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Intimate Partner Violence and Victim Blaming

Christine A. Weingarten
DePaul University, caweingarten@gmail.com

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Intimate Partner Violence
and Victim Blaming

A Master's Thesis

Presented to the Department of Psychology

DePaul University

By Christine Ann Weingarten

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Abstract

Intimate partner violence (IPV) is highly prevalent within the United States leading to millions of people each year being exposed to violence directly, through involvement in a violent relationship, or indirectly, by witnessing or being close to someone who is in a violent relationship. A common societal response to IPV is victim blaming which attributes fault and responsibility to survivors of abuse. Survivors of IPV report victim blaming as one of the least helpful responses when disclosing to an informal social support. Personal experiences of IPV, either directly or indirectly, can affect levels of victim blame because a person who has been victimized may process the IPV differently. Altered processes related to IPV victimization may be a result of higher levels of depression and PTSD that are often found in IPV victimized populations. This research looked to add to the understanding of IPV and victim blaming by asking undergraduate students to report their IPV exposure and make fault attributions in response to IPV vignettes. Participants were also asked questions about depression and posttraumatic stress disorder (PTSD) symptomology, two common consequences of IPV exposure. Based on past research on IPV and theory regarding victim blaming, it was hypothesized that both direct and indirect IPV exposure would affect a person's level of victim blaming. It was hypothesized that direct IPV exposure will decrease victim blaming, unless the victim reports mental health symptoms, which will increase victim blaming. Additionally, it was hypothesized that indirect victimization will increase levels of victim blame which will be amplified by mental health symptoms. Finally, it was hypothesized that direct IPV victimization later in life will moderate the relationship between early indirect exposure to IPV and victim blaming. A better understanding of victim blaming is essential to providing survivors of partner violence the best possible recovery and this research aims to contribute to this understanding.

Introduction

Violence by a romantic partner has been on the minds and the conversations of many people throughout the country due to numerous recent high-profile cases of domestic abuse within the media. A prominent example would be the release of the video footage of NFL player Ray Rice punching his then-fiancé, now-wife, Janay Palmer in the head, knocking her unconscious in an elevator, and then dragging her limp body out of view. When this recording was released, the response from the public was mixed, but a common reaction was to question Ms. Palmer's actions and to place blame on her, most commonly with the question: "Why doesn't she leave?" This negative societal response of victim blaming increases the likelihood of poorer general and mental health outcomes for the victim. Being able to better understand peoples' tendencies to blame victims is essential to providing survivors of partner violence the best possible recovery.

Intimate Partner Violence

Intimate partner violence (IPV) is defined by the Centers for Disease Control (CDC, 2006) as a single event or ongoing occurrences of physical, sexual, or psychological harm or threats of harm between two people who are or have been in a romantic relationship. Crime within intimate relationships is often underreported with reporting rates estimated as low as 2.5-15% (Gracia, 2004). Surveys show that approximately 27% of women and 12% of men in the United States have experienced physical violence, sexual violence, or stalking by an intimate partner as well as reporting significant short-term or long-term health consequences (Breiding, Smith, Basile, Walters, Chen, & Merrick, 2014). An evaluation of the global prevalence of IPV in 2010 estimated that 30% of women over the age of 15 had experienced some form of partner violence within their lifetime (Devries et al., 2013). Research has also found that male victims,

racial minorities, and victims that are less educated tend to underreport IPV (Breiding, Black, & Ryan, 2008) which can lead to an under-utilization of resources. While prevalence rates vary from country to country, violence against women is a world-wide epidemic and IPV is the most common form of violence that women face.

Potential consequences for victims of IPV have been well established within the literature and vary considerably, possibly due to the large variance of severity and duration of the violence. Common outcomes for survivors of IPV include physical and mental health problems such as: posttraumatic stress disorder (PTSD), substance abuse disorders (SUD), antisocial behavior, chronic pain, depression, and attempted suicide (Campbell, 2002; Cohen, Field, Campbell, & Hien, 2013; Exner-Cortens, Eckenrode, & Rothman, 2013; Hellmuth, Jaquier, Overstreet, Swan, & Sullivan, 2014; Iverson et al., 2013). Altered brain activity may underlie some of these psychiatric problems. Increased hyperactivity in the insula, a structure involved with fear conditioning and phobias, is consistently found in women who have experienced IPV when comparing them to women without IPV victimization (Simmons, Matthews, Stein, & Paulus, 2004; Simmons et al., 2008; Strigo et al., 2010). Additionally, when compared to non-exposed women, IPV survivors show diminished prefrontal cortex (PFC) activity, which is the area responsible for problem solving, judgment, and decision making (Fennema-Notestine, Stein, Kennedy, Archibald, & Jernigan, 2002). Moreover, IPV has been shown to negatively affect the Hypothalamic-Pituitary-Adrenal (HPA) axis through chronic stress which causes HPA hyperactivity and leads to cell death in the amygdala and hippocampus, both of which are involved in memory and decision making (Wong, Fong, Lai, & Tiwari, 2014). In addition to the negative mental and physical outcomes of IPV, women in violent relationships also suffer social and economic consequences including cost of medical care and mental health services, inability

to maintain employment, social isolation, and decreased trust of others (Max, Rice, Finkelstein, Bardwell, & Leadbetter, 2004; Thompson et al., 2000).

In addition to the millions of adults that are affected directly by IPV, millions of children and adolescents are affected by IPV indirectly by witnessing IPV within their family or learning about violence within a relationship of someone they know. It has been estimated that 3.3 to 10 million children in the United States witness IPV each year; however, this is a broad and possibly conservative estimate considering the internal and external barriers of reporting these incidents (Willis, Pearce, Phalen, Keet, & Singer, 2010). One study found that 17% of adult Americans reported witnessing physical or psychological IPV during childhood (Overbeek, Schipper, Lamers-Winkelmann, & Schuengel, 2013), while another study reported that 58% of college aged students had witnessed psychological violence between their parents at some point in their life (Black, Sussman, & Unger, 2010). This disparity in prevalence rates could be a result of difference in reporting methods. Overbeek et al. (2013) used parent report for children witnessing interparental violence, which could lead to underreporting, while Black et al. (2010) used undergraduate students' self-reports of what they witnessed within their home.

Despite undetermined prevalence rates, it is clear that children exposed to parental abuse are at an increased risk for negative developmental outcomes due to the elevated stress and aggression within their household. Past research found associations between witnessing parental violence as a child and an increased likelihood of mental health problems such as depression, lifetime suicide attempts, perpetration and/or victimization of IPV, perpetrating child maltreatment, and alcohol dependence as adults (Black et al., 2010; Dehon & Weems, 2010; Narayan, Englund, Carlson, & Egeland 2013; Roustit, Renahy, Guernec, Lesieur, Parizot, & Chauvin, 2009). Social learning could lead to altered cognitions regarding violence because

aggressive behavior is modeled as acceptable (Lohman, Neppel, Senia, & Schofield, 2013). Because IPV affects the lives and relationships of those who are involved both directly and indirectly, there is a great need for research, understanding, and intervention of this societal epidemic.

