culture at large, shape clinical interventions with battered women" (Bograd, 1982, p. 69). Battered women seeking mental health services in traditional clinical settings have found that the applicability of clinical treatment and theory did not

adequately address their concerns. In fact, feminist based analysis revealed that clinical interventions and diagnosis of battered women were based on patriarchal perspectives of women's health instead of sound empirical research and scientific inquiry (Bograd, 1982). As a result, cultural myths that influenced male and female therapists' sexist attitudes toward women also distorted the true impact of violence against women and women's reactions to violence. Bograd (1992) asserted; however, that politics and therapy were not two distinct endeavors. If integrated, Bograd believed that the therapist was better equipped to engage in interventions that were not only safe, but efficacious. Clinicians, especially family systems therapists, who lacked awareness or acknowledgment of batterers' tendencies to distort or simply ignore the truth ran the risk of misinterpreting the propensity of batterers to minimize the impact of their brutality on their families. Batterers' overarching need to control and maintain power over the therapeutic process obscured the perspective of even the most seasoned family therapist, therefore, Bograd insisted that therapists who engaged in therapeutic relationships with batterers, refrain from accepting explanations for violence that implicated the victims. Therapists who believed that a neutral therapeutic stance and a strong commitment to help the 'couple' were simply not enough to change the behavior or the motivations of a batterer (Bograd, 1992).

Bograd (1986) encouraged therapists to evaluate their own biases to determine the extent of their own adherence to cultural myths before accepting female victims of domestic violence as clients (Bograd, 1986). Mental health professionals who failed to examine their own beliefs could underscore the perceived psychopathology of victims as the precipitators of intimate violence. These beliefs subsequently held victims responsible

for the violence, and minimized the severity of their circumstances by inaccurately communicating to their clients, and to the public at large, that violence against women was acceptable and common place in women's lives. For example, therapists who defined battery as the result of the woman's characterological dysfunction, paranoia, borderline personality disorder, or bipolar depression failed to consider that depression and aspects of a victim's character were the results of being battered (Bograd, 1982).

Research has shown that women who stayed in abusive relationships did so for a variety of reasons. Therefore, victims' survival strategies may appear to professionals as dysfunctional attempts to excuse batterers' behaviors and deny the abuse. In truth, clinical evidence is abundant with regard to batterers' self-talk, also described as the "bitch tape" (Dutton, 1995, p.44), that referred to negative and hostile ruminations of the batterer about his intimate partner. These ruminations were contributors to the batterer's arousal patterns, irrespective of what his wife did or did not do. Batterers escalated on their own, by way of their own choices, independent of a woman's character, her communication style, or her endorsement or rejection of traditional gender roles. Due to the denial and manipulative tactics of batterers, the male batterer is rarely addressed in therapy with individuals, and is contraindicated in couple's therapy for reasons of safety for the victimized spouse.

The long term, positive outcomes of court ordered batterers' treatment remain inconclusive among researchers, except in the area of rates of recidivism, but only if the recidivism was assaultive in nature and was brought to the awareness of law enforcement. Psychological terrorism, coercive control, isolation, and threats to harm were rarely

included in recidivism statistics, though they were as common in men who completed batterer treatment as they are in men who do not (Bograd, 1992).

The dissonance felt by a great number of family therapists could be resolved with ongoing dialogue and continued examination of moral and ethical dilemmas that occurred in treatment with victims and perpetrators of domestic violence (Bograd, 1992).

Consequences of Myths, Sexism, and Victim-Blame

In *The Mythology of Crime and Criminal Justice,* (2005) Kappeler and Potter stressed the importance of criminal myth and the social consequences that resulted from crime myth implications.

> Crime myths are powerful constructions of reality because they speak to our personal values and beliefs and are steeped in rich symbolism, which reinforces those values and beliefs….that bring order and values to an often disorderly and value-conflicted world (pp. 2-3).

The authors spoke to individuals' collective 'unconsciousness' of the function and role of crime myths in our personal perspectives of reality. Kappeler and Potter (2005) asserted that a lack of awareness of the contradictions that were made invisible by myth kept the 'story' going and instructed us on how to adapt specific circumstances to our personal views of the world instead of adapting myths to fit a valid explanation of social phenomena. The impact of myth on our organization of our perspectives of crime and the "proper operation" of the criminal justice system (Kappeler & Potter, 2005, p.3) had its downside. For example, when a myth about crime was generated, it became foundational in the generation of other myths, like crime myths for example, that acted to establish a

social reality, even when evidence existed to the contrary. The consequences of strict adherence to myth resulted in a failure to consider other possible problem definitions and solutions. Our endorsement of crime myths was relative to societal acceptance or rejection of explanations for behavior, and the systems' response (or lack of one) to crime and crime victims.

Rape Myth

Research on the cultural support for rape and rape myth acceptance (Burt, 1980) is more abundant than research on domestic violence myth, therefore the literature on the impact of rape myth on victim safety is pertinent to this study with regard to the predictors of domestic violence myth acceptance. Research that contributed to Burt's development of the Rape Myth Acceptance Scale in 1980 provided an empirical foundation for social psychological and feminist theoretical analysis of rape attitudes and their antecedents (Burt, 1980). In her research Burt tested the relationship of rape myth with three attitude variables and found that acceptance of interpersonal violence was the strongest predictor of rape myth acceptance. Burt demonstrated that predictability of rape myth acceptance was possible with acceptance of interpersonal violence, adversarial sexual beliefs, and sex role stereotyping (Aberle & Littlefield, 2001). Since then, Burt's work has been expanded to include the positive correlates between attitudes of hostility toward women, the acceptance of rape myths (Briere, 1987; Monto & Hotaling, 2001), and sexual violence against women (Lanier, 2001).

If sex role stereotyping was, indeed, the precondition for targeting women as potential victims, Burt (1980) surmised that men's acceptance of interpersonal violence

could serve as the "attitudinal releaser" for sexual assault behaviors. However, Burt added that rape was also a product of a culture that tolerated interpersonal dominance, sexual stereotyping, attitudes toward women, and sex roles. Rape prevention would require systematic change in societal values and attitudes toward rape.

In a study involving three samples of college students (N=429; 199 men and 230 women), Lonsway and Fitzgerald (1995) demonstrated that hostility toward women accounted for a partial explanation for rape myth acceptance constructs in Burt's RMA scale. The authors also found that hostility toward women was predictive of rape myth acceptance among men more so than women. This finding suggested that rape myths functioned differently by gender, which supported the need for further research on misogyny and its relationship to the sexual assault of women. In two studies conducted by Howard (1984), societal characteristics and gender were examined with regard to their influence on attributional blame on crime victims and the perpetrators of crime. Howard asserted that attributions were derived from beliefs about cause and effect behaviors and that these beliefs were shaped by the collective beliefs of a societal group as well as the individual.. When assumptions about individuals were based on stereotypes such as gender, race, economic status, or age, they were likely to shape misconceptions about individuals when assumptions were made without regard to the effect of societal role expectations. Howard (1984) surmised that characterological blame, such as the victim's *choice* to engage in behaviors such as jogging and hitchhiking, were factors in blame attribution. Sex as a societal variable lent credence to the assertion that societal characteristics such as age, and race exerted varied levels of influence on information processing (Howard, 1984).

Domestic Violence Myth

Myths are important factors in a value driven culture and serve first to explain circumstances that are seemingly unexplainable. For example, children who are sexually abused by a family member, or women who are battered by their abusive husbands are often judged harshly by individuals who believe that the victims should have told someone, simply left the abuser, or prevented the abuse from happening at all. These judgments stem from myth endorsement and unintentionally hold the victims more accountable than the perpetrators. In reality, it is dangerous for children or adult women to 'tell someone" or just simply leave the perpetrator without adequate help, a safe place to go, available counseling, financial assistance, or affordable legal resources. The myth that women could just leave is false, since the most dangerous time for women is during their separation from a batterer (Springer & Roberts, 2007).

Numerous studies have been conducted on the influence of rape myth endorsement and sexism on attitudes and behaviors of students, professionals, victims of sexual assault and perpetrators. However, the same cannot be said for research on domestic violence myth. Peters' (2003) recent development of the Domestic Violence Myth Acceptance Scale to begin addressing this research gap. This measure parallels the attitudinal constructs of Burt's Rape Myth measure (1980) that share three fundamental components of domestic violence myth, rape myth, and child sexual abuse: (a) to minimize the crime of rape, domestic violence and child sexual abuse; (b) to blame the victim; and (c) to exonerate the perpetrator (Peters, 2003). Peters defined domestic violence myth as "stereotypical attitudes and beliefs that are generally false but are

widely and persistently held, and which serve to minimize, deny, or justify physical aggression against intimate partners" (2003, p.17). In his development of the DVMAS, Peters suggested useful applications of the measure in populations such as law enforcement and medical personnel, since these individuals were often on the front lines of intercepting and treating victims of domestic assault (Peters, 2003; Walker, 1994).

The DVMAS scale is a valid, reliable instrument that was developed as a measure for individuals, groups, and communities to determine who does and who does not endorse domestic violence myths. It is a also a tool to help us understand the far reaching effects of domestic violence on victims' self-perceptions, and can be used to inform and tailor the responses of misinformed professionals before they interact with victims and perpetrators of these crimes.

Sexism

Sexism is generally considered a stereotype that has been linked, in several studies to prejudice, attitudes toward sexual assault, and rape myth acceptance. Sexism is multidimensional due to its multiple constructs that range on a continuum from benevolent attitudes toward women to hostility towards women in personal and institutional spheres. In a well known study on sexism (Broverman, Broverman, Clarkson, Rosenkrantz, & Vogel, 1970), trained clinicians, including psychologists, psychiatrists, and social workers responded to survey questions about traits of healthy adults, healthy males, and healthy females. The sex-role stereotypes survey found that these groups of professionals made clinical judgments based on gender. This result supported the researchers' hypothesis that clinicians judgments would differ according to

gender and that sex-role stereotypes would be upheld. The study revealed that the respondents characterized a healthy adult in terms that reflected, almost identically, their descriptions of a healthy adult male. The clinician's descriptions of healthy women, however, differed from their standard characterizations of healthy adults. For example, clinicians in this study were more likely to identify healthy women as being (a) submissive; (b) emotionally excitable in a crisis; (c) emotionally vulnerable; (d) vain about their appearance; (e) lacking in objectivity; and (f) harboring disdain for science and math.

Researchers have found that therapeutic interventions were rife with stereotypical views of women and attributed this finding to the male models of psychological development that emphasized adaptation to environmental and intrapsychic change. Stout and McPhail (1998) considered that mental health professions maintained the status quo of misogynist attitudes toward women found in contemporary society. The risk presented for women who sought help was apparent in the blame and judgments they faced from mental health professionals. For example, misdiagnosis and labels such as histrionic, borderline, self-sabotage, fearful, psychotic, and masochistic were judgments made about victims of domestic violence by mental healthcare providers, suggesting that the therapeutic interventions and male-modeled strategies were just as misogynistic as the diagnoses (Stout & McPhail, 1998).

Myths that speak to the social expectations of traditional therapeutic interventions include the belief that problems are psychologically created, unconsciously motivated, and separate from any external context that might help women understand their circumstances (Greenspan, 1983). Additionally, Greenspan identified psychopathology as

a therapeutic myth that supported clinical diagnosis of mental illness based in the medical treatment model. The *expert* was also identified by Greenspan (1983) as a myth supporting the belief that a scientific, objective expert (usually male) could diagnose and treat the illness of an individual. Patriarchy served as the foundation for this type of sexism wherein women were treated as subordinate members of society whose problems were viewed as personal rather than political. Stout and McPhail (1998) emphasized the detriment to women that traditional therapies presented, especially when women's stories of seeking help reflected painful attempts to find assistance from mental health professionals who "ignored or minimized the violence, tried to persuade the victims to have more sympathy for the batterers, or even strategized with the victims regarding how to be better wives and mothers so they would not provoke the violence!" (p. 53).

Prejudice is based on inaccurate generalizations. Glick & Fiske (2001) noted that antipathy and hostility guide our misperceptions of people or events that result in discriminatory thoughts and practices towards disadvantaged groups. Glick & Fiske (2001) point to women as belonging to one of the 'disadvantaged' groups that suffer from the consequences of prejudice, but they also suggest that women, generally, are most often the favored gender by both men and women. Therefore, if attitudes toward women are more positive than we had believed, how can women belong to a group that is considered disadvantaged? The authors explained that traits of women that are most valued, such as nurturance, care for others, and relationship focus place women in a domestic realm where traits such as these are socially accepted, even revered, but at the same time serve to subordinate women and their roles. Therefore, sexism that is hostile in its context does not describe, accurately, the kind of sexism that is more patronizing

and supporting of the inequality of heterosexual females and males that benign sexism has shown in a variety of studies.

To address this distinction, Glick and Fiske (1996) developed the Ambivalent Sexism Inventory that measured two constructs of sexism. The authors believed it was important to consider benign sexism as a sexist construct inherent in the patronizing view of women. Their hypothesis was "that hostile and benevolent sexism are predictable products of structural relations between men and women that are common to human societies" (p.111). This hypothesis was based on 3 factors, "patriarchy, gender differentiation, and sexual reproduction" (p. 111) that influenced hostile and benevolent attitudes toward gender. With regard to sexual reproduction, Glick & Fiske (2001) suggested that men harbored resentment toward women because (according to men's perceptions) women possessed power over men that was demonstrated in women's use of sexual attractiveness to gain an advantage over men. Since men relied on women to reproduce children, engage in sexual intimacy, and maintain the domestic sphere, Glick and Fiske (2001) believed that these views of women fostered benevolent sexism and represented the female as one who needed nurturing and protection. Ambivalent sexism measures the endorsement of both polarized ideologies, hostile and benevolent, that represent a conflict and uncertainty with regard to beliefs about women. Therefore, benign sexism encompasses sexist attitudes toward traditional women that serve to protect, idealize, and romanticize them. On the other hand hostile sexist attitudes encompass negative views that serve to dominate, disparage, and oppose women in unconventional roles.

Two studies were conducted in the United States by Glick, Diebold, Bailey-Werner, and Zhu (1997) with regard to ambivalence and the ability to reconcile both hostile and benevolent perceptions of others. Glick and Fiske (2001) explained that stereotypes of women were common and used everyday to describe a *subtype* of woman, such as "working woman", "stay-at-home mom", "babe", or "lesbian" (Glick & Fiske, 2001, p. 113). As benign as some of these labels appeared, the benevolent ideologies objectified women as wives, mothers, or romantic ideals. Hostile ideologies were directed towards women who threatened men's power such as feminists, 'career track' or sexually seductive women. In their study, Glick et al., (1997) asked men to evaluate women based on traditional (homemakers) versus non-traditional (career women) types. The men who scored high in hostility predicted negative attitudes toward non-traditional women in the *career woman* category, while their scores on benevolent sexism also predicted their positive attitudes toward women in traditional roles. Since these attitudes were directed toward two types of women, researchers Glick et al., (1997) concluded that women whose roles were viewed as conventional were put on a pedestal and rewarded with benevolent attitudes, whereas women who adopted unconventional gender roles that threatened men's power were punished with hostile attitudes toward women.

Glick et al., (1997) found that this explanation brought forth another problem, suggesting that sexism was also directed at individual women in addition to the subgroup types. For example, a batterer demonstrates both hostile and benevolent sexism when he responds abusively to his partner whom he perceives as challenging to his authority. Then, during what is commonly known as the "honeymoon" period, he responds positively when he views her in a traditional role that serves him. These polarized views

of an individual woman demonstrate endorsement of two conflicting sexist views. The researchers suggested further study was needed with men whose attitudes toward women held true in both subscales.

Domestic Violence Blame

Since the Domestic Violence Myth Acceptance Scale was not developed until 2003, it is important to look at studies that incorporate alternative measures to determine underlying attitudes and beliefs held by professionals who interacted with victims of domestic violence. Several studies conducted over the past 20 years have demonstrated an interest in professionals' attitudes toward domestic violence and women victims in particular. For example, Jackson, et al., (2001) encouraged crisis intervention professionals and psychotherapists for victims and perpetrators of domestic abuse to use the results of the research to explore their own beliefs, attitudes, and consequent behaviors during the treatment process. The authors believed that critical components of effective and appropriate treatment required knowledge of victim blame and knowledge of research on gender differences with respect to violence against women. The Domestic Violence Blame Scale (DVBS) was developed as a standardized measure of blame distribution with regard to wife abuse (Petretic-Jackson, Sandberg, & Jackson, 1994). The DVBS was administered to mental health professionals, law enforcement, alcohol and drug counselors, and physicians to investigate attitudes of these populations, and to determine the impact of these professionals' beliefs on services for victims and offenders.

Reliability of the Domestic Violence Blame Scale

Though the DVBS has been used in a variety of populations with similar results in each sample, the reliability is not available in the literature. However, the general conclusions made in their studies do lend some insight into the need for further research in the area of professional bias toward domestic abuse as well as the implications of gender and perspectives of victims.

A study involving physicians and mental health practitioners was conducted by Jackson, et al., (2001) to determine the quality of service provision based on the attitudes of the providers. The first study involved physicians since they were often the first contact made by a victim of domestic violence (Tjaden & Thoennes, 2000). In this study, 145 practicing physicians and medical students were administered the Domestic Violence Blame Scale. A significant gender effect was revealed with male physicians who blamed female victims to a greater extent than did female physicians. Differences were also noted in the referral practices of male and female physicians where males made fewer referrals to mental health services. Male physicians who scored high on the victim blame factor were less likely to develop safety plans or recommend mental health interventions.

The results of a study using the DVBS with licensed psychologists revealed practicing psychologists obtained the same overall blame scores as the initial college student standardization and the physician samples (Sandberg & Jackson, 1986). Male psychologists had higher blame scores than the female psychologists. The research also revealed that professionals who blamed the abuse victims more often recommended treatment for the victims.

A Modified Domestic Violence Blame Scale (MDVBS) was later used with a stratified random sample of licensed psychologists from the National Register of Health Services Providers in Psychology. Those psychologists who showed a preference for couples work scored higher in the situational blame dimension. The researchers were concerned that working with couples increased the risk for revictimization of the victim, or at its worst, demonstrated an alignment with the batterer (Jackson, et al., 2001).

Herman (1992) and Stark & Filtcraft (1988) challenged some of the earlier research on battered women that reported victims' pathology, character deficits, and other stereotypes. Busch (2004) found that misconceptions about the mental health of victims have served to perpetuate myths about battered women and placed blame on the victim for the behaviors of the batterer. Busch asserted that the pathological perspectives found in previous research portrayed women as "masochistic, immature, inadequate, incomplete and sexually perverse" (Busch 2004, pg. 57). Herman (1992) pointed to survivors of trauma from childhood abuse or sexual assault as particularly vulnerable to revictimization by caregivers in medical or mental health systems especially when those professionals behaved in ways that reminded their clients of abusive family members. These interactions can be destructive and the relationships are difficult to terminate by trauma victims who feel disempowered due to their history with abuse. Therefore, before clinicians can adequately assess or provide treatment in cases where intimate partner abuse is present, it is important that they recognize the scope and breadth of intimate partner violence that crosses all boundaries of race, economic status, and professional affiliation. Client safety was stressed by Jackson, et al., (2001) as crucial to service provision, regardless of the personal bias of the practitioner. Clinicians were cautioned by

Jackson, et al., (2001) to be aware of any contributing factors to victim blame or acceptance of domestic violence and concluded that knowledgeable mental health professionals occupy an important role in the education of physicians and other referral sources.

Dispositional Empathy

Empathy is included in this review of the literature since it may be revealed in the analysis as a mediator of domestic violence myth endorsement. Davis, (1983) defined empathy as the reactions of an individual to the experiences of another individual. For the purpose of this study, Davis' (1996) multidimensional, cognitive-affective approach to measuring constructs of empathy was applied. Four distinct but related constructs: (1) *perspective taking*, (2) *empathic concern*, (3) *personal distress*, and (4) *fantasy* provide measures of "dispositional tendencies" (Davis, 1996, p.55) in the Interpersonal Reactivity Index (IRI). The four constructs of empathy in Davis' model are identifiable by the tendencies of an individual to adopt the psychological perspective of others, to experience compassion for others who are less fortunate, to feel uncomfortable with the distress of others, and to use imagination to project oneself into situations that are fictitious.

Although the literature does not specifically address empathy in forensic mental health professionals, the Interpersonal Reactivity Index is often used in research on various types of offenders. Therefore, the following review of empathy includes studies of college students, prisoners, and batterers in order to show that the multidimensional aspects of empathy relate to various groups and their

attitudes, behaviors, and beliefs about others. Perspective taking is a cognitive tendency to see things from the perspective of another (Davis & Oathout, 1987) and allows for one to feel more or less empathy for someone in need by actively imagining how individuals are affected by circumstances that cause them discomfort (Batson, 1987, 1991; Davis, 1996). This aspect of empathy may fit well with this study if forensic specialists apply perspective in their objective, forensic examinations of individual clients, or if they disregard their personal presumptions in exchange for scientific, fact based evidence.

In a study on assessing empathy in prisoners, Lauterbach & Hosser (2007) found that a shortened version was necessary since prisoners with lower IQ and verbal skills experienced difficulty in reading and understanding negatively worded items. Results revealed that fantasy, perspective taking, and empathic concern, facets of dispositional empathy, were different among violent and non-violent perpetrators. Specifically, the study revealed the perspective-taking facet of dispositional empathy as an important predictor of offenders' future violence within 24 months after their release from prison. For samples of individuals with sound verbal skills and an average to above average IQ, the IRI scale should not present a problem with negatively worded items.

Personal distress is the "tendency to experience distress and discomfort in response to the distress in others" (Davis, 1996, p.57). For example "Being in a tense emotional situation scares me." This aspect of empathy is more self-focused and serves to identify individual character, (unlike empathic concern which looks

externally to others and their discomfort). In cases of empathic over-arousal, the distress felt by the observer may detract from the distress experienced by the observed individual (Batson, 1991). This may be relative to forensic professionals who may be more likely to refrain from empathic over-arousal when conducting objective interviews with abuse victims in crisis. Therefore, personal distress may or may not be a significant variable in this study; not because this sample of professionals is not able to empathize, but more because their role as forensic specialists may require differing empathic responses than therapeutic professionals would.

Empathic concern is an affective tendency, an "other-oriented emotional response elicited by and congruent with the perceived welfare of a person in need, [that] includes feelings of sympathy, compassion, tenderness, and the like" (Batson, Eklund, Chermok, Hoyt, & Ortiz 2007, p. 65). In a study on gender effects on attitudes toward sexist language, Parks & Robertson (2005) found that empathic concern mediated neither age nor gender effects in their sample of 402 undergraduate college students, indicating that the affective aspect of empathy in empathic concern was not significantly related to age or gender. However, the cognitive aspect of empathy in perspective taking mediated the small age effect in the male student sample. Though age is not a focus of this study, the study does examine the effect of empathic concern on beliefs by gender.

The fantasy aspect of dispositional empathy is the ability for an individual to transpose oneself into an imaginative situation such as a book or movie. This

construct may prove an important aspect of empathy for forensic specialists who imagine themselves in the circumstances of others, and the fantasy aspect has been found to be significant in those who are more introverted, and not prone to violent behavior (Lauterbach & Hosser, 2007).

Secondary Victimization by Professionals

Police Officers

Negative attitudes, suggestions, or comments to victims by officers can be harmful and may cause more despair to the victim than the battering itself (Keilitz, Hannaford, & Efkemann,1995). Keilitz et al., found that police officers who subscribed to traditional attitudes toward domestic violence and victims of abuse were more likely than officers who scored low on traditional attitudes to arrest the victim instead of the perpetrator. Those police officers who attributed blame to the victim for provoking the violence have often done so to justify their decision not to arrest the perpetrator. These practices only demonstrated to the victim her powerlessness over her circumstances (Erez & Belknap, 1998).

Zorza (1998) found that police officers viewed domestic violence calls as annoying aspects of police work and perceived intimate partner violence as less serious than violence perpetrated by a stranger. Consequently, other studies have found interactions of victims and law enforcement to be what the researchers have termed "demoralizing" (Erez & Belknap, 2002). For example, some researchers found victims to

be intimidated to such an extent that they refrained from using the criminal justice system to arrest the batterer, file an emergency protective order, or report any violations of a protective order (Logan, Shannon, & Walker, 2005). Due to these negative, demoralizing experiences with law enforcement, victims/survivors often refrained from asking law enforcement for any further assistance, thus creating another barrier to victims' safety.

Though domestic violence offenses have been legislated as violent criminal acts researchers Logan, Shannon, & Walker (2005) considered that police officers needed additional training on the illegal aspects of domestic abuse. The authors pointed to an ample body of research indicating the likelihood that perpetrators would have a history of domestic violence offenses in addition to a familiarity with the criminal justice system for crimes other than domestic violence. Historically, domestic violence has been viewed as a less serious offense than crimes perpetrated by strangers. Since spouse abuse and assaults by a stranger are often viewed differently by police and other professionals, in many instances intimate partner violence has not been given the same priority as stranger violence. Attitudes that continue to influence these beliefs range from traditional views of women as property of their husband, to beliefs that hold women responsible for their victimization by an intimate. Because police officers are generally the first respondents to domestic 911 calls, their attitudes and beliefs are important determinates in their accurate assessment of the scene and protection of the victim.

Family Law Attorneys

Sarah Buel, criminal prosecutor, law professor and survivor of domestic violence, is a leading expert in the field of domestic violence and the law. In her article, *Domestic*

Violence and the Law: An Impassioned Exploration for Family Peace, Buel (1999) expressed her concern that though many family attorneys and judges hold prime positions where their assistance in domestic violence cases could be effectively and legally executed, a significant number of these legal professionals have failed "to grasp even the most basic tenets of victim safety and offender accountability" (Buel, 1999, p. 720). Buel noted that a lack of basic education and knowledge had contributed to the mishandling of domestic violence cases by attorneys and judges and recommended that law schools and continuing education programs increase their academic instruction on issues of domestic violence and gender bias (1999).

Almost three decades after the movement in the 70s to take domestic violence seriously as a crime not to be tolerated, Buel (1999) discovered that victims of DV still have tremendous difficulty securing legal counsel. Battered women have little access to finances and even if they can scrape up a retainer for legal counsel, the chances of finding an attorney or a court that takes her allegations seriously are just as difficult. Due to this ongoing challenge to victims who suffer economic hardships as a result of leaving an abusive partner, Buel challenged family lawyers to become active in community legal services for the indigent, to stop blaming victims, and to engage in practices that insure offender accountability.

Instead of looking at their role as one that could assist with issues of victim safety, Buel found that lawyers often fall prey to blaming victims and judging women for failing to meet standards that lawyers deem acceptable. In her research and practice, Buel (1999) found several trends that emerged with regard to the legal community and their responsibility to be proactive in domestic violence cases. The first trend related to the

lack of adequate legal representation for victims of domestic violence, especially in cases where divorce, custody and visitation were the focus of litigation. Two of the most pressing problems facing victims in domestic violence cases were batterers' seeking and obtaining custody of the children, and visitation orders that put victims and their children at risk for further harm before, during, and after the exchange of the children. Inadequate, incompetent, and unsafe legal representation can impede the safety and well being of the victim and can even effect future generations of her family.

Another trend addressed the quality of legal services and its relationship to the victims' ability to be safe and stay that way. Since screening is required for other groups of professionals such as mental health and medical practitioners, lawyers who wish to provide quality representation were urged by Buel (1999) to adopt screening as a routine practice with their clients when their clients were the victims, the children, or the perpetrators. If a lawyer remains silent and does not inquire of the safety or risk of a client's circumstances, Buel cautioned that two undesirable outcomes could be malpractice and collusion with the batterer.

Additional trends that emerged from Buel's research involved what she found to be a less than comprehensive approach to domestic violence cases by judges and family lawyers who failed to consider past history of alleged batterers; the failure to address unintended outcomes of the court process; and the courts' reluctance to hold batterers accountable for abusive behaviors that were found to be criminal acts of domestic violence. Although her research paints quite a negative perspective of the legal system, Buel added that there are courts and practicing lawyers who have adopted effective practices such as safety planning and client referrals to other community resources as

needed to address the problems presented in domestic violence cases and Buel advises that these efforts be duplicated in family law courts and legal practices across the country.

Social Workers

Professionals in the field of social work have been portrayed unfavorably in the literature for their lack of training and their insensitivity to battered women with children. Although social workers are in prime positions to detect domestic violence and make appropriate referrals and recommendations for safety, housing, legal services, and child protection, many do not even screen for domestic violence. Gomberg (2001), in her dissertation, *Barriers in Screening for Victims of Domestic Violence: A Survey of Social Workers, Family Practitioners, and Obstetrician-Gynecologists,* made the important point that these professionals are mandated by professional ethics to detect domestic violence and assist victims in getting treatment. However, Gomberg found that the detection of domestic violence by social workers and physicians remains a problem. She compared the importance of early detection in domestic violence cases to the success of early detection of cancer, suggesting that early access to information could reduce the likelihood of injury, death, or disease related to domestic abuse. Based on these findings, Gomberg urged social workers and physicians to practice routine screening for domestic violence to reduce the risk to victims and to provide safe and appropriate intervention and treatment.

Implications for Forensic Mental Health Specialists

Although prior research has consistently identified victim blaming attitudes in various groups of students, helping professionals, social workers, and physicians whose work involved patients, and/or clients as victims of sexual assault or intimate partner violence (Petretic-Jackson, 1994), a gap exists in the literature for empirical studies that examine the predictors of domestic violence myth acceptance in forensic mental health specialists. Since domestic violence blame has been identified in groups of professionals reviewed previously, this study looks at domestic violence myth endorsement by forensic specialists whose professional roles involve expert witness testimony, custody evaluations, forensic psychological examinations, or clinical treatment in cases where domestic violence is an issue. Gender differences will also be examined in the analysis of forensic mental health specialists surveyed for this study.

The implication of formal reactions to victims of intimate partner violence by forensic mental health practitioners lies in the risk of labeling or blaming victims of domestic violence for circumstances over which victims of violence may have little to no control (Petretic-Jackson, 1994). For example, it is common for psychologists who treat victims abused by intimate partners to diagnose borderline personality disorder or other mental illnesses as opposed to a less stigmatizing disorder of post traumatic stress (Buel, 1999; Walker, 1984). These diagnoses run the risk of labeling the victim and contributing to victim attribution resulting in a profound impact on victims' self-blame, especially if labels such as "pathological or abnormal" are reported or implied. These labels can stigmatize victims and result in consequences including the loss of custody of her children, to imprisonment for life if they kill an abusive intimate partner.

Therefore it is paramount that forensic mental health practitioners who specialize in the treatment of the effects of domestic violence recognize that battered women are in no way responsible for being abused, and understand that evaluation and assessment of this population calls for acknowledgement that symptoms common to battered women do not necessarily indicate diagnosable mental disorders. Domestic violence dynamics and battering behaviors are maintained by the men who are abusive. Mental health practitioners who look for pathology in the victims of violence, instead of providing or recommending clinical, legal, or psychoeducational interventions for the perpetrator, may miss prime opportunities to assist in preventative strategies to stop men's violence against women.

Roberts (2005) emphasized the importance of experienced, skilled practitioners who fully comprehend the impact of domestic violence on women's psychological and physical health, to routinely implement crisis interventions that are consistent with coordinated responses to domestic violence. Roberts' (2005) seven year study on forensic assessment in domestic violence crisis intervention was conducted with 501 female victims/survivors of intimate partner abuse. The women experienced either chronic abuse from an intimate, or short term abuse that ended when the women left the batterer early on in the relationship. Robert's proposed a model by which service provision involving law enforcement staff, anti-domestic violence units, 24 hour crisis hotlines, and additional social services were implemented to assist victims whose experience ranged on a continuum of duration and severity of abuse. Roberts noted that most classification schemes had focused on the nature or typology of the offenders, or the characteristics of crime victims, including victims of intimate partner violence. Roberts proposed that a

system that focused on the nature and extent of abusive relationships was better equipped to provide adequate interventions at multiple levels to meet the variety of victims' needs dependent on the circumstances in their relationships. Roberts suggested that interventions be tailored to the pattern of the detected abuse instead of solely on the typology of the victim or offender (2005).