While direct or indirect exposure to IPV can happen at any point within a person's lifetime, the college years (ages 18-24) are a critical time with a heightened risk for perpetration and victimization. Partner victimization rates for physical, sexual, and psychological violence range from 13-74% among college students, with best estimates documenting the incidence of IPV at around 20-33% (Fincham, Cui, Braithwaite, & Pasley, 2008). In addition, 47% of women who experienced either physical or sexual IPV within their lifetime indicated violence occurring between the ages of 18 and 24 (Black et al., 2011) and both men and women are at the highest risk of perpetrating physical IPV during this developmental stage (Johnson, Giordano, Manning, & Longmore, 2015). Research targeting this age group would help to better understand the experiences of many victims and perpetrators in order to develop interventions. Currently, interventions related to dating violence within the college population do not adequately address victim blame, if the subject is included at all. Improved education on IPV may increase the likelihood of disclosure and service seeking, promote more appropriate responses to disclosures from a peer, and destigmatize victimization within romantic relationships (Postmus, McMahon, Warrenner, & Macri, 2011). Educational programs within colleges such as the Green Dot intervention, which includes a focus on relationship building and mastery of skills in order to intervene in situations of potential IPV, have been shown to effectively reduce rape myth acceptance and increase active bystander behaviors (Coker et al., 2011), suggesting that interventions with this population may have the potential to decrease the rates of IPV and

enhance outcomes for all who are directly and indirectly exposed to IPV within this high-risk population.

Victim blaming

To address the negative sequelae of IPV exposure it is key to understand what is most and least helpful after direct or indirect exposure to IPV. Research suggests that at least 75% of IPV survivors disclose to at least one person within their social or family network and if support is received, this disclosure is associated with better mental health outcomes for the survivor (Sylaska & Edwards, 2014). On the other hand, survivors reported victim blaming as one of the least helpful reactions to disclosure of IPV. Negative disclosure experiences have been linked to increased mental health problems such as depression, PTSD, suicidality, and self-blame (Sylaska & Edwards, 2014). Unfortunately, victim blaming is a common phenomenon within American culture and throughout the world, making the focus on what the victim in an abusive relationship should and should not be doing instead of the actions of the perpetrator. Internalizing the cultural tendency to blame the victim can be a barrier to recovery from mental health problems because victims that believe they are at fault may believe that they deserve additional instances of victimization or that they do not deserve services or assistance. For example, research with survivors of rape who did not seek support from formal social systems found that some of the survivors chose not to utilize these services because they did not feel they were worthy of help (Patterson, Greeson, & Campbell, 2009). Education and intervention programs can help those exposed to IPV by mitigating victim blaming tendencies within their social contexts.

There are deep societal implications for victim blaming that can put pressure on survivors of IPV. One example is the cultural expectation for a woman to prevent the violence while maintaining the family structure. In a community-based vignette study, the victim was assigned

responsibility to find a solution to the violence 83.2% of the time: 52.1% of participant responses stated both the assailant and the victim are responsible and 31.1% of responses attributed responsibility solely to the victim to find a solution (Taylor & Sorenson, 2005). The same study found that when violence was viewed as less serious or if the couple was in a long-term relationship observers endorsed relationship-promoting strategies, such as “talking,” over victim-protective strategies, such as “leaving” (Taylor & Sorenson, 2005). This emphasis on relationship-promoting solutions in certain scenarios exemplifies the cultural pressure for victims of IPV to try to fix violent relationships instead of supporting approaches that put the victim’s safety first.

Victim blaming has been studied throughout the field of psychology as a process in which the victim is overtly or covertly attributed fault for their misfortunes (Harber, Podolski, & Williams, 2015). Placing attributions of blame onto the victims is a result of the observer processing the event in a way that finds the victim’s actions or inactions as the reason for the negative outcome. One factor that has been shown to influence victim blame greatly is perceived similarity to the victim. The Defensive Attribution Hypothesis (DAH) conceptualizes victim blame as a mechanism of relatedness between observers and victims where observers will increase or decrease the amount of blame they attribute based on perceived similarity to the victim and believed likelihood that comparable misfortunates could happen to them (Shaver, 1970). Evidence has supported this hypothesis and found that individuals assign less victim blame when the victim of a crime is objectively similar to them (Sylaska & Walters, 2014; van der Bruggen & Grubb, 2014) or perceived as being similar (Bell, Kuriloff, & Lottes, 1994). Correspondingly, people who were more similar or rated themselves as being more similar to the perpetrator were less likely to blame the perpetrator and more likely to blame the victim (Sylaska

& Walters, 2014). The Defensive Attribution Hypothesis has not been examined in the context of IPV, but these theories suggest that experiencing IPV is likely to reduce victim blaming, because individuals will be more likely to relate to the victim and therefore less likely to place blame on the victim.

Predictors of Victim Blaming in the Context of IPV

Research has also shown that factors other than perceived closeness can affect victim blame attributions in instances of IPV, such as demographic variables and specifics of the relationship and the violence within it. Demographic characteristics of the victims and abusers, as well as the people making the judgments can have an effect on victim blaming tendencies as found in both vignette studies and research that has used scales to measure victim blame, most commonly the Domestic Violence Blame Scale (DVBS; Petretic-Jackson, Sandberg, & Jackson, 1994). Males are more likely than females to blame a female IPV victim and less likely to encourage a victim to seek help, while for both genders a male victim is more likely to be blamed and the violence he endured is seen as less serious (Romano & De Luca, 2001; Sylaska & Walters, 2014). Victim blaming attitudes have also been found to be more common among older and/or less educated individuals and those who perceive IPV to be more common and acceptable within society (Gracia & Tomás, 2014). Another finding of note in the Gracia & Tomás (2014) study was that if participants knew women who were IPV victims, their likelihood of endorsing victim blaming attitudes when reading IPV vignettes increased. In addition, victims, specifically women, are more likely to be blamed if they defy stereotypes or behave in a way that explicitly violates social norms (Viki & Abrams, 2002). This evidence suggests there could be a general prototype of who a victim is and increased deviance from this prototype (e.g., gay or male; Taylor & Sorenson, 2005) is more likely to result in more victim blame.