Summary

This review of literature was intended to inform the discourse on domestic violence myth acceptance among professionals who interact with female victims and/or male perpetrators of intimate partner violence. Feminist epistemology, particularly the liberal feminist perspective provided the contextual framework for the examination of domestic violence myth acceptance, its purpose, and the contributors to it. Since violence against women has an extensive documented history rooted in patriarchy, the attitudes and beliefs about victims and the impact of those beliefs on women and their roles in a patriarchal society were examined using feminist critique as a framework. This approach offers a critical perspective on violence against women that designates the context for examining likely consequences to victims who experience professionals' victim blaming attitudes and stereotypical beliefs. This review of the literature exposed gaps in the area of research on domestic violence myth acceptance of forensic mental health practitioners. This current study is designed to add to the literature on domestic violence myth acceptance.

CHAPTER III

METHODS AND PROCEDURES

This chapter provides an overview of the methods and procedures used in this study. The procedures for initially selecting and contacting participants in the sample, instructing participants on the purpose of the study, and initiating follow-up contact correspondence will be provided. The instruments used in the survey will be described in this chapter, and a brief description of the statistical analyses for this study will be presented.

The research design was a correlation and regression design that utilized a survey methodology. The survey included several survey instruments as well as demographic questions to determine the characteristics of the sample. The primary purpose of this study was to examine the relationship between domestic violence myth acceptance (dependent variable), empathic response, and ambivalent sexism (independent variables) and to predict domestic violence myth endorsement in forensic mental health specialists by gender.

Participants

A nonrandom sample selection procedure was utilized to select a "convenience sample" (Rudestom & Newton, 2001, p. 79) of 800 forensic specialists from the American College of Forensic Examiners Institute (ACFEI) to complete an online survey

about their perceptions of violence in heterosexual relationships. The participants in this study were selected from the psychology and counseling divisions of the American College of Forensic Examiners Institute. Permission was obtained from the administrator of the ACFEI website to use contact information that was provided on the website by the forensic specialists.

Out of the 800 forensic specialists contacted for this study, 183 were returned as undeliverable due to incorrect e-mail addresses. Of the 617 contacts with current e-mail addresses, 138 returned the completed survey questionnaires, generating a return rate of 23%.

Data Collection

A letter describing the scope of the study was sent out via Oklahoma State University intranet student e-mail on the World Wide Web to 800 forensic specialists internationally. The letter of participation is included in Appendix B. All correspondence was sent to the forensic specialists by way of blind copy distribution lists to protect their anonymity.

Submission of the completed survey indicated consent (see Appendix A) to participate in the research study. Participants who did not wish to participate were removed from the list by e-mail response. Within ten days of the initial mailing, 67 responses had been submitted and 183 of the 800 notifications were returned as 'undeliverable' due to outdated e-mail addresses. Initially, four people requested not to participate and asked that their name be removed from the list. A small percentage of the 183 surveys returned as undeliverable were contacted by calling their offices and asking for a current e-mail address. Those who provided current addresses were contacted in a

subsequent mailing and asked to participate in the study. This yielded 15 participants, and a response rate of 50%. A first follow-up reminder notice was sent to the remaining 617 contacts ten days after the initial contact and generated 23 responses. The second and final follow-up reminder notice was sent two weeks later including the link to the URL site and a thank you statement for those who had previously submitted a completed survey. Procedures to insure anonymity prevented this researcher from knowing who had responded. Therefore, the follow-up reminders were sent to the addresses remaining in the distribution lists after the undelivered email addresses were removed. Again, participants were informed of their ability to exit the survey at any point during their participation if they chose to do so. Several respondents sent an e-mail to this researcher to report their submission of the survey, and as a result their names were removed from the distribution lists. This final reminder generated 48 responses, making a total of 138 respondents.

Data were collected from participants online via the web page, and stored in secure Microsoft Excel worksheet files. The files were located in a secure folder on the web server http://frontpage.okstate.edu/coe/ that was accessible to this researcher and the web-server administrator. Since data located on a server cannot be secure to an absolute certainty, the data were downloaded for analysis after the data collection was completed and deleted from the server at the end of the semester. To protect confidentiality of the participants, no identifying names of participants or ID numbers were attached to the folders.

Measures

Five assessment instruments (see Appendix C) were selected: (a) The Domestic Violence Myth Acceptance Scale (DVMAS) (Peters, 2003); (b) The Interpersonal Reactivity Index (IRI) (Davis, 1996); (c) the Ambivalent Sexism Inventory (ASI) (Glick & Fiske, 1996); (d) The Attitudes Toward Women (ATW) scale (Spence, Helmreich, & Stapp, 1974); and (e) The Crowne-Marlowe Social Desirability Scale short form (Greenwald & Satow, 1970). These instruments were chosen because of the appropriateness of the measures for this research study. Consideration was also given to the ease and cost efficiency of administering Likert-type surveys via the intranet rather than showing a video and administering pre- and post-tests, or conducting personal individual interviews with large samples of participants.

Domestic Violence Myth Acceptance Scale.

The Domestic Violence Myth Acceptance Scale (DVMAS) scale used in this study is an 18 item scale developed by Peters (2003) to measure myth acceptance related to domestic violence. Peters (2003) used radical feminist theory as a basis for his assertion that sex role stereotypes and negative views of women are the expression of a patriarchal culture that encourages violence against women. Peters expected that the DVMAS would correlate highly with four scales, two of which were the Burt's (1980) Rape Myth Acceptance Scale, a validated measure of rape myths, and the Attitudes Toward Women Scale (Spence, Helmrich, & Stapp, 1974) measuring sexual conservatism and attitudes toward women. The DVMAS scale was validated by Peters (2003) for use in the administration of surveys via the intranet, making it appropriate for

this study. The DVMAS was constructed using a seven point Likert-type scale with strongly worded anchors, a midpoint indicator, and no titles for intermediate points. Items were worded with end points of *Strongly Disagree* or *Strongly Agree.*

Given the strong social desirability related to the Domestic Violence Myth Acceptance Scale, negatively and positively worded items were deliberately intermixed (Peters, 2003). Examples of three out of the eighteen questions on the DVMAS are (a) "Making a man jealous is asking for it"; (b) "Abusive men lose control so much that they don't know what they're doing"; and (c) "Women instigate most family violence."

The psychometric properties of an initial pool of 80 items was tested by Peters (2003) with a systematic random sample ($N = 351$) of university students and employees. Based on item contributions to scale reliability and validity, 18 of the 80 items were selected to form the Domestic Violence Myth Acceptance Scale. The scale showed internal consistency reliability (alpha) of .81. A subsequent study of the reliability of the DVMAS was conducted with a similar sample ($N = 284$) and exhibited very good reliability ($\alpha = .88$).

Attitudes Toward Women Scale (ATW)

In this study, researcher error contributed to the omission of the ATW scale. The Attitudes toward Women (ATW) scale is a short version of the original 55 item questionnaire developed by Spence & Helmrich (1978) to assess attitudes toward women's roles in society. This short version was a 15-item paper and pencil test that required participants to choose one of four options; (A) agree strongly (B) agree mildly, (C) disagree mildly, or (D) disagree strongly. Participants were to select the option that

they believed best represented their opinion about each of the statements. Answers represented opinions and were considered as neither right nor wrong. In scoring the items A=0, B=1, C=2, and D=3 except for items with an asterisk where the scoring was reversed. High scores indicated pro-feminist, egalitarian attitudes; while low scores indicated traditional, conservative attitudes.

In multiple studies on the reliability of the short version of the Attitudes Toward Women 15-item scale (Daugherty, & Dambrot, 1986) the obtained test re-test reliability alpha and split-half reliabilities were (α = .85) and (α = .86), respectively. Due to researcher error, an incorrect short form was used in the survey and as a result, the instrument was dropped in the final analysis.

Interpersonal Reactivity Index (IRI)

The Interpersonal Reactivity Index (IRI) (Davis, 1996) is a multidimensional measure of empathy for an adult population. The 28 item self-report measure has four seven-item subscales: 1) Perspective Taking (PT) is a cognitive measure of an individual's dispositional tendency to adopt another's perspective or point of view; (2) Fantasy (FS) is a cognitive measure indicative of an individual's propensity to become imaginatively involved with fictional characters & situations; (3) Empathic Concern (EC) is an affective measure of an individual's self-reported tendency to feel concern for others (4) Personal Distress (PD) is an affective measure of the extent to which one feels distress over another's personal distress. Davis (1980) reported acceptable reliability for the IRI (α = .70 to .78).

Ambivalent Sexism Inventory (ASI)

Glick and Fiske (1996) conceptualize sexism as multifaceted. Their Ambivalent Sexism Inventory is a 22-item Likert-type scale that measures two polarized constructs of sexism: benevolent sexism and hostile sexism (11 items each). For example, hostile sexism was measured by items such as "Most women fail to appreciate fully all that men do for them" and "Women exaggerate problems they have at work." Example items that measure benevolent sexism include "A good woman should be set on a pedestal by her man" and "Many women have a quality of purity that few men possess." The response range is 0 (strongly disagree) to 5 (strongly agree). These measures have demonstrated excellent psychometric properties in a number of investigations (Abrams, 2003; Begany and Milburn, 2002; Christopher & Mull, 2006).

Social Desirability

Since Peters (2003) found a strong social desirability bias of the DVMAS, a short, 10 item form of the Crowne-Marlowe Social Desirability Scale (Greenwald, & Satow, 1970) was used in this study. Peters (2003) found that a Likert-type response format would lessen the social desirability responses to the original true/false format of the social desirability scale. The correlation of the short form of the SDS with the mean DVMAS scores indicates the degree to which participants are "faking good" (Peters, 2003) on the DVMAS. According to Peters (2003) significant correlations indicate social desirability in DVMAS responses.

Demographic Variables

Select demographic information (see Appendix D for survey demographic questions) on gender, years of experience as a forensic professional, and clinical supervision on cases involving domestic violence were included in a correlational analysis by gender. Previous gender studies on rape myth acceptance found differences in responses by gender and significantly higher mean scores for men (Bohner & Schwarz, 1996, Burt, 1980; Ellis, O'Sullivan, and Soward,1992; Peters, 2003). Therefore, it was important to examine the relationship of gender and the responses of females and males in this study.

Research Questions and Hypothesis

The purpose of the study is to determine predictors of domestic violence myth acceptance in forensic mental health specialists using the following measures and their subscales: The Interpersonal Reactivity Index with four subscales (a) Empathic Response Subscale; (b) Perspective Taking; (c)Personal Distress; and (d) Fantasy; the Ambivalent Sexism Inventory with two subscales (a) Benevolent Sexism, and (b) Hostile Sexism; the Crowne-Marlowe Social Desirability short form; the Domestic Violence Myth Acceptance Scale; and demographic variables of interest.

Research Questions

The research questions for this study were based on theory and empirical research and include:

1. Do relationships exist between demographic variables of interest and Domestic

Violence Myth Acceptance by gender?

2. Do relationships exist in forensic mental health specialists and dispositional empathy, ambivalent sexism, & domestic violence myth acceptance by gender?
3. Will social desirability significantly correlate with females' scores on the DVMAS?
4. Will social desirability significantly correlate with males' scores on the DVMAS?
5. Is dispositional empathy a significant predictor of domestic violence myth acceptance in female forensic mental health practitioners?
6. Is dispositional empathy a significant predictor of domestic violence myth acceptance in male forensic mental health practitioners?
7. Is ambivalent sexism a significant predictor of domestic violence myth acceptance in female forensic mental health practitioners?
8. Is ambivalent sexism a significant predictor of domestic violence myth acceptance in male forensic mental health practitioners?

Hypotheses

Domestic violence myth endorsement by forensic mental health specialists was assessed by testing the following hypotheses:

Hypothesis one. It was hypothesized that gender differences will be evident in domestic violence myth endorsement as measured by the DVMAS (Peters, 2003).

Hypothesis two. It was hypothesized that the DVMAS would correlate significantly with one or more subscales in the Interpersonal Reactivity Index (Davis, 1996) in the female sample.

Hypothesis three. It was hypothesized that the DVMAS would correlate significantly with one or more subscales of the Interpersonal Reactivity Index (Davis, 1996) in the male sample.

Hypothesis four. It was hypothesized that the DVMAS would correlate significantly with hostile or benevolent sexism, subscales of the Ambivalent Sexism Inventory (Glick, 1996) in the female sample.

Hypothesis five. It was hypothesized that the DVMAS would correlate significantly with hostile or benevolent sexism, subscales of the Ambivalent Sexism Inventory (Glick, 1996) in the male sample.

Hypothesis six. It was hypothesized that the DVMAS would correlate significantly with social desirability in the female sample.

Hypothesis seven. It was hypothesized that the DVMAS would correlate significantly with social desirability in the male sample.

Hypothesis eight. It was hypothesized that demographic variables such as age, education, and years of practice significantly predict domestic violence myth acceptance in female forensic mental health specialists.

Hypothesis nine. It was hypothesized that demographic variables such as age, education, and years of practice significantly predict domestic violence myth acceptance in male forensic mental health specialists.

Hypothesis ten. It was hypothesized that dispositional empathy in one or more subscales of the IRI would significantly predict domestic violence myth acceptance in female forensic mental health specialists.

Hypothesis eleven. It was hypothesized that dispositional empathy in one or more of the subscales of the IRI would significantly predict domestic violence myth acceptance in male forensic mental health specialists.

Hypothesis twelve. It was hypothesized that ambivalent sexism in one or more of the of the ASI subscales (hostile and benevolent sexism) would significantly predict domestic violence myth acceptance in female forensic mental health specialists.

Hypothesis thirteen. It was hypothesized that ambivalent sexism in one or more of the of the ASI subscales (hostile and benevolent sexism) would significantly predict domestic violence myth acceptance in male forensic mental health specialists.

CHAPTER IV

DATA ANALYSIS

This chapter will present the findings from the analysis of 138 surveys administered online and collected from November, 2007 to January, 2008. Data analysis focused on the proposed hypotheses and additional noteworthy demographic data. Included in the analysis as intervening variables were gender, years of experience, and clinical supervision in domestic violence cases. Frequency statistics were run on all variables to calculate means, standard deviations, and percentages.

Sample Characteristics

Frequencies were calculated for the total sample ($N = 138$) in order to describe the characteristics of the sample (see Table I). The majority of respondents were white males with 20 or more years of experience as forensic specialists. The highest college degree was indicated by 120 of the 138 respondents as a Ph.D. ($n = 105$), Ed.D. ($n = 6$), and Psy.D. ($n = 9$) accounting for 86.9% of the total. Respondents with a Masters degree ($n = 11$, 8%) and four respondents indicated "other" (2.9%). Missing data accounted for three respondents (2.2%) who did not indicate their highest degree achievement. Of the 138 study participants, the majority of respondents (61.6 %) were between the ages of 53-64; 2% between the ages of 18-28; 2% between the ages of 29-40; 25% between the ages of 41-52; and 22% of the total participants were age 65 or older. Missing data accounted for two respondents (1.4%) in the age category.

With regard to gender, females accounted for 46 (33.6%) of the total respondents, and 90 males (65.2%) accounted for the majority of respondents. Only one respondent out of 138 participants reported his or her gender as transgender, therefore this category had to be removed from the analysis due to the inability to make meaningful comparisons with the other variables. Missing data accounted for one participant who did not indicate gender.

Variability in the race demographic was low, with 128 (92.8%) of the respondents indicating "white"; two (1.4%) American Indian or Alaskan Native; five (3.6%) African American; and two (1.4%) who wished not to provide this information. Years of experience as a forensic specialist demonstrated a small increase in variability that resulted in 66 respondents (47.8%) who indicated 20 or more years experience; 33 respondents (23.9%) indicated 14-20 years; 23 respondents (16.7%) indicated 8-13 years; eight respondents (5.8%) indicated four to seven years; four respondents (2.9%) indicated one to three years; and two respondents (1.4%) indicated less than one year experience as a forensic specialist. Missing data accounted for two respondents (1.4%) in this category.

Professional experiences for the total sample indicated 116 respondents (84.1%) were experienced as an expert witness; 83 (60.1%) forensic specialists were experienced with child custody evaluations; 105 (76.1%) were experienced with violence risk assessments; 88 (63.8%) were experienced with sexual abuse assessment, and 66 (47.8%) had professional experience in Battered Woman's Syndrome evaluation. Forensic specialists who had attended graduate courses in domestic violence accounted for 50 respondents (36.2%); post graduate continuing education (domestic violence was not specified) accounted for 123 respondents (85%); and clinical supervision in domestic

violence cases accounted for 60 respondents (44%). Of the 138 respondents, 92 (67%) had attended a conference on domestic violence.

Table 1

Sample Characteristics

Characteristics	n	%
Age		
18-28	2	1.4
29-40	2	1.4
41-52	25	18.1
53-64	85	61.6
65>	22	15.9
Gender		
Female	46	33.3
Male	90	65.2
Transgender	1	.7
Race		
American Indian or Alaskan Native	2	1.4
Asian	0	0.0
Black/African American	5	3.6
Native Hawaiian or other Pacific Islander	0	0.0

White	128	92.8
Do not wish to provide information	2	1.4
Highest Degree		
Masters Degree	11	8.0
Psy.D.	9	6.5
Ed.D.	4	2.9
Ph.D.	105	76.1
Other	6	4.3
Years of Experience		
<1 year	2	1.4
1-3	4	2.9
4-7	8	5.8
8-13	23	16.7
14-20	33	23.9
20>	66	47.8
Professional Experience in:		
Expert Witness Testimony	116	84.1
Custody Evaluation	83	60.1
Violence Risk Assessment	105	76.1
Sexual Abuse Assessment	88	63.8
Battered Woman's Syndrome	66	47.0

Attended:		
Graduate Course in Domestic Violence	50	36.2
Post Graduate Continuing Ed.	123	84.8
Certification Training in DV	27	19.6
Clinical supervision in DV Cases	60	43.5
Conference on DV	92	66.7

Tests of Scale Reliability

Psychometric tests for reliability were conducted on all instruments, including their subscales (see Table 2). Cronbach's Alpha, the reliability coefficient, was used to measure the internal consistency of each instrument to determine a measure of how consistently individuals responded to items in each scale. Alpha, a measure of mean intercorrelation for the standardized data in this study, measured the extent to which the item responses were highly correlated with each other. The most accepted cut-off for alpha in the behavioral sciences is .60 or higher for a set of scale items. Researchers caution against accepting alpha lower than .60 since the standard error of measurement will be over half a standard deviation.

Subscale alphas for the Interpersonal Reactivity Index ranged were: Empathic Concern (α =.710), Perspective Taking (α =.672), Personal Distress (α=.670), and

Fantasy (α=.766). Subscale alphas for the Ambivalent Sexism Inventory were: Benevolent Sexism (α=.828), and Hostile Sexism (α=.852). Cronbach's Alpha for measuring the dependent variable, Domestic Violence Myth Acceptance, was acceptable, (α=.874). Cronbach's Alpha for the Crowne-Marlowe Social Desirability Scale was acceptable (α = .780).

Cronbach's Alpha for the Attitudes Toward Women (ATW) scale was extremely low (α = .395) as a result of researcher error. Five items, numbers 2-5, and 8 in the 15-item scale were incorrectly entered into the short form during the survey construction and had to be omitted from the scale. Ten of the 15 items were appropriate for the ATW short form scale, numbers 1, 6, 7, and 10-15, however, the reliability for a 10-item scale was insufficient. The ATW was also found to be inappropriate as a valid instrument for this particular sample of forensic specialists because ten of the correct statements were overtly worded with socially correct responses that were possibly too obvious for highly educated, experienced forensic professionals. Variability was minimal in the responses for this particular instrument as most participants responded with selections identical to their peers. The instrument was, therefore omitted from the data analysis.

Table 2

Scale Reliability for Measures in Overall Sample

Scales	N	Mean	SD	# of Items	Cronbach's Alpha (α)
DVMAS	133	39.1278	13.9552	18	.874
IRI					
Empathic Concern	136	20.2353	3.6842	7	.710
Personal Distress	134	4.7985	3.2922	6	.670
Perspective Taking	133	20.4361	3.4626	7	.672
Fantasy	135	12.4815	5.1844	7	.760
ASI					
Hostile Sexism	133	17.1203	9.1841	11	.852
Benevolent Sexism	137	20.1898	9.7048	11	.828
CMSD	137	28.1460	6.7098	10	.780

Note: DVMAS = Domestic Violence Myth Acceptance Scale; IRI = Interpersonal Reactivity Index; ASI = Ambivalent Sexism Inventory; CMSD = Crowne-Marlowe Social Desirability

Descriptive Statistics

A descriptive analysis (see Table 3) and a univariate analysis of variance (ANOVA) (see Table 4) were conducted on females and males respectively with the criterion variable, domestic violence myth acceptance. Since the total respondents in the male group (n = 90) created an uneven sample size compared to the size of the female group (n = 45), the male sample was reduced (n= 45) solely to determine equality across groups. The reduced sample size for males was used only in the descriptive statistics, the univariate ANOVA, and the between subjects effects. All subsequent analyses were conducted with the total male sample (n = 90). The descriptive statistics in Table 3 show the means and standard deviations for each gender (n = 45) females and (n = 45) males.

Females' mean scores on the Domestic Violence Myth Acceptance Scale (M = 32.9), and males' mean scores on the DVMAS (M = 41.8) indicated differences in mean scores on the DVMAS by gender for the reduced sample.

A univariate analysis using Levene's Test of Error Variances (see Table 4) tested the null hypothesis that the error variance of the independent variable was equal across samples for females (n = 45) and males (n = 45); $\boldsymbol{F}$ (1,88) = 3.128, p = .080. The univariate analysis found equal variances of gender across the two samples (females and males), meeting the assumptions of ANOVA for equal variances. As seen in Table 5, a test of between subjects effects was conducted with the Domestic Violence Myth Acceptance Scale (dependent variable) and gender (female and male respectively), concluding that gender had a significant, though small (Cohen, 1988) effect (R^2 [n =] = .111, F = 10.942, p = .001) on domestic violence myth acceptance (F = 778.238, p = .000).

Table 3

Descriptive Statistics for DVMAS and Split Gender Sample

Gender	Mean	SD	N
Female 1	32.955	10.84174	45
Male 2	41.8	14.34524	45

Dependent Variable: DVMAS

Table 4

Levene's Test of Equality of Error Variances

F	df1	df2	Sig.
3.128	1	88	.080

Design: Intercept + Gender (1,2)
p<0.05

Table 5

Tests of Between –Subjects Effects for Sample

Dependent Variable: DVMAS

Source	Type III Sum Of Squares	Df	Mean Square	F	Sig.
Corrected Model	1768.900[a]	1	1768.900	10.942	.001
DVMAS	125813.611	1	125813.611	778.238	.000
GEND2	1768.900	1	1768.900	10.942	.001
Error	14226.489	88	161.665		
Total	141809.000	90			
Corrected Model	15995.389	89			

a. R Squared = .111 (Adjusted R Squared = .100)
p<.01

Bivariate Correlation Analysis

Two bivariate correlation analyses (see Table 6) were conducted for the total female (n = 47) and male (n = 90) samples respectively with the Domestic Violence Myth Acceptance Scale and the independent variables including the Interpersonal Reactivity Index, the Ambivalent Sexism Inventory, and the Crowne-Marlowe social desirability scale. The analyses described the relationships between the measures and

selected potential predictors of Domestic Violence Myth Acceptance in women and men forensic specialists. Analysis of the demographics was conducted in two separate bivariate correlation analyses for the total female ($N = 47$) and male ($N = 90$) samples (see Tables 8 and 9). Results of the bivariate correlations of the measures with the DVMAS are discussed in the hypothesis testing section of this chapter. Results of the intercorrelation analysis of the IRI subscales, ASI subscales, and the Crowne-Marlowe social desirability scale are explained below.

Hostile sexism (ASI subscale) correlated moderately with benevolent sexism (ASI subscale), reflecting a large effect size ($r = .512$, $p < 0.01$) in the female group. This finding is consistent with previous correlation studies in the literature where both constructs of sexism show a significant relationship with one another (Davis, 1996). Benevolent sexism negatively correlated with the Crowne-Marlowe measure ($r = -.349$, $p < 0.05$) indicating that high scores on social desirability correlated with females' lower scores in benevolent sexism.

A significant relationship between the IRI subscales empathic concern and perspective taking ($r = .477$, $p < 0.01$) indicated a large effect size. However, neither of these variables were included in the regression analysis for females since they were not significantly related to the criterion variable. The fantasy construct of the IRI correlated with the remaining three constructs of the IRI: perspective taking ($r = .228$, $p<0,05$); personal distress ($r = .370$, $p<0.01$); and empathic concern ($r = .476$, $p<0.01$). The empathy constructs of perspective taking and empathic concern also indicated a significant relationship ($r = .354$, $p<0.01$) to each other, a finding consistent with correlational studies using the IRI (Davis,1996).

Significant relationships between hostile sexism and benevolent sexism for males (r = .310, p<0.01) indicated a medium effect size, a finding consistent with previous correlation studies using the ASI (Glick, 1996). Social desirability negatively correlated with perspective taking (IRI subscale) and benevolent sexism (ASI subscale) (r = -.318, p < 0.01). These results indicated that the high scores on the Social Desirability Scale were reflected in the low scores on perspective taking and benevolent sexism for the male sample. However, none of the correlations of the measures other than hostile sexism and domestic violence myth acceptance were included in the subsequent regression analysis for men.

Table 6

Bivariate Correlations for Domestic Violence Myth Acceptance by Gender

	1	2	3	4	5	6	7	8
Variable	DVMAS	IRIFS	IRIPT	IRIPD	IRIEC	ASIBS	ASIHS	SDS
1. DVMAS	1.000	-.040	-.272	.003	-.421**	.075	.195	.166
2. IRIFS	-.014	1.000	.046	.220	.088	.043	.408	.279
3. IRIPT	-.103	.228*	1.000	-.081	.477**	.103	.098	-.226
4. IRIPD	.222*	.370**	-.035	1.000	.219	.004	.511	.082
5. IRIEC	-.105	.476**	.354**	.068	1.000	.221	.146	-.259
6. ASIBS	.169	.110	.124	.042	.079	1.000	.512**	-.349*
7. ASIHS	.430**	-.208	-.114	.161	-.171	.310**	1.000	-.107
8. SDS	.158	.064	-.318**	.188	-.163	-.228*	.105	1.000

* Correlation is significant at the 0.05 level (2-tailed).
**Correlation is significant at the 0.01 level (2-tailed).
Note: **Females: Upper diagonal; Males: Lower diagonal.**
N = 137, DVMAS=Domestic Violence Myth Acceptance Scale; IRIF=Interpersonal Reactivity Index Fantasy Subscale; IRIPT=Interpersonal Reactivity Perspective Taking Subscale; IRIPD=Interpersonal Reactivity Index Personal Distress subscale; IRIEC=Interpersonal Reactivity Index Empathic Concern subscale; ASIBS=Ambivalent Sexism Inventory Benevolent Sexism Subscale; ASIHS=Ambivalent Sexism Inventory Hostile Sexism Subscale.

Regression Analysis

Separate regression analyses by gender were conducted to test the research hypotheses that DVMAS is predicted by three measures: IRI, ASI, and CMSD (see Table 7). The regression analysis for female respondents found that the regression model was significant (p. = .004). Women's lower scores on the DVMAS were driven by their higher scores on the Empathic Concern subscale (R = .421, R^2 = .177, F [1,42] = 9.043, p = .004). Females' empathic concern for others significantly contributed to explaining approximately 18% of the variance in domestic violence myth acceptance. Since personal distress, fantasy, and perspective taking (subscales of the IRI), were not identified in the correlational analysis as significantly related to domestic violence myth acceptance they were omitted from the regression analysis. Empathic concern was a significant predictor of DVMAS in the female sample.

The personal distress subscale of the IRI was significantly correlated with the DVMAS for males, and was selected for the regression analysis. However, the relationship did not hold in the regression, suggesting that personal distress did not predict scores on the DVMAS for men. Since the correlational analysis did not reveal a relationship between DVMAS and the remaining IRI subscales (perspective taking, empathic concern, and fantasy) for the male sample, they were not selected for the regression analysis. Additionally, benevolent sexism, a subscale of the Ambivalent Sexism Inventory (ASI), was not selected for the regression analysis for men since the variable did not correlate with the criterion variable in the bivariate correlation analysis. As shown in Table 7, male's higher scores on the DVMAS were driven by their high

scores on the Hostile Sexism subscale of the ASI (R = .474, R^2 = .224, F [2,80] = 11.564, p = .000). Approximately 22% of the variance in domestic violence myth acceptance was accounted for by the males' hostile sexism towards women.

Table 7

Regression Results by Gender for Predictors of DVMAS

	b	*ß*	R^2	adj. R^2	Sig.
Female					
IRIEC	-.421	-1.191	.177	.158	.004
Male					
ASIHS	.452	.700	.224	.205	.000
IRIPD	.090	.411	.224	.205	.370

Dependent Variable: DVMAS. Independent Variables: Interpersonal Reactivity Index Empathic Concern (IRIEC), Ambivalent Sexism Inventory Hostile Sexism (ASIHS), Interpersonal Reactivity Index Personal Distress (IRIPD).
$P < .01$

Hypothesis Testing

Hypothesis One

Hypothesis one stated that gender differences would be evident in domestic violence myth endorsement. Descriptive statistics (see Table 3) for DVMAS females (n = 45) and DVMAS males (n = 45), indicated an approximate 9-10 point difference in mean scores on the DVMAS by gender. Females were associated with lower domestic violence myth acceptance scores (M = 32.9) than men (M = 41.8). A test of between subjects effects of gender (see Table 5) on domestic violence myth acceptance resulted in a significant, though small (Cohen, 1988) effect (R^2 [n = 138] = .111, F = 10.942, p = .001) on DVMAS (F = 778.238, p = .000).

See Figures 1 and 2 for distributions by gender for the total samples respectively, supporting hypothesis one that gender differences would be evident in the DVMAS.

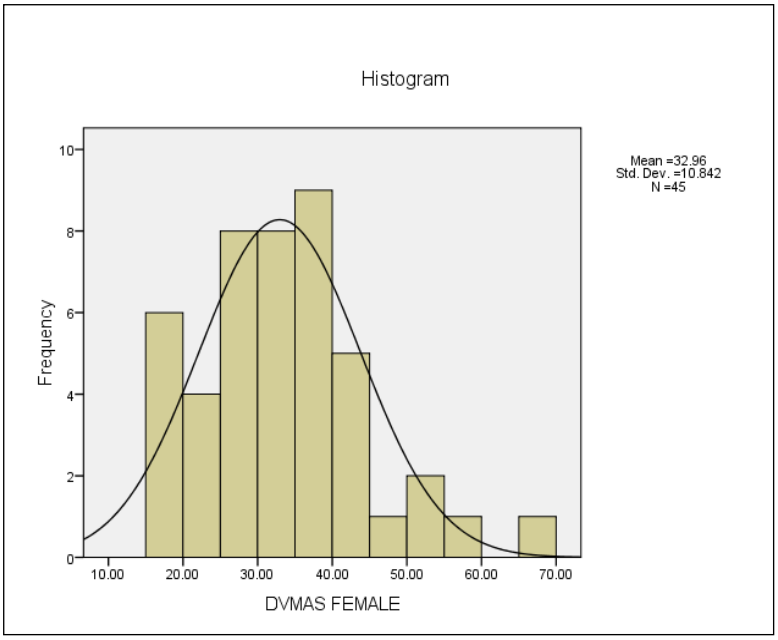

Figure 1. Distribution of DVMAS for Total Female Respondents ($N = 45$)

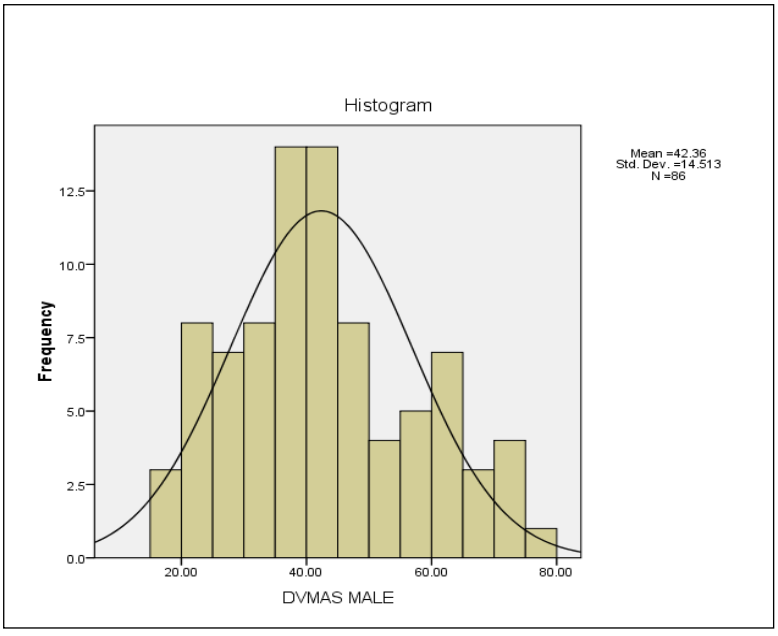

Figure 2. Distribution of DVMAS for Total Male Respondents ($N = 86$)

Figure 1 shows that females' scores ($N = 45$) on the Domestic Violence Myth Acceptance Scale ($M = 32.96$) are normally distributed between females' lowest score of 18 to female's highest score of 66. Inspection of the distribution in Figure 2, shows men's ($N = 86$) scores on the Domestic Violence Myth Acceptance Scale ($M = 42.36$) are normally distributed between the lowest score of 18 to the highest score of 75.