Additionally, the actions of the victim and perpetrator can influence people's judgments of who is to blame in an IPV situation. Research participants place more blame on victims and less blame was attributed to perpetrators if the victim is perceived to have provoked the assault, for example by consuming too much alcohol or behaving in a way that could be interpreted as flirtatious (Witte, Schroeder, & Lohr, 2006). In a vignette study, the majority of the time (69.2%) the assailant was attributed causal responsibility, however, 23.1% of attribution ratings assigned equal blame to the assailant and the victim (Taylor & Sorenson, 2005). Fault was assigned equally to the victim and perpetrator when the victim's behavior was considered provocative or negligent leading up to the abuse, the abuse was more frequent within the relationship as opposed to being the first time, or the victim had been drinking (Taylor & Sorenson, 2005). On the other hand, fault was less likely to be assigned to the victim if the violence was more severe, for example the victim needed medical treatment (Taylor & Sorenson, 2005). These results show that individual, situational, and relational factors are taken into consideration when observers determine the amount of blame to place on the victim and perpetrator. While there is some research exploring external factors of how individuals perceive IPV situations, there is a lack of research on how personal experiences of interpersonal violence could impact victim blaming attitudes.

Direct and Indirect Victimization

Currently, there is little research exploring how survivors of IPV conceptualize abusive relationships, specifically taking into consideration victim blaming attitudes. In one of the few articles that assessed participants' IPV involvement, students who reported perpetrating sexual violence in their own relationships were less likely to blame the perpetrator or the situation in a vignette scenario and more likely to blame the victim and society than students who did not

report sexual violence within their relationships (Bryant & Spencer, 2003). These findings could be explained by increased perceived similarity to the perpetrator, because the study only collected data on perpetration of sexual coercion IPV; therefore the findings of less blame attributed to the perpetrator would support the Defensive Attribution Hypothesis. However, because data were only collected for perpetration of IPV the implications for victimization experiences on victim blaming cannot be determined.

Research with other types of interpersonal violence suggests that prior victimization could be a predictor of less victim blaming. Studies of sexual assault victim blame found that individuals who had experienced sexual victimization endorsed higher perceived similarity to the victim and rape victim empathy, while also attributing less blame to the victim (Miller, Amacker, & King, 2011). Related previous research has found differences between survivors and non-traumatized participants in levels of empathy. In a study of acquaintance rape, participants who were raped by someone they knew tended to be more empathetic to victims who shared similar experiences than non-victimized controls; however, levels of empathy were higher in victimized participants for both scenarios than ratings of participants who had not experienced rape (Osman, 2014). Findings for victim blame may be most similar to IPV in scenarios of acquaintance rape, as opposed to stranger rape, because in both instances the victim knows the perpetrator, which should be considered when comparing rape and IPV literature. However, the effect of IPV may be somewhat different due to the unique characteristics of IPV, including its chronic nature and ambivalent feelings towards the perpetrator due to abuse episodes interspersed along “good times” (Jordan, Campbell, & Follingstad, 2010). Thus, research must focus specifically on IPV victimization.

Additionally, the finding that previous victimization leads to less victim blaming has not been found consistently. A separate study found no difference between sexual assault victims and non-victims in levels of victim blame (Mason, Riger, & Foley, 2004). The differing results could possibly be attributed to methodological differences specifically in the measurement of victim blame. For example, some researchers have asked participants to allocate blame to the victim and perpetrator so that the combined score equaled 100%, while others have used a Likert-scale rating each person involved for blame individually. Because there is no “gold standard” for measuring victim blame, more research needs to be done to compare victim blame scales and their validity.

Although frequently co-occurring, indirect exposure to IPV and direct victimization may exert different effects on victim blaming attitudes. Exposure to IPV indirectly could increase victim blaming due to desensitization to violence. There has been a considerable amount of research that shows that witnessing IPV within the home leads to increased normalization of violence (Clarey, Hokoda, & Ulloa, 2013), maladaptive attitudes and beliefs towards violence (Howell, Miller, & Graham-Bermann, 2012), and perpetration of violence (Black et al., 2010). This desensitization toward violence could lead to altered levels of victim blaming compared to the population that has not been exposed to IPV. Greater acceptability of violence was found to be a mediator between witnessing interparental violence and perpetration of IPV (Clarey et al., 2013). This acceptability of violence could be a strong influencing factor in victim blaming beliefs, either by minimizing the violence or having unrealistic expectations for the victims experiencing it. One study found that history of IPV within the family increased college students’ likelihood of attributing blame to societal factors, suggesting an acceptability of

violence, while situational, perpetrator, and victim blame scores were not significantly different between those with indirect exposure to IPV and controls (Bryant & Spencer, 2003).

Witnessing parental violence during childhood and adult victimization often occurs within the same individual's lifetime. Within the literature, there is strong support linking familial violence while growing up to adult IPV victimization (Mihalic & Elliott, 1997; Jin, Eagle, Yoshioka, 2007; Schewe, Riger, Howard, Staggs, & Mason, 2006; Stith, Rosen, Middleton, Busch, Lundeberg & Carlton, 2000). However, these two types of exposure are often studied separately as predictors of outcomes among victims of IPV (Bredin et al., 2014; Simmons et al., 2008; Strigo et al., 2010). In order to gain a better understanding of how both direct and indirect IPV exposure affects victims, it is important to consider how experiencing both of these traumas could affect victim blame.

The Effects of Depression and PTSD on Victim Blaming

Due to the fact that mental health problems are common and often correlate with exposure to IPV, the effect of mental health symptomology on victim blaming is important to consider and could help explain some the mixed findings of the previously reviewed studies. Research within the field has shown that survivors of trauma not only have increased levels of mental health problems but that the resulting mental illness may lead to lower levels of empathy. Empathy has been studied in trauma survivors and results show empathy to be significantly lower after continuous exposure to stress and trauma (Grevin, 1996). People with diagnosed PTSD have been found to have significantly lower levels of empathy when compared to non-traumatized controls (Nietlisbach, Maercker, Rössler, & Haker, 2010). Similarly, people diagnosed with depression have been shown to have significantly lower levels of empathy, when compared to non-depressed controls (Cusi, MacQueen, Spreng, & McKinnon, 2011). Moreover,

functional imaging studies have shown decreased activity in brain areas related to empathy in patients with PTSD (Farrow et al., 2005). Empathy disturbances may cause increased victim blaming beliefs. This mechanism may be particularly relevant for survivors who were directly victimized, as victim empathy has been hypothesized to be a potential pathway between individual experience and victim blaming, such that those with similar experiences are less likely to victim blame. If mental health problems such as depression and PTSD decrease survivor's ability to empathize, psychiatric symptomatology could be a moderating factor in the relation between direct IPV victimization and victim blaming.

Self-blame and guilt are also common outcomes for survivors of IPV who experience symptoms of depression or PTSD, especially in samples where victims are seeking help or protection from the violence (Jordan et al., 2010). Trauma survivors with mental health problems often experience negative cognitions including negative views of themselves. Higher levels of depression in IPV survivors have been linked to increased negative cognitions and self-blame (Beck et al., 2015). Increased self-blame may also contribute to higher victim blaming among survivors of IPV, due to self-blame beliefs translating into the blaming of others who have experienced IPV. Such a relation between victimization, mental health, and victim blame would further support a moderating effect of mental health on the relationship between direct IPV exposure and victim blaming.