Hypothesis Two

Hypothesis 2 stated that DVMAS for females would correlate significantly with one or more subscales of the Interpersonal Reactivity Index (Davis, 1996). Relationships between DVMAS (the criterion variable), and dispositional empathy (IRI) were explored. In the bivariate correlations shown in Table 6, female responses are presented in the upper diagonal of the correlation matrix. The results of the correlational analysis for female respondents ($N = 45$) and their scores on the IRI Empathic Concern (IRIEC) subscale negatively correlated with the DVMAS and were statistically significant ($r = -.421$, $p < 0.01$).

With regard to effect size, Cohen (1988) found that correlations of $r = .24$ should be considered moderate, and correlations of $r = .37$ should be considered large. Therefore, the effect size of the relationship between empathic concern and DVMAS for females was large. No significant relationship was found between the DVMAS and the remaining three IRI subscales - perspective taking, personal distress, or fantasy. The statistically significant correlation of DVMAS with empathic concern supports hypothesis one that the DVMAS is correlated with one or more of the IRI subscales.

Hypothesis Three

Hypothesis 3 stated that the DVMAS for males would correlate significantly with one or more subscales of the Interpersonal Reactivity Index (Davis, 1996). Relationships between DVMAS (the criterion variable), and dispositional empathy subscales (IRI) were explored. In the bivariate correlations, shown in Table 6, male responses are presented in the lower diagonal of the correlation matrix. The results of the correlational analysis for male respondents ($n = 86$) and their scores on the DVMAS and IRI personal distress (IRIPD) subscale were found to be statistically significant ($r = .222$, $p < 0.05$). The strength of the relationship with the DVMAS and personal distress is weak however, with regard to effect size, Cohen (1988) found that correlations of $r = .24$ should be considered moderate, and correlations of $r = .10$ should be considered small. Therefore, the effect size of the relationship between personal distress and DVMAS for males was small.

Significant relationships between the DVMAS and the remaining three IRI subscales (perspective taking, empathic concern, and fantasy) were not found. The results do support differences in gender responses for dispositional empathy since males did not correlate with empathic concern subscale as did the females. It is unclear in the literature (Davis, 1996) if the personal distress subscale represents the ability to better connect with an individual when feeling personal distress with regard to their circumstances, or if it indicates being less likely to empathize. Caution should be taken when drawing conclusions with regard to the relationship of personal distress with the DVMAS. Though the strength of the relationship of the DVMAS and personal distress was moderately low, the statistically significant correlation supports hypothesis three that the DVMAS for males is correlated with one or more of the IRI subscales.

Hypothesis Four

Hypothesis four stated that the DVMAS for females would correlate significantly with hostile or benevolent sexism, subscales of the Ambivalent Sexism Inventory (ASI). Relationships between DVMAS (the criterion variable), and benevolent and hostile sexism were explored, however, no significant correlations between DVMAS and ambivalent sexism on either subscale were found for the female sample. Hypothesis 4 was not supported by the results in the female sample.

Hypothesis Five

Hypothesis five stated that the DVMAS for males would correlate significantly with hostile or benevolent sexism subscales of the Ambivalent Sexism Inventory. Relationships between DVMAS (the criterion variable), and benevolent and hostile sexism were explored. As seen in Table 6 in the lower diagonal of the correlation matrix, results of the correlational analysis for males (n = 86) revealed a statistically significant correlation between men's responses on the DVMAS (M = 42.29) and the Hostile Sexism (r = .430, p<0.01) subscale of the ASI. The results are low to moderately correlated with the DVMAS, however, the effect size of hostile sexism on domestic violence myth acceptance is considered large. High scores in hostile sexism drove men's high scores in domestic violence myth endorsement on the DVMAS. The resulting significant correlation of DVMAS and hostile sexism lend support for hypothesis five that a statistically significant relationship exists between the DVMAS and one or more of the subscales for ASI. Therefore hypothesis five was supported by males' scores on the ASIHS.

Hypothesis Six

Hypothesis six stated that the DVMAS for females would correlate significantly with social desirability scores. Relationships between the DVMAS and social desirability were explored. As shown in Table 6 a significant correlation with the DVMAS and social desirability was not evident for females. The results did not support hypothesis 6.

Hypothesis Seven

Hypothesis seven stated that the DVMAS for males would correlate significantly with social desirability scores. Relationships between the DVMAS and social desirability were explored (see Table 6). A significant correlation with the DVMAS and social desirability was not evident for males. Therefore the results do not support hypothesis seven.

Hypothesis Eight

Hypothesis eight stated that selected demographic variables in the female sample would predict DVMAS. Bivariate correlations of demographic variables for females in age, years of experience, and race are seen in Table 8. Significant correlations were identified in females' lower scores on the DVMAS with age (r = .335, p<.05) and indicated a medium effect size; race (r = .320, p<.05) indicated a medium effect size; and years of experience as a forensic specialist (r = .348, p<.05) also indicated a medium effect size. The majority of the female sample were white and between the ages of 53-64. The majority of female respondents had between 14-20+ years of forensic experience.

The interpretation of the relationship of domestic violence myth acceptance with age and race in the female sample is unclear due to the lack of variability in age, and the lack of diversity in the race variable. All three variables were extremely negatively skewed so the relationships among them may be an artifact of the distribution shapes rather than a valid relationship. Due to the relatively small sample size, it would be ill advised to interpret these as valid relationships. Therefore, the demographic variables were not selected for the subsequent regression analysis for females. The results for demographic relationships with the DVMAS did not support Hypothesis 8.

Hypothesis Nine

Hypothesis nine stated that selected demographic variables in the male sample would predict DVMAS (see Table 9). A bivariate correlation analysis of demographic variables for males was conducted for the total male sample ($N = 90$). Significant correlations between the criterion variable, years of experience, and clinical supervision in domestic violence cases were found. A significant correlation was found in males' higher scores on the DVMAS with years of experience as a forensic specialist ($r = .266$, $p<.05$) and indicated a small effect size. Additionally, a significant correlation with DVMAS for males and clinical supervision in domestic violence cases ($r = .242$, $p<.05$) indicated a small effect size. The majority of male respondents had 20+ years of experience as forensic specialists, resulting in an extreme negative skew for that variable.

Table 8

Bivariate Correlations for Female Respondents: Demographic Variables and Domestic Violence Myth Acceptance

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
	DVMAS	AGE	ETHN	RACE	DGRE	YRSEXP	EXPW	CUEV	VRA	SAA	BWS	GRDV	DVCR	CSDV	DVC
1. DVMAS	1	.335*	-.043	.320*	.021	.348*	-.181	-.155	-.030	-.123	-.095	-.141	.046	.083	-.078
2. AGE		1	.375	.164	.435**	.464**	-.100	-.171	-.138	-.008	-.335*	-.184	-.027	.020	-.185
3. ETH			1	-.037	.184	-.038	.086	-.192	.070	.076	-.191	.151	-.093	.142	.094
4. RACE				1	.179	.078	-.198	-.007	.119	.129	.212	.046	.447**	.242	.159
5. DGRE					1	.241	-.124	-.142	-.105	-.162	-.005	-.075	.087	-.010	-.035
6. YRSEXP						1	-.335*	-.443**	-.450**	-.224	-.361*	-.152	-.035	-.293	.406**
7. EXPW							1	.353*	.283	.125	.027	.174	-.01	.003	.214
8. CUEV								1	.301	.369*	.308*	.164	-.118	.199	.379*
9. VRA									1	.490**	.412**	.122	.259	.367*	.189
10. SAA										1	.363*	.231	.153	.202	.257
11. BWS											1	.187	.251	.330*	.372*
12. GRDV												1	.207	.103	.269
13. DVCR													1	.393*	.165
14. CSDV														1	.530**
15. DVC															1

* Correlation is significant at the 0.05 level (2-tailed). **Correlation is significant at the 0.01 level (2-tailed).

Table 9

Bivariate Correlations for Male Respondents: Demographic Variables and Domestic Violence Myth Acceptance

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
	DVMAS	AGE	ETHN	RACE	DGRE	YREXP	EXPW	CUEV	VRA	SAA	BWS	GRDV	DVCR	CSDV	DVC
1. DVMAS	1	.090	-.017	.-.107	.053	.266*	.086	.143	-.049	-.072	.014	.101	.212	.242*	.014
2. AGE		1	.112	.151	.385**	.371**	-.020	-.013	.041	.125	-.216	.258*	.080	-.025	.000
3. ETH			1	-.024	-.045	.037	.036	-.050	.068	.103	-.007	.052	.317**	.011	.103
4. RACE				1	-.043	.147	-.210	-.110	-.112	.045	-.225	-.056	-.083	-.050	.160
5. DGRE					1	.201	-.095	.004	.028	.044	-.102	.249*	.153	.107	.204
6. YRSEXP						1	-.126	-.226*	-.049	-.109	-.418**	.195	.116	-.072	-.123
7. EXPW							1	.196	.210	.124	.135	.157	-.178	.096	-.019
8. CUEV								1	.242	.416**	.433**	-.080	.110	.070	.120
9. VRA									1	.393**	.433**	.302**	-.023	.196	.334**
10. SAA										1	.412**	.159	.099	.367**	.352**
11. BWS											1	-.018	.027	.256*	.320**
12. GRDV												1	.282*	.303**	.121
13. DVCR													1	.014	.505
14. CSDV														1	.286*
15. DVC															1

* Correlation is significant at the 0.05 level (2-tailed). **Correlation is significant at the 0.01 level (2-tailed).

The interpretation of the relationships among domestic violence myth acceptance with years of experience, and clinical supervision in cases involving domestic violence is unclear due to the lack of variance in the supervision variable and the extreme negative skew on the years of experience variable. The relationships among them may be an artifact of the distribution shapes rather than a valid relationship. Due to a lack of variance in the supervision variable and an extreme negative skew on the years of experience, these two variables were not selected for the subsequent regression analysis for males. The results did not support Hypothesis 9.

Hypothesis Ten

Hypothesis 10 stated that dispositional empathy (IRI) would predict domestic violence myth acceptance by female forensic mental health specialists. Separate regression analyses by gender were conducted to test the research hypotheses that DVMAS was predicted by three measures: IRI, ASI, and CMSD. As seen in Table 9, the regression analysis for female respondents found that the regression model was significant (p = .004) and that women's lower scores on the DVMAS were driven by their higher scores on the Empathic Concern subscale (R = .421, R^2 = .177, F [1,42] = 9.043, p = .004).Females' empathic concern for others significantly contributed to explaining approximately 18% of the variance in domestic violence myth acceptance, supporting the hypothesis that female forensic specialists' empathic concern (subscale of the IRI) was predictive of lower scores in domestic violence myth acceptance. Since personal distress, fantasy, and perspective taking (subscales of the IRI) were not correlated with domestic violence myth acceptance, these IRI subscales were omitted from the regression analysis.

Hypothesis 10 was supported by empathic concern as a predictor of lower scores by female forensic specialists on the DVMAS.

Hypothesis Eleven

Hypothesis 11 stated that dispositional empathy (IRI) would predict domestic violence myth acceptance by male forensic mental health specialists. The personal distress subscale of the IRI was significantly correlated with the DVMAS for males, and was selected for the regression analysis. However, the relationship did not hold in the regression, concluding that personal distress, a dimension of dispositional empathy, did not predict scores on the DVMAS for men. Since the correlational analysis did not reveal a relationship between DVMAS and the remaining IRI subscales (perspective taking, empathic concern, and fantasy) for the male sample, they were not selected for the regression analysis. Hypothesis 11 was not supported.

Hypothesis Twelve

Hypothesis 12 stated that Ambivalent Sexism would be a predictor of the DVMAS for females. These variables were not selected for the regression analysis since they failed to correlate with the criterion variable (DVMAS). Therefore, hypothesis 12 was not supported.

Hypothesis Thirteen

Hypothesis 13 stated that Ambivalent Sexism (hostile and benevolent) was a predictor of DVMAS for the male sample. The regression analysis for male respondents revealed that the regression model was significant ($p = .000$). Benevolent sexism, a

subscale of the Ambivalent Sexism Inventory (ASI), was omitted from the regression analysis for men since the variables did not correlate with the criterion variable in the bivariate correlation analysis.

Hostile Sexism, the remaining subscale of the ASI, was entered onto the regression analysis for men. The regression analysis revealed that Hostile Sexism was a significant predictor of Domestic Violence Myth Acceptance (R = .474, R^2 = .224, F [2,80] = 11.564, p = .000). Therefore, men's higher scores on the DVMAS were driven by their high scores on the Hostile Sexism subscale of the Ambivalent Sexism Inventory. Approximately 22% of the variance in domestic violence myth acceptance in the male sample was accounted for by males' hostile sexism towards women, supporting the hypothesis that hostile sexism is a predictor of domestic violence myth endorsement in male forensic mental health specialists.

CHAPTER V

DISCUSSION

This chapter presents a summary of the study and conclusions from the data presented on Chapter IV. It provides a discussion for the implications for action and recommendations for future research. This research presents an opportunity to raise public and professional awareness with regard to forensic professionals whose perceptions of domestic violence are not found in the literature.

Summary of the Study

Stereotypes, sexism, and negative attitudes toward women remain persistent throughout the institutions and programs that are designed to offer assistance and safety to women survivors of domestic violence (Bancroft & Silverman, 2002; Buel, 1999; Busch & Valentine, 2000; Dye & Roth, 1990; Jackson, Witt, & Petretic-Jackson, 2001). This is due, in part, to what some social science researchers believe is the endorsement of cultural myths by mental health and other helping professionals who interact with victims and perpetrators of intimate partner violence and sexual assault (Burt, 1980; Peters, 2002). Previous research on survivors of intimate partner violence and their experiences with social and clinical services revealed that victim-blame and a general lack of understanding of victims' circumstances existed among clinical professionals, social

workers, law enforcement, judges, court personnel, defense attorneys, and prosecutors (Bancroft & Silverman, 2002; Buel, 1999; Jackson, et. al., 2001; Ptacek, 1999).

Therefore, the extent of domestic violence and victim-blame among social and mental health service providers lent support to the hypothesis that forensic specialists' interactions with survivors and perpetrators could be influenced by their acceptance or rejection of domestic violence myth acceptance.

Overview of the Problem

A review of the literature in Chapter II illuminated the prevalence of domestic violence in society and the pervasiveness of victim-blaming attitudes among professionals. The problem of domestic violence is extensive. Therefore, mental health professionals, specifically those who specialize in forensic psychology, will undoubtedly find victims or offenders among their clients (Jordan et al., 2004). Since forensic specialists are key players in the evaluations of victims and perpetrators, their examinations and investigative practices are critical to the outcome of custody litigations and criminal prosecution with regard to intimate partner abuse (Stark, 2007). Additionally, forensic specialists are in a strategic position to make a serious impact on safety and social justice for survivors of domestic violence.

Forensic mental health specialists interact in a variety of ways with victims and perpetrators of domestic violence during periods of litigation over divorce, child custody litigation, and criminal matters such as violations of protective orders, assault and battery, and domestic homicide. This study examined correlates and potential predictors of domestic violence myth endorsement by forensic psychologists (N=138). The four self-

report measures used in this study were (a) the Domestic Violence Myth Acceptance Scale (DVMAS) scale (Peters, 2003); (b) the Interpersonal Reactivity Index (IRI) (Davis, 1980); (c) the Ambivalent Sexism Inventory (Glick & Fiske, 1996), and (d) the Crowne-Marlow Social Desirability short form, (Greenwald & Satow, 1970).

Purpose Statement

The purpose of this study was four fold: (a) to make a contribution to the existing body of literature in the field of violence against women by identifying predictors of domestic violence myth endorsement by forensic mental health specialists; (b) to test the hypothesis that domestic violence myth acceptance by forensic mental health practitioners can be predicted by gender, empathic disposition, and hostile or benevolent sexism; (c) to examine the relationship between domestic violence myth endorsement, and dimensions of dispositional empathy (empathic concern, personal distress, perspective taking, and fantasy); and (d) to examine the relationship between domestic violence myth acceptance and dimensions of ambivalent sexism (benevolent sexism, and hostile sexism).

The selection of expected predictors of domestic violence myth endorsement was based on theory, related literature, and 15 years of clinical experience with survivors of intimate partner abuse, their struggles in various systems, and their experiences with mental health professionals. The research design was a correlation and regression design that utilized a survey methodology for data collection. A nonrandom sample selection procedure was utilized to select a convenience sample (Rudestom & Newton, 2001) of 800 forensic specialists from the American College of Forensic Examiners Institute

(ACFEI). Incorrect e-mail addresses accounted for 183 undeliverable contacts, which were omitted from the contact list. Therefore, the remaining 617 forensic specialists were contacted for this study. Completed surveys were submitted by 138 forensic specialists, generating a return rate of 23%.

Research Questions

The following research questions for this study were based on theory and empirical research:

1. Do relationships exist between demographic variables of interest and domestic violence myth acceptance by gender?
2. Do relationships exist between gender of forensic mental health specialists and dispositional empathy, ambivalent sexism, & domestic violence myth acceptance?
3. Will social desirability significantly correlate with females' scores on the DVMAS?
4. Will social desirability significantly correlate with males' scores on the DVMAS?
5. Is dispositional empathy a significant predictor of domestic violence myth acceptance in female forensic mental health practitioners?
6. Is dispositional empathy a significant predictor of domestic violence myth acceptance in male forensic mental health practitioners?
7. Is ambivalent sexism a significant predictor of domestic violence myth acceptance in female forensic mental health practitioners?
8. Is ambivalent sexism a significant predictor of domestic violence myth acceptance in male forensic mental health practitioners?

Relationships of Demographic Variables and Domestic Violence Myth Acceptance

Select demographic variables in this study, specifically age, race of the respondents, years of experience as a forensic specialist, and clinical supervision in domestic violence cases were expected to contribute to forensic specialists' endorsement of domestic violence myths.

Age, race, and years of experience. Significant relationships between females' lower scores on the DVMAS with age (r = .335, p<.05); race (r = .320, p<.05); and years of experience as a forensic specialist (r = .348, p<.05) were revealed in the analysis. The majority of the female sample was white, between the ages of 53-64, and had 14-20+ years of experience as forensic mental health specialists. The interpretation of the relationship was unclear due to the lack of variability in age and years of experience, and the lack of diversity in the race variable. All three variables were extremely negatively skewed so the relationships among them may have been an artifact of the distribution shapes rather than a valid relationship. Additionally, due to the relatively small sample size, it would be ill advised to interpret these as valid relationships. Therefore, those demographic variables were not selected for the regression analysis as potential predictors of domestic violence myth acceptance in the female sample.

Years of experience and clinical supervision. Significant relationships between males' higher scores on the DVMAS, years of experience as a forensic specialist (r = .266, p<.05), and clinical supervision in domestic violence cases (r = .242, p<.05) were revealed in the analysis. Similar to the female sample, the majority of male respondents had 20+ years of experience as forensic mental health specialists. The interpretation of

the relationships among domestic violence myth acceptance with males' years of experience, and clinical supervision in cases involving domestic violence was unclear due to the lack of variance in the clinical supervision variable and the extreme negative skew in years of experience. The relationship between clinical supervision, forensic experience, and domestic violence myth acceptance in the male sample might also be an artifact of the distribution shapes rather than a valid relationship. Therefore, the demographic variables were not selected for the regression analysis as potential predictors of domestic violence myth acceptance in the male sample.

These findings, with respect to demographics, were consistent with Lonsway and Fitzgerald (1994). Their research of rape myth instruments revealed that a number of demographics and background variables had been examined with regard to rape myth; however, the only demographic variable that demonstrated a consistent relationship with rape myth acceptance was gender. The findings with regard to demographics and domestic violence myth acceptance were inconsistent with previous research on rape myth since demographics such as age, education, and occupation held the strongest relationships with Rape Myth Acceptance (Burt, 1980).

Gender. Statistical differences in responses in this study to domestic violence myth acceptance by gender were significant ($p < .01$) and indicated a nine point difference in the mean scores on the DVMAS, females ($M = 32.9$, $SD = 10.8$), and males ($M = 42.8$, $SD = 14.3$). Therefore, male forensic specialists' higher scores on the DVMAS indicated significant differences when compared to the lower scores of female forensic specialists. The lower mean scores on the DVMAS for the female sample were consistent with previous studies on gender differences in attitudes, beliefs about women,

and rape myths (Lonsway, & Fitzgerald 1999; Peters, 2003). Additionally, previous gender studies on rape myth acceptance have found differences in responses by gender and significantly higher mean scores for men (Bohner & Schwarz, 1996, Burt, 1980; Ellis, O'Sullivan, and Soward,1992; Peters, 2003).

In this study, responses to the first statement on the DVMAS, "Domestic violence does not effect many people," reflected *minimal* differences by gender. Both female and male forensic specialists in this sample overwhelmingly agreed that domestic violence was an extensive problem that effected many people. This finding indicated that the majority of female and male forensic specialists in this sample did not minimize the prevalence of domestic violence which is not consistent with prior research on other professionals including social workers, law enforcement, and attorneys who minimized domestic violence as a prevalent concern (Bancroft & Silverman, 2002; Buel, 1999; Jackson, et al., 2001).

Similarly, the majority of females and males disagreed with the behavioral statement "Women instigate most family violence." However, differences in responses by gender were evident in a specific statement in the DVMAS relative to the *character* of the victim, "If a woman goes back to the abuser it is something in her character." A large number (86%) of female forensic specialists *disagreed* that a victim's character affected decisions to return to an abusive partner, while only 57% of men disagreed.

Relationship of Domestic Violence Myth Acceptance and Dispositional Empathy

Empathic Concern (EC). A relationship between empathic concern, a subscale of the IRI, and low mean scores on the DVMAS was revealed for female forensic specialists in this study. The female respondents in this sample demonstrated significant empathic concern for victims of domestic violence which had a significant effect on females' low scores in domestic violence myth acceptance. Empathic concern is an affective tendency that is elicited by the perceived welfare of a person in need (Batson, Eklund, Chermok, Hoyt, & Ortiz, 2007). Batson, et al., asserted that empathic feelings relative to sympathy, compassion, and tenderness were congruent with empathic concern.

Since empathic feelings and concern for others were related to female forensic specialists in this study, females' lower scores on the DVMAS can be attributed to their ability to identify with others, such as victims of domestic violence, who were less fortunate. The findings for females in this sample; however, were inconsistent with findings from a study with 402 undergraduate college students (Parks & Robertson, 2005) where gender was not significantly related to the affective aspect of dispositional empathy in the IRI (Davis, 1996). This finding might be related to the daily utilization of empathy in therapeutic relationships by clinical practitioners. Professionals who devote a significant amount of their day to their concern for others might differ from the general public whose opportunities to empathize with others might vary in frequency and intensity. The remaining aspects of dispositional empathy in the IRI (personal distress, perspective taking, and fantasy) did

not reveal a relationship with domestic violence myth acceptance for female forensic specialists.

Personal Distress (PD). Personal distress (subscale of the IRI) is an affective aspect of dispositional empathy, and was associated with male forensic specialists' endorsement of domestic violence myth in this study. The personal distress subscale was designed to measure the extent to which an individual feels distress as a result of witnessing the personal distress of another (Beven, O'Brien-Malone, & Hall 2004). This aspect of empathy is more self-focused and serves to identify individual character, (unlike empathic concern which looks externally to others and their discomfort). In cases of empathic over-arousal, the distress felt by the observer may detract from the distress experienced by the observed individual (Batson, 1991). This could be relative to forensic professionals who might be more likely than other mental health professionals to refrain from empathic over-arousal when conducting objective interviews with abuse victims in crisis. Victims being evaluated might also be especially guarded and might not exhibit personal distress to the extent that it is noticeable. Forensic specialists might not engage in affective empathy to the same extent as therapeutic professionals due to individual differences or circumstances of their practice. However, this supposition warrants further research.

Caution is advised when drawing conclusions with regard to the relationship of personal distress with the endorsement of domestic violence myth by male forensic specialists. Significant relationships between the DVMAS and the remaining three IRI subscales (perspective taking, empathic concern, and fantasy) were not found. Further

study on the role of dispositional empathy in domestic violence myth acceptance is warranted to determine if individual or professional differences might account for these findings.

Relationship of Domestic Violence Myth Acceptance and Ambivalent Sexism

A relationship between domestic violence myth acceptance and ambivalent sexism were not found in the female sample. This is inconsistent with previous studies (Glick & Fiske, 1996) where women were more likely to subscribe to benevolent, but not less harmful, beliefs about women. The finding that women did not subscribe to hostile sexism was consistent with previous findings for females (Glick and Fiske, 1996) where women were less likely to indicate hostile, sexist attitudes toward women. It was expected that females who did not subscribe to benevolent sexism would not subscribe to hostile sexism. Since previous research has found empathic concern to be positively correlated with pro-socialization (Bevin, et al., 2004), the results for female forensic specialists in this study may speak positively to the socialization of the females in this sample, their training, or experience with feminist therapeutic approaches that might have influenced their beliefs about women.

With respect to male forensic specialists, hostile sexism toward women was significantly associated with their endorsement of domestic violence myths (r = .430, p<0.01). This finding is consistent with other studies of university samples where men scored higher in hostile sexism than women (Lonsway & Fitzgerald, 1995). Further explanation of this relationship is discussed in the section on predictors of DVMAS.

Social Desirability

The correlation of the Crowne-Marlowe social desirability scale with the study measures were not significant and indicated that both female and male participants responded to the survey in ways that were not socially desirable (Peters, 2003). Therefore, their responses were more likely to be accurate self reports of their perspectives with regard to domestic violence myth, dispositional empathy, and ambivalent sexism.

Predictors of Domestic Violence Myth Acceptance

Dispositional Empathy. Females' empathic concern was a significant predictor of domestic violence myth acceptance for this sample of forensic mental health specialists. The regression analysis revealed that empathic concern for others significantly contributed to explaining approximately 18% of the variance in domestic violence myth acceptance for female forensic specialists. Due to the significant negative correlation of empathic concern with domestic violence myth acceptance, female forensic specialists' high scores on empathic concern drove their low scores on the DVMAS, indicating that their empathic concern for others less fortunate made them less likely to endorse domestic violence myths.

Relative to females' survey item responses to the empathic concern subscale (Davis, 1996), the majority of women's responses reflected their "tender feelings for

those who were less fortunate." Female respondents also "felt sorry for people who had problems," and "felt protective of those who were exploited." Women were "disturbed a great deal by others' misfortunes", and described themselves as "soft-hearted and often touched by things they saw happen."

With respect to male forensic specialists, the personal distress subscale of the IRI was entered into the regression analysis but was not a significant predictor of domestic violence myth endorsement for male forensic specialists in this sample. The literature is not clear about whether the personal distress of the observer, relative to the distress of another, represented the ability to better connect with an individual who is feeling personal distress, or if personal distress of the observer indicated he was less likely to empathize with others in distress. Individuals may respond in different ways with regard to empathy depending on the circumstances of the observer as well as the observed. As recommended earlier, further study on the role of dispositional empathy in domestic violence myth acceptance is indicated to determine if individual differences account for these findings.

Ambivalent Sexism. With respect to the female sample, benevolent and hostile sexism (subscales of ambivalent sexism) were not entered into the regression analysis since the correlational analysis did not reveal a significant relationship between domestic violence myth endorsement and ambivalent sexism.

However, hostile sexism toward women was a significant predictor of male forensic specialists' endorsement of domestic violence myths. With regard to males' responses to specific items in the hostile sexism subscale, more than one quarter of the male participants agreed that women were "too easily offended," and that women were

"seeking special favors under the guise of asking for equality." With regard to relational statements, over a third of the males in this sample agreed that most women "fail to appreciate all that men do for them;" one quarter of the male sample agreed that women "seek to gain power by gaining control over men;" one third of the male sample agreed that "once a woman gets a man to commit she usually tries to put him on a tight leash," and more than one half of the male sample believed that "feminists are making unreasonable demands of men."

These findings were consistent with a study involving a university sample (N=429; 199 men and 230 women) where Lonsway and Fitzgerald (1995) demonstrated that hostility toward women accounted for a partial explanation for rape myth acceptance in Burt's Rape Myth Acceptance scale. Hostility toward women was also predictive of rape myth acceptance among men more so than women. Individuals who endorse hostile sexism are more likely to have negative views of rape victims, and are more likely to believe that rape victims deserved to be raped (Sakalli-Ugurlu, Yalcin, & Glick, 2007). Additionally, Glick (1996) also found that men subscribed more often than women to hostile sexist beliefs about women. Those findings suggested that rape myths functioned differently by gender, which supported the need for further research on misogyny and its relationship to the sexual assault of women (Lonsway & Fitzgerald, 1995).

Limitations

Sample Selection

Several methodological limitations exist in this study. The sample in this study was selected for convenience and for making the study amenable to online administration. Therefore, a requirement for participation included current and available e-mail addresses so that the survey could be administered via the internet. Of the 800 addresses, 183 were returned after the first contact due to incorrect e-mail addresses. From the remaining 617 queried, 138 (23%) responses were generated, diminishing generalization to the larger population. Another methodological limitation existed in the unequal sample sizes by gender, with females (n = 47) and males (n = 90). An increased sample size of female respondents would have optimized the generalization of the findings to the larger population.

Procedures

In an attempt to remove barriers for respondents, the survey was administered via the internet. For example, the time needed to complete the survey was estimated to be reduced by online completion; paper and pencil surveys were replaced with a hyperlink to an easily navigated website; and the extra steps required to return the results via the U.S. Postal Service were eliminated. However, the inclusion of a preliminary e-mail contact might have elicited more responses. The first contact was sent with an attachment that may have been automatically sent to respondents' SPAM folders. Additionally, the participants in the sample may have preferred paper pencil surveys, especially since several of the forensic specialists in the sample responded with that request since their computers would not open attachments

Measures

The Attitudes Toward Women scale was not used in the final analysis due to researcher error, and might have added additional information to explain domestic violence myth acceptance. Additionally, the Interpersonal Reactivity Index was designed for the general population. An scale designed to assess dispositional empathy in mental health practitioners might provide more information with respect to empathy and domestic violence myth endorsement.

Implications for Future Research and Practice

This study revealed that empathic concern predicted low scores on domestic violence myth acceptance in the female sample. The regression analysis for female respondents revealed that 18% of the variance in domestic violence myth acceptance was explained by female forensic specialists' empathic concern for others. Hostile sexism toward women predicted high scores on domestic violence myth acceptance in the male sample. The regression analysis for male respondents revealed that 22% of the variance in domestic violence myth acceptance was explained by male forensic specialists' hostile, sexist attitudes towards women. These findings supported the hypotheses that dispositional empathy and hostile sexism were predictors of domestic violence myth acceptance in forensic specialists, and that gender influenced low mean scores for women on the DVMAS and high mean scores for men.

Forensic Practice

The findings in this study inform the field of domestic violence by first raising awareness of domestic violence myth, and second, by identifying the contributors to domestic violence myth endorsement by forensic professionals in this sample. As discussed earlier in this chapter, forensic specialists are key players in the evaluations of victims and perpetrators, and their examinations and investigative practices are critical to the outcome of child custody litigations, and criminal prosecution with regard to intimate partner abuse (Stark, 2007). Additionally, forensic specialists are in a strategic position to make a serious impact on safety and social justice for survivors of domestic violence. Forensic specialists who harbor hostile, sexist attitudes toward women could negatively influence the outcome of child custody evaluations and mental health assessments by focusing on perceived responsibility of the victim more so than the batterer, minimizing the victim's concerns for safety, or blaming the victim's character instead of the batterer's behavior.