Indirect victimization via witnessing IPV while growing up can similarly lead to mental health problems such as anxiety and depression (Capaldi & Clark, 1998) as well as PTSD (Carpenter & Stacks, 2009). In addition to mental health symptomatology, witnessing IPV can lead to the perception of violence as an acceptable way of behaving due to social learning (Bandura, Ross, & Ross, 1961). Similarly, studies on community violence exposure have found

a curvilinear relationship between witnessing violence and depressive symptoms (Gaylord-Harden, Cunningham, & Zelencik, 2011). This finding supports the idea of desensitization as a defense mechanism because the violence exposure is distressing up to a certain point after which emotional numbing or aggression-supporting beliefs become the most common forms of coping (Boxer et al., 2008). Therefore, in addition to exposure to indirect IPV leading to a greater likelihood of mental health symptomology, those who have been exposed to indirect IPV may have even higher levels of victim blame due to an increase in avoidant coping and emotional numbing (Boxer et al., 2008), as well as heightened desensitization to and more acceptability of violence (Gracia & Tomas, 2014).

Rationale

Victim blaming is common practice within American society and throughout the world and is often seen in cases of IPV. Blaming the victim can have deleterious effects on survivors of IPV such as lowered self-esteem, increased likelihood of mental health problems, and lower utilization of formal services (Sylaska & Edwards, 2014). A person's previous exposure to IPV is likely to play a significant role in these attitudes due to increased victim empathy or conversely increased acceptability of violence. However, the relationship between previous direct and indirect IPV exposure and IPV victim blame has been the focus of very limited research. The Defensive Attribution Hypothesis (DAH) posits that victim blaming attitudes decrease as similarity to the victim increases. Research has supported this hypothesis, thus far, showing that less blame is attributed to people in abusive relationships who are more similar to the rater. This theory suggests a person's past exposure to direct IPV would lead to a decrease in victim blame because of the increased similarity between the victim and the rater. On the other

hand, indirect IPV exposure has been associated with higher victim blame in two studies, likely as a result of increased normalization of violence. Notably, indirect and direct victimization experiences are not fully independent experiences, as childhood indirect victimization increases likelihood for adult direct victimization; thus, early IPV witnessing is likely to influence the victim blaming attributions of an IPV survivor. Last, psychopathology, a common outcome for those directly or indirectly exposed to IPV, is also likely to affect blame attributions. Depression or posttraumatic stress disorder (PTSD) could lead to an increase in victim blaming because of diminished capacity to empathize and increased self-blame, which could then be transferred to blame of others, as well as emotional numbing and avoidance symptoms. No research to date has examined the interactive influences of direct and indirect IPV experiences and mental health problems on victim blame.

The purpose of this research was to investigate the relationship of previous exposure to IPV, either direct or indirect, and victim blaming attitudes. Previous research on victim blaming and interpersonal violence suggests that a relationship likely exists; however, IPV victim blame has not been examined as it relates to previous exposure and mental health symptomology specifically. This study used an online questionnaire administered to college students to measure past history of trauma, focusing on direct and indirect IPV involvement, mental health symptomology, and beliefs about IPV. Participants were also asked to read vignettes depicting IPV scenarios and answer questions about fault and responsibility for each of the partners in the relationship. This methodology allowed comparison of different measures of victim blame (vignette and questionnaire), addressing some of the limitations of previous studies. Regressions were used to analyze the relationships between variables of interest, specifically direct and indirect IPV exposure, depression and PTSD symptoms, and victim blame attributions, while

controlling for gender and non-IPV related lifetime trauma exposure because these factors are believed to also influence victim blame. Results contribute to the literature by investigating how previous exposure to IPV and related mental health problems might influence victim blaming tendencies. A better understanding of victim blaming attitudes could help to inform future education and intervention programs. Spreading awareness about IPV in order to decrease victim blame could help mitigate negative outcomes experienced by survivors of both direct and indirect IPV exposure, as well as informing the unexposed population.

Statement of Hypotheses

Hypothesis I: Lifetime experiences of direct IPV victimization will predict current victim blaming; specifically, increases in direct IPV exposure predict decreases in victim blaming.

Hypothesis II: Current mental health symptoms will moderate the effect of direct IPV victimization on victim blaming. For participants with low levels of depression or PTSD, increases in reported direct IPV victimization will lead to lower levels of victim blame. For participants with high levels of depression and PTSD, increases in direct IPV victimization will lead to an increase in victim blame.

Hypothesis III: Lifetime indirect exposure to IPV will predict victim blaming; specifically, increases in indirect IPV exposure predict increases in victim blaming.

Hypothesis IV: Current mental health symptoms will moderate the effect of indirect IPV victimization on victim blaming. For participants with low levels of depression or PTSD, increases in indirect IPV exposure will lead to increases in victim blame. For participants with high levels of depression and PTSD, increases in reported indirect IPV exposure will lead to a greater increase in victim blame, as compared to participants with low mental health symptoms.

Hypothesis V: Direct IPV victimization will moderate the effect of indirect IPV exposure on victim blaming. Because there is minimal previous research addressing this issue, the specific direction of this effect is not hypothesized.

Methods

Participants

Participants for this study were all students that were attending DePaul University in Chicago, Illinois. Qualtrics, an online questionnaire administration resource, was used to collect all data for this study and credit was awarded to students after completion through the DePaul Sona Experiment Management System. In total there were 256 responses, but after data cleaning and processing there were 212 entries classified as valid participants. Participants were asked general demographic questions to help identify the makeup of the sample, including gender, age, year in school, race, sexual orientation, and parents' education levels. The demographics of the final sample are reported below. Data processing is described further in the results section.

Table 1

Demographic Information of Sample

<u>Personal Characteristics</u>	<u><i>n</i> = 212</u>	<u>%</u>
Gender:		
Female	155	73.1%
Male	56	26.4%
Gender-fluid	1	0.5%
Age:		
18	52	24.5%
19	46	21.7%
20	32	15.1%
21	24	11.3%
22+	49	23.1%
Year in School		
Freshman	69	32.5%

Sophomore	55	25.9%
Junior	59	27.8%
Senior	25	11.8%
Other	4	1.9%
Race (check all that apply)		
African American	21	9.9%
Asian or Pacific Islander	28	13.2%
Caucasian/White	134	63.2%
Hispanic or Latino	34	16.0%
Other	7	3.3%
Sexual Orientation		
Heterosexual	189	89.2%
Homosexual	2	0.9%
Bisexual	14	6.6%
Other (Pansexual $n = 5$; Hetero-romantic $n = 2$)	7	3.3%
Highest Level of Education of Mother		
Did not complete high school	9	4.2%
High school/GED	47	22.2%
Some college	54	25.5%
Bachelor's degree	63	29.7%
Master's degree	26	12.3%
Advanced graduate work or Ph.D.	12	5.7%
Not sure	1	0.5%
Highest Level of Education of Father		
Did not complete high school	18	8.5%
High school/GED	49	23.1%
Some college	38	17.9%
Bachelor's degree	54	25.5%
Master's degree	30	14.2%
Advanced graduate work or Ph.D.	18	8.5%
Not sure	5	2.4%

Procedure

Participants were recruited through DePaul University's Psychology Department online research participation subject pool. Students enrolled in courses within the psychology department are encouraged to participate in ongoing research studies as a part of their learning experience and receive course credit for participation. The survey was available to students for approximately 7 weeks and closed at the end of an academic term because the desired number of participants had been reached. All participants started with an informed consent webpage that

indicated the nature of this research and made participants aware that they would be asked about past victimization and trauma. Participants were also informed that their answers were confidential and completing this study does not mean that a report of the violence had been made. If they chose to continue, they completed a demographic questionnaire and well validated questionnaires about traumatic and stressful life events, lifetime IPV victimization and witnessing, current depressive symptoms, current PTSD symptoms, and victim blaming endorsement. All items in the validated scales and vignette questions were required meaning that a participant could not move on in the survey until they had selected an answer. Each participant then read a series of the four vignettes of IPV scenarios and answered questions to assess victim blaming. No identifying information was collected. After participants completed the questionnaires and responded to the vignettes, they were directed to a debriefing page with information and resources regarding IPV as well as the contact information for the investigators on this study in case any participants wanted assistance being connected with resources. Participants were then directed to a separate page where they entered their SONA ID number to receive credit for their course.

Measures

Dependent Variables.

Domestic Violence Blame Scale (DVBS; Petretic-Jackson, Sandberg, & Jackson, 1994). This questionnaire includes 23 items and was used to gauge participants' attitudes toward partner violence. The DVBS was modified to be more applicable to the college population by changing terms such as "husband" and "wife" to "boyfriend" and "girlfriend." A full version of the modified DVBS can be found in Appendix G. In this scale, there are four categories within which blame of partner violence is measured: perpetrator blame (example: "Boyfriends who

physically assault their girlfriends should be locked up”), victim blame (“Girlfriends encourage partner violence by using bad judgment”), societal blame (“Partner violence is a byproduct of a male dominated society”), and situational blame (“Partner violence is more likely to occur in unstable relationships”). Each item was rated on a Likert scale from 1 meaning “strong disagreement” to 6 meaning “strong agreement” and mean scores were obtained for each subscale. The authors of the measure reported adequate reliability and validity (Petretic-Jackson et al., 1994), however, no other psychometric data on this scale has been published. This measure has been used previously within college populations to assess attitudes towards partner violence (Black et al., 2009; Bryant & Spencer, 2003; Postmus, McMahon, Warrener, & Macri, 2011). In the present study, only the victim blame and perpetrator blame subscales were used in analyses. Internal consistency for the DVBS, as measured by Cronbach’s alpha, was adequate to good in the present study, for the victim blame subscale $\alpha = .89$ and for the perpetrator subscale $\alpha = .61$.

Vignettes and Vignette Questions. Vignettes have been used in previous research successfully to measure victim blame attributions with high measures of internal consistency (Taylor & Sorenson, 2005; Witte, Schroeder, & Lohr, 2006). The vignettes were written using models of previous IPV vignette studies (Carlson, 1999; Reddy, Knowles, Mulvany, McMahon, & Freckelton, 1997; Sylaska & Walters, 2014; Taylor & Sorenson, 2005). All four vignettes are included in Appendix H. Vignettes have been previously used in the field along with questionnaires to collect data on attitudes towards stigmatized populations in a less overt manner (Siu et al., 2012). Participants read each of the 4 vignettes in the order they are presented in the Appendix H and then answered questions (listed in Appendix I) immediately after each vignette. To represent a variety of violent relationships and situations, the vignettes varied in: the length of

the relationship (new relationship or dating for a while), frequency of the abuse (the incident being the first time or one of many times) and the type of abuse (belittled/insulted, minor injury, severe injury, and sexual coercion).

Immediately after reading each vignette the participants answered three questions to assess fault and responsibility; these questions were based on a vignette study by Taylor & Sorenson (2005). Participants were asked, "Who do you think is most at fault, that is, who is most responsible, in this situation?", and chose from four options: the assailant's name, the victim's name, they both are responsible, or neither is responsible. Follow-up questions asked participants to separately rate both the assailant's and the victim's responsibility on a scale of 1 (*not at all responsible*) to 10 (*completely responsible*). Participants were then asked, "Who should do something about this situation?", and given the same options: the assailant, the victim, both people, or neither. Participants then rated the degree to which they believed both the assailant and victim should do something about the situation on a scale from 1 (*should not do anything*) to 10 (*should absolutely do something*). The final question was an open-ended question: "What is the most important thing that should be done to make things better?" and participants typed in their responses into a short textbox provided in the survey. The continuous data was used in analyses to get more variance within the sample, instead of the categorical data or the qualitative data from the open-ended question. The internal consistency for the questions that asked participants to rate the victim and the perpetrator separately on a scale from 1-10 was adequate, for victim items $\alpha = .69$ and for perpetrator items $\alpha = .75$, but acceptable due to the exploratory nature of the vignettes and the vignette questions. The first 11 participants did not receive the last vignette in the survey due to researcher error, so these participants had mean

scores calculated out of the three vignettes they did respond to; The mean scores were not significantly different between these participants and those who completed all 4 vignettes.

Predictors.

Center for Epidemiologic Studies Depression Scale (CES-D; Radloff, 1977). A 20-item questionnaire, the CES-D was used to measure the frequency of depressive symptoms during the past week, including: depressed mood, feelings of guilt, feelings of helplessness and hopelessness, psychomotor retardation, decreased appetite, and trouble sleeping. A sample question is “I thought my life had been a failure.” Participants in the study chose from the following options: “Rarely or none of the time (less than 1 day),” “Some or a little of the time (1–2 days),” “Occasionally or a moderate amount of time (3–4 days),” or “Most or all the time (5–7 days).” Some items were worded positively to discourage participants from selecting the same answer for all questions and were reverse scored before summing items into a total score. This scale has high internal consistency ($\alpha = .85$ for the general population and $\alpha = .90$ for clinical samples; Radloff, 1977). Test-retest reliability of this measure is expected to be weaker due to the scale’s focus on current symptomology by asking specifically about the past week. Depending on time between testing the test-retest correlation ranged from .51-.67 (Radloff, 1977). Validity is supported by strong correlations, ranging from .69 to .75, with other clinical measures of depression (Radloff, 1977). This measure has been used widely in IPV research to assess depression levels (Stein et al., 2002; Tschann, Pasch, Flores, Marin, Baisch, & Wibbelsman, 2008). A total score is calculated by summing all item ratings with higher scores indicate more depressive symptoms. A score of 16 represents clinically significant depressive symptoms. For the present study, the CES-D appeared to have excellent internal consistency, $\alpha = .92$.