Recommendations to the courts for batterers that might affect the short and long-term safety and well being of victims of intimate partner violence could be misdirected if misperceptions of the victim's 'character' is an issue instead of the behavior of the abuser. Forensic experts who endorse myths that serve to blame victims and exonerate batterers could potentially influence judges or members of juries with inaccurate explanations of victim behaviors and character issues not relevant to her circumstances. Additionally, the gender of forensic specialists in this study was identified as a mediating variable for females, but the effect of gender was the opposite for males in their endorsement of domestic violence myths.

"The knowledge of distribution of blame in marital violence by medical, legal, and mental health service providers of both sexes has concrete and practical application for improving service delivery," (Petretic-Jackson, Sandberg, & Jackson, 1994). Bograd (1992) asserted that clinical interventions with batterers and the victims of their crimes may not only be ineffective, they may put the victim in danger of being physically injured or murdered. Since violence is a crime, and therefore should not be granted different legal or social remedies (Bograd, 1992) it is reasonable to surmise from this study that knowledge of the impact of domestic violence myth endorsement by forensic specialists has practical application for securing the safety of victims and supporting accountability for the perpetrators of intimate partner violence. The safety of victims' could be compromised by hostile, sexist attitudes harbored by professionals who were unaware of their hostility toward women and the influence of those attitudes on their decisions, diagnoses, or recommendations.

Implications for Future Research

The findings in this study did not account for a full explanation of the variance in domestic violence myth acceptance in forensic specialists. Future research is needed to explore other variables that may account for domestic violence myth endorsement. For example, a measure of attitudes toward women, questions about adult experiences with abuse or experiences in witnessing abuse as a child; and experiences with compassion fatigue or secondary stress from professional practice might be pertinent. A qualitative study with forensic professionals might better provide a method by which to explore aspects of dispositional empathy and ambivalent sexism in forensic professionals.

Additional contributors to domestic violence myth endorsement might be revealed through personal interviews, lending more textural components to the analysis than operational variables can detect.

The impact of domestic violence myth endorsement on forensic investigative processes in gathering evidence, trust-building issues, and risks of dual roles in forensic practice with victims and perpetrators of domestic violence are areas for future research. Since this study lacked variability in race, age, and years of experience, further research with racially diverse groups of graduate students in forensic psychology programs, and mental health professionals with minimal experience in forensic practice is recommended. Forensic social workers have also become more actively involved with domestic violence cases. Therefore, information on domestic violence myth acceptance among forensic social workers, and their attitudes and beliefs about intimate partner violence would serve to expand knowledge with respect to domestic violence myth and service provision. Finally, a study that examined forensic specialists' attitudes toward victims and perpetrators, before and after specialized feminist based training is advised. and might reveal differences in service provision that not only protected the victim but assessed the seriousness of the abuse.

Conclusion

Recognition and prediction of intimate partner violence against women is critical to forensic practice with regard to the duration, intensity, and lethality of the violence (Roberts, 1995). Forensic mental health professionals are in a unique position to facilitate court decisions that will take into account victim safety, and whether the risk to her

wellbeing is low, moderate, or high for escalation or continuation of battering, serious injury, or homicide. Roberts (2005) has recommended that all assessments begin by evaluating specific psychological and physical harm to the victim, then to determine how likely it is that she can escape the battering safely, with minimal risk to herself and her children. It is questionable, given the results of this study, if these steps would be taken by forensic professionals who harbor hostile attitudes toward female victims.

Finally, it is recommended that program and curriculum development in domestic violence intervention and forensic practice with victims and perpetrators be implemented in forensic psychology programs at the graduate level as well continuing education for forensic professionals. Cross-training might prove helpful to forensic mental health specialists, victim advocates, and batterer counselors whose special considerations and practices often intersect, and in some cases conflict. Knowledge of the limitations inherent in therapeutic, forensic, and advocacy roles with respect to domestic violence might offer explanations to these varied groups of professionals about special issues in each discipline such as confidentiality, the role of empathy with victims and batterers, dual role conflicts; and state laws pertaining to protective orders, mandatory arrest, and custody issues.

Continuing education for forensic professionals with survivors or convicted perpetrators of domestic violence who are volunteers in community education programs might facilitate a better understanding of the issues from all sides. Bograd (1992) implored clinicians who worked with battered women to understand and honor battered women's experiences, and to think hard about the work they do with families and violence. Violence against women is not simply a feminist issue. It is a humanist issue

that requires concerted efforts from both women and men who want solutions, or at the very least, safe interventions for battered women in crisis.

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APPENDICES

APPENDIX A

INFORMED CONSENT

Informed Consent

Contributors to Attitudes Toward Violence Survey
Voluntary Consent Form

Introduction
Welcome! You are invited to participate in a research project conducted by Lynda Driskell, Licensed Professional Counselor, and Ph.D. Candidate in the School of Health and Educational Psychology at Oklahoma State University. Assistance for making an informed decision about your consent to participate in this project can be found in the information below. You must be 18 years of age to participate.

Purpose
This research will add to the literature on violence by helping us to understand the contributors to personal perceptions of human relationships and violence by intimates.

Procedures
If you agree to participate in this study, you will be asked to respond to an online survey. The survey is comprised of a series of questions that will be answered by clicking on the response that best indicates how much you agree or disagree with a statement. For example "Swearing and obscenity are more repulsive in the speech of a woman than of a man." Other types of questions ask how well a statement describes you. For example "I would describe myself as a pretty soft hearted person." Answering all of the questions in the survey should take a total of 12-15 minutes.

Risks of Participation
There are no foreseen risks associated with this project which are greater than those ordinarily encountered in daily life. The training and experience of forensic specialists prepares them for a multitude of encounters with psychological issues such as those in this study. The subject matter in this study will be familiar to forensic specialists and does not exceed what they would experience in their daily encounters with clients, court appearances, or consultations, or investigations.

Benefits
It is doubtful that this research will benefit you directly. However, the results of this study will assist us in our understanding of the contributors to attitudes toward human relationships and violence by intimate partners. This understanding could effect social change by assisting professionals in our mental health communities, law enforcement, the justice system, academia, and social services in finding more effective and efficient ways to serve the men and women who seek help for their experiences with intimate partner violence.

Confidentiality
Your responses to the statements and questions in this survey are completely confidential. Your name will not be recorded on the survey or on any other documents that could connect you to this study. Additionally, steps will be taken to delete the numerical

"name" of your computer from the database so that your identity will in no way be connected to the your responses to this survey.

The records of this study will be kept private. Any written results will discuss group findings and will not include information that will identify you. Research records will be stored securely and only researchers and individuals responsible for research oversight will have access to the records. It is possible that the consent process and data collection will be observed by other research oversight staff responsible for safeguarding the rights and wellbeing of people who participate in research.

Voluntary Participation
Your participation in this research study is completely voluntary.
Your consent to participate will be indicated by clicking on the "Accept" button on the survey website. If you do not wish to participate you may click on the "Do not Accept" button without consequence. You may stop at any time without any negative consequences by exiting the survey.

Contact Information
Please contact my dissertation advisor or myself if you have questions or concerns about participating in this study:

Lynda Driskell, LPC, Ph.D. Candidate
School of Applied Health and Educational Psychology
Oklahoma State University
Stillwater, OK 74078
918-459-8996 or 918-830-4426
lynda.driskell@okstate.edu

Barbara Carlozzi, Ph.D.
School of Applied Health and Educational Psychology
Oklahoma State University
405-744-9457

Any questions related to your rights as a research participant should be directed to Dr. Sue Jacobs, IRB Chair, 219 Cordell North, Stillwater, OK 74078, 405-744-1676 or irb@okstate.edu

APPENDIX B

SOLICITATION AND FOLLOW-UP LETTERS

E-mail Notification

Subject: Request for Research Participation

Link to study http://frontpage.okstate.edu/coe/driskell

Remember when you were a graduate student and needed data for your research in order to complete your dissertation? Did you lie awake at night and ruminate over whether you would get the responses you needed for an adequate sample? I am conducting research for my dissertation at Oklahoma State University on *perceptions of violence in heterosexual relationships*. Would you be willing to assist me in my research by completing a survey on a secure website? It should only take 12-15 minutes of your time.

This study has been approved by the Institutional Review Board at Oklahoma State University. The current membership of the divisions of psychology and counseling of the American College of Forensic Examiners was selected to receive a survey. A number of attitudes toward violence have been thoroughly researched, yet others have not been readily identified. The goal of this research is to determine contributors to attitudes toward intimate partner violence that are missing in the literature. The knowledge of these contributors could, in the long term, contribute to the development of programs to reduce intimate partner violence in our communities and society at large.

Individual responses will not be identified since respondents are not asked to put their name on the survey and researchers are deleting any computer identifiers.

Your participation in completing the survey is strictly voluntary and you must be at least 18 years of age. By completing the questionnaire you could make a significant impact on our knowledge of perceptions of intimate partner violence. If you choose to participate, you may do so by clicking on the hyperlink below to view the informed consent and access the survey. If you agree to participate you should click on the "I Agree to Participate Button" located at the bottom of the consent form. This allows you to access the survey on the website. If you have any questions or comments about this study, I am available to speak with you by phone at (918) 459-8996; or by e-mail lynda.driskell@okstate.edu

Thank you very much for helping with this important study. To view the consent form and access the survey please click on the link below. You may exit at any time without consequence.

Link to study http://frontpage.okstate.edu/coe/driskell

Lynda Driskell, LPC
Ph.D. Candidate
Educational Psychology
Oklahoma State University

First Follow-up E-mail

Dear Forensic Specialists (Psychology and Counseling Divisions of ACFEI):

Last week I sent an e-mail to request your assistance with a research study I am conducting at Oklahoma State University on *perceptions of violence in heterosexual relationships*. If you have already completed the survey online and submitted it, then please accept my thanks and disregard this notice.

Many professionals have already responded by completing the survey on perceptions of violence in heterosexual relationships. I want to make sure that I hear from all of you who would like to respond. Your participation is valuable in helping me to understand contributors to perceptions of intimate partner violence. I am grateful for your assistance in this study.

Thank you in advance for taking the time to complete this survey.

Link to study: http://frontpage.okstate.edu/coe/driskell

Lynda Driskell, LPC
Ph.D. Candidate
Educational Psychology
(918) 459-8996 or
lynda.driskell@okstate.edu

You must be at least 18 years old to participate.

Second Follow-up E-mail

Final Research Request

I am very interested in your responses!

Over the past few weeks, I have sent e-mails requesting your assistance with a research study I am conducting on *perceptions of violence in heterosexual relationships*. If you have already completed the survey online and submitted it, then please accept my thanks and disregard this notice.

People who respond later to surveys such as this one have different perspectives and beliefs than those who respond immediately. Therefore, your responses are extremely important to this study since they will reduce any bias related to the responses of those who completed the survey soon after receiving the first notice.

Please take 12-15 minutes to complete the survey. Your thoughts and attitudes are important to me and will contribute to the accuracy of this study.

Your responses are confidential and your name will not appear anywhere on the survey. At no time will your responses be connected to your identity.

Thank you for your participation.

Lynda Driskell, LPC
Ph.D. Candidate
Educational Psychology
Oklahoma State University

Click here to access the study: http://frontpage.okstate.edu/coe/driskell

You are welcome to contact me with any questions or concerns with regard to this research by replying to this e-mail or calling me at (918) 459-8996.

Thank You E-mail

Thank you for the time and effort you contributed to the completion of this survey. Your participation in this important research study is greatly appreciated!

My sincerest thanks,

Lynda Driskell, LPC

APPENDIX C

DEMOGRAPHIC INFORMATION

Demographic Information

Listed below are a few demographic questions that may help with the analysis of the data. Please click on the response that most closely represents you.

1. Your age: ___18-28 ___29-40 ___41-52 ___53-64 ___65+

2. Your gender: ___Female ___Male ___Transgender

3. **Ethnicity**:
Do you consider yourself to be Hispanic or Latino? (see definition below.) Select one.
Hispanic or Latino. A person of Mexican, Puerto Rican, Cuban, South Central American, or other Spanish culture or origin, regardless of race. The term "Spanish origin," can be used in addition to "Hispanic or Latino."

____ Hispanic or Latino

____ Not Hispanic or Latino

4. **Race**:
What race to you consider yourself to be? Select one or more of the following.

____ ***American Indian or Alaskan Native***. A person having origins in any of the original peoples of North, Central, or South America, and who maintains a tribal affiliation or tribal attachment.

____ ***Asian***. A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, including, for example, Cambodia China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Viet Nam. (Note: Individuals from the Philippine Islands have been recorded as Pacific Islanders in previous data collection strategies.

____ ***Black or African American.*** A person having origins in any of the black racial groups of Africa. Terms such as "Haitian" or "Negro" can be used in addition to "Black" or "African American."

____ ***Native Hawaiian or Other Pacific Islander***. A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or **other** Pacific Islands.

____ ***White***. A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

____ Check here if you do not wish to provide some or all of the above information.

5. College Degree:
___Masters ___Psy.D. ___Ph.D. ___Ed.D ___Other

6. Years of experience as a forensic specialist:

___less than 1 year ___1-3 years
___4-7 years ___8-13 years
___14-20 years ___20 + years

7. Professional experience in:

___Yes ___No Expert witness testimony
___Yes ___No Child custody evaluations
___Yes ___No Violence Risk Assessment
___Yes ___No Sexual abuse assessments
___Yes ___No Battered Woman's Syndrome

8. Have you attended any of the following?

___Yes ___No Graduate course on domestic violence
___Yes ___No Post graduate continuing education
___Yes ___No Certification training in domestic abuse response
___Yes ___No Clinical supervision related to domestic violence cases
___Yes ___No Conference on domestic violence

APPENDIX D

RESEARCH INSTRUMENTS

Interpersonal Reactivity Index

Listed below are a number of statements concerning personal dispositions and interpersonal reactivity. Please indicate the degree to which these items describe you. Choose the appropriate point on the 5 point Likert type scale by clicking on the number that best describes you.

1. I daydream and fantasize, with some regularity, about things that might happen to me.

Does not describe me well	____ 0	____ 1	____ 2	____ 3	____ 4	Describes me very well

2. I often have tender, concerned feelings for people less fortunate then me.

Does not describe me well	____ 0	____ 1	____ 2	____ 3	____ 4	Describes me very well

3. I sometimes find it difficult to see things from the "other guy's" point of view.

Does not describe me well	____ 0	____ 1	____ 2	____ 3	____ 4	Describes me very well

4. Sometimes I don't feel very sorry for other people when they are having problems.

Does not describe me well	____ 0	____ 1	____ 2	____ 3	____ 4	Describes me very well

5. I really get involved with the feelings of the characters in a novel.

Does not describe me well	____ 0	____ 1	____ 2	____ 3	____ 4	Describes me very well

6. In emergency situations, I feel apprehensive and ill at ease.

Does not describe me well	____ 0	____ 1	____ 2	____ 3	____ 4	Describes me very well

7. I am usually objective when I watch a movie or play, and I don't often get completely caught up in it.

Does not describe me well	____ 0	____ 1	____ 2	____ 3	____ 4	Describes me very well

8. I try to look at everybody's side of a disagreement before I make a decision.

Does not describe	____ 0	____ 1	____ 2	____ 3	____ 4	Describes me very well

9. When I see someone taken advantage of, I feel kind of protective towards them.

Does not describe me well	0	1	2	3	4	Describes me very well

10. I sometimes feel helpless when I am in the middle of a very emotional situation.

Does not describe me well	0	1	2	3	4	Describes me very well

11. I sometimes try to understand my friends better by imagining how things look from their perspective.

Does not describe me well	0	1	2	3	4	Describes me very well

12. Becoming extremely involved in a good book or movie is somewhat rare for me.

Does not describe me well	0	1	2	3	4	Describes me very well

13. When I see someone get hurt, I tend to remain calm.

Does not describe me well	0	1	2	3	4	Describes me very well

14. Other people's misfortunes do not usually disturb me a great deal.

Does not describe me well	0	1	2	3	4	Describes me very well

15. If I'm sure I'm right about something, I don't waste much time listening to other people's arguments.

Does not describe me well	0	1	2	3	4	Describes me very well

16. After seeing a play or a movie, I have felt as though I were one of the characters.

Does not describe me well	0	1	2	3	4	Describes me very well

17. Being in a tense emotional situation scares me.

Does not describe me well	0	1	2	3	4	Describes me very well

18. When I see someone being treated unfairly, I sometimes don't feel much pity for them.

Does not describe me well						Describes me very well
	0	1	2	3	4	

19. I am usually effective in dealing with emergencies.

Does not describe me well						Describes me very well
	0	1	2	3	4	

20. I am often quite touched by things that I see happen.

Does not describe me well						Describes me very well
	0	1	2	3	4	

21. I believe that there are two sides to every question and try to look at them both.

Does not describe me well						Describes me very well
	0	1	2	3	4	

22. I would describe myself as a pretty soft-hearted person.

Does not describe me well						Describes me very well
	0	1	2	3	4	

23. When I watch a movie I can easily put myself in the place of the leading character.

Does not describe me well						Describes me very well
	0	1	2	3	4	

24. I tend to lose control during emergencies.

Does not describe me well						Describes me very well
	0	1	2	3	4	

25. When I'm upset at someone, I usually try to put myself "in his shoes" for awhile.

Does not describe me well						Describes me very well
	0	1	2	3	4	

26. When I'm reading a story or novel, I imagine how *I* would feel if the events in the story were happening to me.

Does not describe me well	____ 0	____ 1	____ 2	____ 3	____ 4	Describes me very well

27. When I see someone who badly needs help in an emergency, I go to pieces.

Does not describe me well	____ 0	____ 1	____ 2	____ 3	____ 4	Describes me very well

28. Before criticizing somebody, I try to imagine how *I* would feel if I were in their place.

Does not describe me well	____ 0	____ 1	____ 2	____ 3	____ 4	Describes me very well

Davis, M.H. (1996). *Empathy: A social psychological approach.* Bolder, CO: Westview Press.