PTSD Checklist—Civilian Version (PCL-C; Weathers, Litz, Herman, Huska, & Keane, 1994). This questionnaire was used to assess the severity of PTSD symptoms using 17 questions. Directions asked participants to indicate how much they have been bothered by specific PTSD symptoms, for example “Feeling very upset when something reminded you of a stressful experience from the past?” Items were rated on a 5-point Likert scale ranging from 1= *not at all* to 5= *extremely*. The PCL-C has been shown to have very good internal consistency ($\alpha = .94$) as well as good convergent and discriminant validities (Conybeare, Behar, Solomon, Newman, & Borkovec, 2012). Test-retest reliability ranges considerably depending on time between testing from .92 with immediate retesting to .68 for retesting after two weeks (Conybeare et al., 2012). This measure has been used widely in research specifically focusing on IPV exposure and outcomes (Fonzo, Simmons, Thorp, Norman, Paulus, & Stein, 2010; Rodriguez et al., 2008; Sandberg, Suess, & Heaton, 2010). This questionnaire has been used successfully with a wide range of populations (Lang & Stein, 2005; Martinez-Torteya et al., 2014) including college students (Blanchard, Rowell, Kuhn, Rogers, & Wittrock, 2005). A total PTSD score was obtained by summing all item ratings. Scores range from 17 to 85 with a suggested cutoff score of 30 for clinical levels of PTSD symptoms in civilian populations (National Center for PTSD). Internal consistency for the PCL-C in this study was excellent, $\alpha = .94$.

Revised Conflicts Tactics Scale (CTS2; Straus, Hamby, Boney-McCoy, & Sugarman, 1996). The purpose of this 39-item questionnaire was to assess whether the participant had ever directly experienced IPV victimization. Participants rated each item on the CTS2 on a scale of 1–6 based on how often they experienced the listed relationship behaviors within their lifetime. Participants were asked to indicate the frequency of these experiences by selecting one of the

following options: 1 = once, 2 = twice, 3 = 3-5 times, 4 = 6-10 times, 5 = 11-20 times, 6 = more than 20 times, or 0 = they have never experienced the behavior from a partner. This scale was modified slightly by asking participants to indicate how frequently they have experienced each item within their lifetime and if they selected an answer other than “0” a follow-up question asked if they had experienced the item within the last year. The CTS2 has strong content and discriminant validity and internal reliability for each category of abuse: $\alpha = .86$ for physical assault, $\alpha = .86$ for psychological aggression, $\alpha = .95$ for injury, $\alpha = .87$ for sexual coercion, and $\alpha = .86$ for negotiation (Straus, Hamby, Boney-McCoy, & Sugarman, 1996). Test-retest scores for the CTS2 has also been shown to be strong in all categories except sexual coercion which showed weak stability: $r = .76$ for physical assault, $r = .69$ for psychological aggression, $r = .70$ for injury, $r = .30$ sexual coercion, and $r = .60$ for negotiation, (Vega & O’Leary, 2007). The CTS2 has also been tested and shown to have high cross-cultural reliability and validity (Straus, 2004). This measure has been used frequently within the field and specifically for research on IPV, often as an indicator of involvement in a violent relationship (Overbeek, de Schipper, Lamers-Winkelmann, & Schuengel, 2013; Stein, Kennedy, & Twamley, 2002) and successfully with college populations (Hines & Saudino, 2003; Milletich, Kelley, Doane, & Pearson, 2010). The time period for the CTS2 has been modified successfully between studies to meet the needs of the research from the original timeframe written by the authors as “within the last year” (Edwards, Dixon, Gidycz, & Desai, 2014; Jones, Ji, Beck, & Beck, 2002; Straus, Hamby, Boney-McCoy, & Sugarman, 1996). In this study, a total score for lifetime direct IPV victimization was attained by adding subscale scores for physical assault, psychological aggression, and sexual coercion, with higher numbers indicating higher frequency. The injury subscale was not

included in the total IPV score to avoid double-counting of IPV physical assault events that led to injury. In the present study, the CTS2 was found to have good internal consistency, $\alpha = .84$.

Adult-Recall Version of the Revised Conflict Tactics Scale (CTS2-CA; Straus, 1999).

This measure was used to collect data regarding the witnessing of IPV between parents, when the participant was a child or any point in life. The same items that were previously asked of the participant's own relationships was rephrased to ask about abuse between their mother and father, with the exception of sexual coercion category which was removed for the adult-recall version as children are less likely to witness this kind of abuse. Each item was asked twice with the order counterbalanced, half the time with the mother as the perpetrator and the father as the victim first and the other half of the time with the order reversed, for example: "Mother pushed or shoved father" "Father pushed or shoved mother." The timeframe for this questionnaire was also "within your entire life" to collect data about any indirect IPV exposure experienced. The scale was similar to the CTS2, ranging from 1 = once to 6 = more than 20 times and 0 = "This never happened." This version of the CTS2 has good internal consistency with $\alpha = .90$ for mother-to-father violence and $\alpha = .93$ for father-to-mother violence (Milletich, et al., 2010). The present study had good internal consistency for the CTS2-CA, $\alpha = .86$. A total indirect IPV score was calculated by summing physical assault and psychological aggression with higher score indicating higher frequency.

Covariates.

Demographics. Participants were asked their age in years, year in school, gender (female, male, or open-ended response), highest level of education attained by both parents/guardians (Did not complete high school, High school/GED, Some college, Bachelor's degree, Master's degree, Advanced graduate work or Ph.D., or Not sure), ethnicity (African

American/Black, Asian or Pacific Islander, Caucasian/White, Hispanic or Latino, Write-in option, Would rather not say), and sexuality (Heterosexual, Homosexual, or open-ended response).

Life Stressor Checklist-Revised (LSC-R; Wolfe, Kimerling, Brown, Chrestman, & Levin, 1996). This questionnaire consists of 30 items asking about specific traumatic events that the participants may or may not have experienced at some point in their life. The LSC-R asked about a variety of possible traumatic life experiences including natural disasters, physical or sexual assault, accidents, death of a loved one, and other potentially traumatizing events. The published version of this checklist has follow-up questions for each event; however, the scale was revised for the purposes of this study to reduce burden and only asked participants to select “yes” or “no” regarding whether they experienced a specific life stressor. Shortened versions of the LSC-R have been used successfully and shown to be valid with a variety of populations including children, military men, and military women (O'Donovan, 2011; Smith et al., 2013). The LSC-R has been tested and found to have good construct validity (Humphreys et al., 2011). The internal consistency is moderate ($\alpha = .59$), but this is common among life events measures (Schnider, Elhai, & Gray, 2007). Test-retest reliability was found to be relatively high with absolute agreement between administrations of the survey between 84-89% (McHugo et al., 2005). This survey has been used successfully in a range of different age groups (Lieberman, Van Horn, Ippen, 2005) and populations (Humphreys et al., 2011), and specifically with women who have experienced IPV to test other traumatic events in addition to partner violence (Schumacher et al., 2010). A total score was calculated by summing the number of events endorsed. For the present study, internal consistency was found to be good, $\alpha = .75$.

Results

Data Processing

The original Qualtrics dataset had 256 entries, however, 16 were incomplete because participants ended the study prior to completing the survey. During consent, it was stated that the participants could end the study at any point by exiting the browser and their data would not be used, which led to a sample size of 240 participants who completed the survey. Due to the online nature of the study, data cleaning is an important step to ensure data quality because the experimenter has little control over data collection (Rahm & Do, 2000). All responses were examined for the possibility of duplicates by identifying identical demographic information, similar responses on the LSC, and similar write-in answers for the vignette questions, and for the possibility of invalid responses, by reviewing measures that had reverse scored items such as the CTS and the CES-D. Any participants who were believed to be duplicates or to have invalid responses with a high level of certainty were removed from the dataset ($n = 28$ deleted entries). After thoroughly examining each potential participant and eliminating invalid responses, the final dataset included 212 participants. All items were checked to ensure that values were in the correct ranges and average, domain, or total scores were computed (as described in Measures). Lastly, variables that were highly skewed were transformed using a natural logarithm transformation so make the dataset more normal for analyses. The variables that were highly skewed were the CTS2 measure of direct IPV victimization, DVBS victim blame mean score, and vignette perpetrator responsibility factor score. Both the CTS2 and the DVBS victim blame had minimum scores of 0, so a natural logarithm of 1 plus the variable was taken to create a natural logarithm score for each. The natural logarithm scores for the CTS2 and DVBS victim blame had better skewness and kurtosis statistics and, therefore, were used in analyses.

Perpetrator responsibility factor score variable was transformed using both a natural logarithm transformation and square root transformation but neither improved normality of the variable so the untransformed variable was used in analyses.

Data Reduction

Factor analyses were run to test that the structure of the Domestic Violence Blame Scale (DVBS) was upheld within this sample and to examine the participant's responses to the vignette questions. The structure of the DVBS was tested because modifications were made in order to make the scale more relatable to college students, for example changing words like "husband" and "wife" to "boyfriend" and "girlfriend." To test the structure of the modified DVBS, principal axis components extraction with promax rotation was used with 4 factors, based on the four subscales of the original measure. These methods were chosen because principal axis components extraction is the most straight forward method for testing structure and, based on the nature of the original scale, the assumption cannot be made that the factors are independent of each other. The Kaiser-Meyer-Olkin measure of sampling adequacy for the DVBS was .834, which is well above the recommended cutoff of .6. Additionally, Bartlett's test of sphericity was significant ($\chi^2(253) = 2226.84, p < .00$), indicating that the dataset is appropriate for factor analysis.

Eigen values for the first four factors explained 25%, 16%, 11% and 6% of the variance respectively. All other factors explained no more than 4.5%. Altogether, the four factors explained 58% of the total variance. This was compared to a three factor solution which only explained 52% of the variance and five factor solution which had more items that had cross-loadings onto two or more factors. Most item loadings were adequate and supported the item distribution of the original scale. Although there were two items that did not load clearly into one

factor (“A boyfriend who physically assaults his girlfriend should be locked up for the act” and “The boyfriend’s abuse of alcohol and drugs causes partner violence,”), the pattern of factor loadings suggests the structure of the DVBS was generally maintained with modifications for the college population and the subscale scores can be used to represent victim and perpetrator blame.

Table 2 lists the factor loadings of each of the 23 items onto the 4 factors.

Table 2

Factor Loadings Based on a Principal Axis Components Analysis with Promax Rotation for 23 Items from the Domestic Violence Blame Scale (DVBS) (n = 212)

	<u>Victim</u> <u>Blame</u>	<u>Situation</u> <u>Blame</u>	<u>Society</u> <u>Blame</u>	<u>Perp.</u> <u>Blame</u>
Partner violence can be avoided by the girlfriend trying harder to please her boyfriend	.850	.071	.137	.134
Girlfriends are physically assaulted by her boyfriend because they deserve it	.783	-.031	.193	.028
Girlfriends exaggerate the physical and psychological effects of partner violence	.764	.144	.106	.118
The girlfriends encourage partner violence by using bad judgment, provoking the boyfriend’s anger, and so on	.761	.196	.192	.136
It is the girlfriend who provokes the boyfriend to physically assault her	.736	.222	.110	.242
In our society, it is a boyfriend’s prerogative to strike his girlfriend in his own home	.675	.050	.409	-.011
The rise of the “women’s movement” and feminism has increased the occurrence of partner violence	.592	.312	.250	.086
Partner violence is more likely to occur in unstable relationships	.000	.813	.067	.431
Partner violence is more likely to occur when people have poor interpersonal relationships	.086	.812	.212	.488
As stress on the relationship increases, so does the probability of partner violence	.137	.692	.375	.296
Partner violence is more likely to occur in relationships that are socially isolated from the community	.097	.657	.258	.256
Partner violence is more likely to occur in “slum” or bad areas	.346	.556	.126	.206
The boyfriend’s abuse of alcohol and drugs causes partner violence	.055	.528*	.325	.528*
Partner violence occurs because society accepts it	.187	.246	.768	.126
Partner violence is a result of women being regard as	.014	.268	.743	.278

property by society				
Boyfriends physically strike their girlfriends because in our society this is defined as acceptable masculine behavior	.352	.081	.701	.115
Partner violence is the product of a male-dominated society	.065	.294	.691	.348
The amount of sex and violence in the media today strongly influences the boyfriend to physically assault his girlfriend	.176	.169	.581	.104
A boyfriend who physically assaults his girlfriend is “mentally ill” or psychologically disturbed	.086	.203	.028	.636
Partner violence can be mainly attributed to peculiarities in the boyfriend’s personality	.153	.260	.283	.516
Boyfriends who physically assault their girlfriends had dominant, aggressive fathers who also engaged in partner violence	.133	.428	.338	.503
Boyfriends who physically assault their girlfriends cannot control their violent behavior	.341	.324	.129	.469
A boyfriend who physically assaults his girlfriend should be locked up for the act	-.256	.286	.165	.376*

Note. Italicized loadings correspond to the original item classification of the DVBS and bold loadings indicate a factor loading greater than .400. Asterisks indicate items that did not fit the hypothesized factor (one item loaded equally onto two factors and another item did not have any factor loadings above the .400 cutoff).

Exploratory factor analysis was also used to aggregate data from the vignette questions. Principle axis factoring with promax rotation was used with the 16 items asking participants to rate the perpetrator and victim’s responsibility or the degree to which they should do something on a scale of 1-10. The Kaiser-Meyer-Olkin measure of sampling adequacy for these questions was .664, which is above the recommended cutoff of .6, meaning that the correlation matrix represents strong enough correlations between the variables to allow for the use of factor analysis. Additionally, Bartlett’s test of sphericity was significant ($\chi^2(120) = 1396.80, p < .00$) which indicates that the dataset is appropriate for factor analysis.