Ambivalent Sexism Inventory

Below are a series of statements concerning men and women and their relationships in contemporary society. Please indicate the degree to which you agree or disagree with each statement using the scale below:

0	1	2	3	4	5
disagree strongly	disagree somewhat	disagree slightly	agree slightly	agree somewhat	agree strongly

____ 1. No matter how accomplished he is, a man is not truly complete as a person unless he has the love of a woman.

____ 2. Many women are actually seeking special favors, such as hiring policies that favor them over men, under the guise of asking for "equality."

____ 3. In a disaster, women ought not necessarily to be rescued before men.

____ 4. Most women interpret innocent remarks or acts as being sexist.

____ 5. Women are too easily offended.

____ 6. People are often truly happy in life without being romantically involved with a member of the other sex.

____ 7. Feminists are not seeking for women to have more power than men.

____ 8. Many women have a quality of purity that few men possess.

____ 9. Women should be cherished and protected by men.

____ 10. Most women fail to appreciate fully all that men do for them.

____ 11. Women seek to gain power by getting control over men.

____ 12. Every man ought to have a woman whom he adores.

____ 13. Men are complete without women.

____ 14. Women exaggerate problems they have at work.

____ 15. Once a woman gets a man to commit to her, she usually tries to put him on a tight leash.

____ 16. When women lose to men in a fair competition, they typically complain about being discriminated against.

____ 17. A good woman should be set on a pedestal by her man.

____ 18. There are actually very few women who get a kick out of teasing men by seeming sexually available and then refusing male advances.

____ 19. Women, compared to men, tend to have a superior moral sensibility.

____ 20. Men should be willing to sacrifice their own well being in order to provide financially for the women in their lives.

____ 21. Feminists are making entirely reasonable demands of men.

____ 22. Women, as compared to men, tend to have a more refined sense of culture and good taste.

Glick, P., & Fiske, S.T. (1996). The ambivalent sexism inventory: Differentiating hostile and benevolent sexism. *Journal of personality and social psychology, 70*, 491-512.

Domestic Violence Myth Acceptance Scale (DVMAS)

Below are a series of statements with regard to attitudes about men, women, and domestic violence. Please indicate the how much you agree or disagree with each statement by clicking on a response below the statement. If you agree with the statement, click the button over the number that corresponds with the degree of your agreement. If you disagree with a statement, click the button over the number that corresponds with the amount you disagree.

1. Domestic violence does not affect many people.

Strongly Disagree	1	2	3	4	5	6	7	Strongly Agree

2. When a man is violent it is because he lost control of his temper.

Strongly Disagree	1	2	3	4	5	6	7	Strongly Agree

3. If a woman continues living with a man who beat her then it's her own fault if she is beaten again.

Strongly Disagree	1	2	3	4	5	6	7	Strongly Agree

4. Making a man jealous is asking for it.

Strongly Disagree	1	2	3	4	5	6	7	Strongly Agree

5. Some women unconsciously want their partners to control them.

Strongly Disagree	1	2	3	4	5	6	7	Strongly Agree

6. A lot of domestic violence occurs because women keep on arguing about things with their partners.

Strongly Disagree	1	2	3	4	5	6	7	Strongly Agree

7. If a woman doesn't like it, she can leave.

Strongly Disagree	1	2	3	4	5	6	7	Strongly Agree

8. Most domestic violence involves mutual violence between partners.

Strongly Disagree	1	2	3	4	5	6	7	Strongly Agree

9. Abusive men lose control so much that they don't know what they are doing.

Strongly Disagree	1	2	3	4	5	6	7	Strongly Agree

10. I hate to say it, but if a woman stays with the man who abused her, she basically deserves what she gets.

Strongly Disagree	1	2	3	4	5	6	7	Strongly Agree

11. Domestic violence rarely happens in my neighborhood.

Strongly Disagree	1	2	3	4	5	6	7	Strongly Agree

12. Women who flirt are asking for it.

Strongly Disagree	1	2	3	4	5	6	7	Strongly Agree

13. Women can avoid physical abuse if they give in occasionally.

Strongly Disagree	1	2	3	4	5	6	7	Strongly Agree

14. Many women have an unconscious wish to be dominated by their partners.

Strongly Disagree	1	2	3	4	5	6	7	Strongly Agree

15. Domestic violence results from a momentary loss of temper.

Strongly Disagree	1	2	3	4	5	6	7	Strongly Agree

16. I don't have much sympathy for a battered woman who keeps going back to the abuser.

Strongly Disagree	1	2	3	4	5	6	7	Strongly Agree

17. Women instigate most family violence.

Strongly Disagree	1	2	3	4	5	6	7	Strongly Agree

18. If a woman goes back to the abuser, how much is that due to something in her character?

Strongly Disagree	1	2	3	4	5	6	7	Strongly Agree

Peters, J. (2003). The Domestic Violence Myth Acceptance Scale: Development and psychometric testing of a new instrument [Electronic Version]. *Dissertation Abstracts International.*

Attitudes Toward Women

Instructions: The statements listed below describe attitudes toward roles of women in society which different people have. There are no right or wrong answers, only opinions. You are asked to express your feelings about each statement by indicating whether you (A) agree strongly, (B) agree mildly, (C) disagree mildly, or (D) disagree strongly.

1. Swearing and obscenity are more repulsive in the speech of a woman than of a man.

   A__ Agree strongly B__ Agree mildly C__ Disagree mildly D__ Disagree strongly

2. Women should take increasing responsibility for leadership in solving the intellectual and social problems of the day.

   A__ Agree strongly B__ Agree mildly C__ Disagree mildly D__ Disagree strongly

3. Both husband and wife should be allowed the same grounds for divorce.

   A__ Agree strongly B__ Agree mildly C__ Disagree mildly D__ Disagree strongly

4. Telling dirty jokes should be mostly a masculine prerogative.

   A__ Agree strongly B__ Agree mildly C__ Disagree mildly D__ Disagree strongly

5. Intoxication among women is worse than intoxication among men.

   A__ Agree strongly B__ Agree mildly C__ Disagree mildly D__ Disagree strongly

6. Under modern economic conditions with women being active outside the home, men should share in household tasks such as washing dishes and doing laundry

   A__ Agree strongly B__ Agree mildly C__ Disagree mildly D__ Disagree strongly

7. It is insulting to women to have the "obey" clause remain in the marriage service.

   A__ Agree strongly B__ Agree mildly C__ Disagree mildly D__ Disagree strongly

8. There should be a strict merit system in job appointment and promotion without regard to sex.

A__	B__	C__	D__
Agree strongly	Agree mildly	Disagree mildly	Disagree strongly

9. A woman should be free as a man to propose marriage.

A__	B__	C__	D__
Agree strongly	Agree mildly	Disagree mildly	Disagree strongly

10. Women should worry less about their rights and more about becoming good wives and mothers.

A__	B__	C__	D__
Agree strongly	Agree mildly	Disagree mildly	Disagree strongly

11. Women earning as much as their dates should bear equally the expense when they go out together.

A__	B__	C__	D__
Agree strongly	Agree mildly	Disagree mildly	Disagree strongly

12. Women should assume their rightful place in business and all the professions along with men.

A__	B__	C__	D__
Agree strongly	Agree mildly	Disagree mildly	Disagree strongly

13. A woman should not expect to go to exactly the same places or have quite the same freedom of action as a man.

A__	B__	C__	D__
Agree strongly	Agree mildly	Disagree mildly	Disagree strongly

14. Sons in a family should be given more encouragement to go to college than daughters.

A__	B__	C__	D__
Agree strongly	Agree mildly	Disagree mildly	Disagree strongly

15. It is ridiculous for a woman to run a locomotive and for a man to darn socks.

A__	B__	C__	D__
Agree strongly	Agree mildly	Disagree mildly	Disagree strongly

Spence, J. T., Helmreich, R., & Stapp, J. (1973). A short version of the Attitudes toward Women Scale (AWS). *Bulletin of the Psychonomic Society, 2*, 219-220.

Short Form of Marlow-Crowne Social Desirability Scale

Listed below are a number of statements concerning personal attitudes and traits. Read each item carefully and indicate how true or false the statement is as it pertains to your personality.

1. No matter who I'm talking to, I'm always a good listener.

Always True	____ 1	____ 2	____ 3	____ 4	____ 5	____ 6	Always False

2. I have sometimes taken unfair advantage of another person.

Always True	____ 1	____ 2	____ 3	____ 4	____ 5	____ 6	Always False

3. I am always courteous, even to people who are disagreeable.

Always True	____ 1	____ 2	____ 3	____ 4	____ 5	____ 6	Always False

4. I sometimes try to get even, rather than forgive and forget.

Always True	____ 1	____ 2	____ 3	____ 4	____ 5	____ 6	Always False

5. I am quick to admit making a mistake.

Always True	____ 1	____ 2	____ 3	____ 4	____ 5	____ 6	Always False

6. I sometimes feel resentful when I don't get my way.

Always True	____ 1	____ 2	____ 3	____ 4	____ 5	____ 6	Always False

7. I am always willing to admit when I make a mistake.

Always True	____ 1	____ 2	____ 3	____ 4	____ 5	____ 6	Always False

8. There have been occasions when I took advantage of someone I disliked.

Always True	____ 1	____ 2	____ 3	____ 4	____ 5	____ 6	Always False

9. I would never think of letting someone else be punished for my wrongdoing.

Always							Always
True	1	2	3	4	5	6	False

10. At times I have wished that something bad would happen to someone I disliked.

Always							Always
True	1	2	3	4	5	6	False

Crowne, D.P., & Marlowe, D. (1960). A new scale of social desirability independent of social pathology. *Journal of Consulting Psychology, 24,* 349, 354.

Short version was tested by:

Greenwald, H.J. & Satow, Y. (1970). A short social desirability scale. *Psychological Reports, 27,* 135-135.

APPENDIX E

INSTITUTIONAL REVIEW BOARD FORM

Oklahoma State University Institutional Review Board

Date:	Wednesday, November 07, 2007
IRB Application No	ED0798
Proposal Title:	Contributors to Domestic Violence Myth Acceptance in Forensic Mental Health Practioners
Reviewed and Processed as:	Expedited

Status Recommended by Reviewer(s): Approved Protocol Expires: 11/6/2008

Principal Investigator(s

Lynda Driskell
305 N. Magnolia Ave.
Broken Arrow, OK 74012

Barbara Carlozzi
422 Willard
Stillwater, OK 74078

The IRB application referenced above has been approved. It is the judgment of the reviewers that the rights and welfare of individuals who may be asked to participate in this study will be respected, and that the research will be conducted in a manner consistent with the IRB requirements as outlined in section 45 CFR 46.

☑ The final versions of any printed recruitment, consent and assent documents bearing the IRB approval stamp are attached to this letter. These are the versions that must be used during the study.

As Principal Investigator, it is your responsibility to do the following:

1. Conduct this study exactly as it has been approved. Any modifications to the research protocol must be submitted with the appropriate signatures for IRB approval.
2. Submit a request for continuation if the study extends beyond the approval period of one calendar year. This continuation must receive IRB review and approval before the research can continue.
3. Report any adverse events to the IRB Chair promptly. Adverse events are those which are unanticipated and impact the subjects during the course of this research; and
4. Notify the IRB office in writing when your research project is complete.

Please note that approved protocols are subject to monitoring by the IRB and that the IRB office has the authority to inspect research records associated with this protocol at any time. If you have questions about the IRB procedures or need any assistance from the Board, please contact Beth McTernan in 219 Cordell North (phone: 405-744-5700, beth.mcternan@okstate.edu).

Sincerely,

Sue C. Jacobs, Chair
Institutional Review Board

VITA

Lynda Driskell

Candidate for the Degree of

Doctor of Philosophy

Dissertation: PREDICTORS OF DOMESTIC VIOLENCE MYTH ACCEPTANCE IN FORENSIC MENTAL HEALTH SPECIALISTS

Major Field: Educational Psychology

Biographical:

Personal Data: Born in Ft. Sill, Oklahoma, on November 5, 1954.

Education: Graduated from Tahlequah High School, Tahlequah, Oklahoma, May 1972; received Bachelor of Science degree in Industrial Technology from Oklahoma State University, Tahlequah, Oklahoma in July, 1979. Completed the requirements for the Master of Human Relations degree with a major in Human Relations at University of Oklahoma, Tulsa, Oklahoma, August 1993. Will complete requirements for a doctorate in Educational Psychology from Oklahoma State University, Stillwater, Oklahoma in May 2008.

Experience: Licensed Professional Counselor since 1996. Employed by Domestic Violence Intervention Services from 1993-2001. Private clinical practice from 2000-2004. Expert witness in civil cases, & high conflict divorce mediator since 1998. Adjunct faculty, Human Relations Program, at University of Oklahoma from 1997-present.

Professional Membership: AERA, APA- Psychology, and Law Division.

Name: Lynda Driskell Date of Degree May, 2008

Location: Oklahoma State University Location: Stillwater, Oklahoma

Title of Study: PREDICTORS OF DOMESTIC VIOLENCE MYTH ACCEPTANCE IN FORENSIC MENTAL HEALTH SPECIALISTS

Pages in Study: 150 Doctoral Candidate for Doctorate of Philosophy

Major Field: Educational Psychology

Scope and Method of Study: The purpose of this study is two fold (a) to make a contribution to the existing body of literature in the field of violence against women by identifying predictors of domestic violence myth acceptance in forensic specialists, and (b) to test the hypothesis that domestic violence myth acceptance by forensic mental health practitioners can be predicted by gender, empathic disposition, and hostile or benevolent sexism. This study will show that gender influences dispositional empathy and hostile sexism, and that traditional gender role expectations are related to domestic violence myth endorsement in forensic specialists. 138 forensic mental health specialists from the American College of Forensic Examiners Institute were surveyed on their perceptions of violence in intimate relationships. Instruments included The Domestic Violence Myth Acceptance Scale, Interpersonal Reactivity Index, Ambivalent Sexism Inventory, and the Crowne-Marlowe Social Desirability short form. Multiple regression, bivariate correlations, and ANOVA were used in the analysis to predict domestic violence myth acceptance in the sample respondents.

Findings and Conclusions: Separate regression analyses were conducted by gender. The regression analysis for female respondents revealed that the model was significant and women's lower scores on the DVMAS were driven by their higher scores on the Empathic Concern subscale ($R^2 = .177$, F [1,42] = 9.043, $p = .004$). Approximately 18% of the variance in domestic violence myth acceptance was accounted for by the females' empathic concern for others. Gender and empathic concern, (IRI subscale) were predictors of low scores on domestic violence myth acceptance in females. The regression analysis for male respondents revealed that the model was significant and men's higher scores on the DVMAS were driven by their scores on the Hostile Sexism subscale of the ASI ($R^2 = .224$, F [2,80] = 11.564, $p = .000$). Approximately 22% of the variance in domestic violence myth acceptance was accounted for by the males' hostile sexism towards women, supporting the hypothesis that gender and hostile sexism were predictors of domestic violence myth endorsement.

Advisor's Approval: Barbara Carlozzi