Two, three, and four factor models were compared. The 3-factor model was deemed as the best solution. The eigen values indicated that the first three factors explained 24%, 18%, and 14% of the variance, respectively for a combined 56% of the variance explained altogether. In contrast, the two factor model explained only 41% of the variance and the four factor model had factor loadings that were not as high and more items that loaded equally onto two factors. The factor analysis confirmed aggregating scores across vignettes. The rotated matrix supported the use of one variable for responsibility scores because items for both perpetrators and victims loaded onto one factor. However, the rotated pattern matrix did not support a “Do Something” score because victim do something scores and perpetrator do something scores loaded onto separate factors. Factor scores from the three factor model were saved and labeled “Vignette Perpetrator Responsibility,” because higher scores indicated more perpetrator responsibility and less victim responsibility, “Vignette Victim Do Something” and “Vignette Perpetrator Do Something.” These variables were used as outcomes in hypotheses testing.

Table 3

Factor Loadings Based on a Principal Axis Components Analysis with Promax Rotation for 16 Items Asked of Participants After They Read the Vignettes (n = 212)

<u>Item</u>	<u>Perpetrator Responsibility</u>	<u>Victim Do Something</u>	<u>Perpetrator Do Something</u>
Rick is responsible	.715	.105	.182
Peter is responsible	.642	.051	.268
Josh is responsible	.512	.035	.197
Jeff is responsible	.432	.059	.250
Martha is responsible	-.386	.028	-.046
Julie is responsible	-.564	.078	.000
Susan is responsible	-.659	.031	-.155
Teresa is responsible	-.719	.002	-.150
Julie should do something about the situation	-.050	.886	-.152
Teresa should do something about the situation	.052	.794	-.217
Susan should do something about the situation	.043	.738	-.238
Martha should do something about the situation	.052	.583	.150

Josh should do something about the situation	.146	-.171	.877
Peter should do something about the situation	.088	-.146	.753
Rick should do something about the situation	.221	-.234	.718
Jeff should do something about the situation	.244	.115	.560

Note. Bold loadings correspond with largest absolute value loading of each factor.

Data Transformation

All variables were evaluated to identify outliers and values that were above 3 standard deviations from the mean were winsorized (Ghosh, & Vogt, 2012). Initial descriptive statistics for winsorized variables are reported in Table 4.

Table 4

Descriptive Statistics for All Scored Variables

Scale/Construct	Min.	Max.	Mean	SD	Skewness	Kurtosis
CTS2 Total IPV Score	0.00	147.19	19.03	27.89	2.05	3.76
CTS2 Total Parental Recall Score	0.00	283.00	55.81	69.66	1.39	1.13
LSC Total Lifetime Trauma	0.00	16.93	5.59	3.63	0.70	0.10
CES-D Depression Score	0.00	52.43	17.76	11.55	0.73	-0.13
PTSD Checklist Score	17.00	78.99	35.26	14.58	0.75	-0.12
DVBS Victim Blame	1.00	6.00	1.66	0.80	1.99	5.06
DVBS Perpetrator Blame	1.00	6.00	3.41	0.91	0.01	0.54
Vignette Perpetrator Responsibility FS	-4.24	0.86	0.00	0.90	-2.07	4.88
Vignette Victim Do Something FS	-1.59	1.41	0.00	0.94	-0.09	-1.35
Vignette Perpetrator Do Something FS	-2.59	.96	0.00	0.94	-1.24	0.47

Prevalence of Direct and Indirect IPV Exposure

Eighty percent ($n = 170$) of participants reported some type of direct IPV victimization within an intimate relationship within their lifetime. Seventy-five percent ($n = 161$) of students in the study reported some level of psychological aggression in their lifetime, and seventy-three

percent ($n = 118$) of those participants reported experiencing this type of abuse within a relationship in the past year. Thirty-one percent of the sample ($n = 65$) experienced physical assault within an intimate relationship, most of which ($n = 43$) occurred within the last year. Additionally, thirty-one percent ($n = 66$) reported being victimized by sexual coercion within a relationship, and seventy-one percent of the sexually victimized group reported sexual coercion IPV within the last year ($n = 47$).

When asked about exposure to IPV between parents, 83% of the participants ($n = 175$) reported witnessing either physical or psychological IPV between their parents at some point. All 83% of participants ($n = 175$) endorsed psychological aggression and 29% of the sample ($n = 62$) reported witnessing physical IPV between their parents indicating that all participants who witnessed physical assault also witnessed psychological aggression.

Prevalence of Clinically Significant Depression and PTSD

A CES-D score of 16 or higher identifies participants that are at risk for clinical depression (Radloff, 1977). This is of note due to the fact that the mean score on the CES-D for this population was 17.76. Exactly 50% of the participants in this study were at or above the clinical cutoff score of 16. For the PTSD measure, a score of 30 is the suggested cutoff for clinically significant symptoms in civilians. Twenty six percent of the participants in this sample scored within this range. Within the sample, 22.6% of participants scored above the clinical cutoff for both depression and PTSD, 30.7% scored above the clinical cutoff either depression or PTSD, and 46.7% scored below clinical cutoffs for both disorders. A large majority of the sample that scored above the clinical cutoff for PTSD also qualified for clinical levels of depression (87%).

Bivariate Correlations

Correlations of all variables included in the hypotheses are listed in Table 5. As expected, direct and indirect IPV were correlated, $r = .277, p < .001$. Additionally, both forms of IPV exposure were correlated with mental health symptoms. Direct IPV victimization was correlated with depression, $r = .136, p < .05$, and PTSD, $r = .232, p < .01$. Indirect IPV victimization was also correlated with depression, $r = .337, p < .001$, and PTSD, $r = .391, p < .001$. Also, the different measures of victim blame were intercorrelated. Unexpectedly, the DVBS victim blame subscale and DVBS perpetrator blame were positively associated, $r = .176, p < .05$. However, the DVBS victim blame subscale was also negatively associated with the vignette perpetrator responsibility FS, $r = -.541, p < .01$, and the vignette perpetrator do something FS, $r = -.166, p < .05$. In addition, the vignette perpetrator do something score was positively correlated with the vignette perpetrator responsibility FS, $r = .242, p < .001$, but negatively associated with the vignette victim do something FS, $r = -.190, p < .01$. Measures of victim blame that correlated with IPV exposure or mental health symptoms include DVBS victim blame and PTSD, $r = .142, p < .05$, and DVBS perpetrator blame and PTSD, $r = .160, p < .05$.

Table 5

Correlations of Variables Included in Hypotheses

<u>Variable</u>	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>	<u>6</u>	<u>7</u>	<u>8</u>	<u>9</u>
1. IPV	—								
2. Parent IPV	.277***	—							
3. CES-D	.136*	.337***	—						
4. PTSD	.232**	.391***	.689***	—					

5. DVBS Victim	-.056	-.042	.098	.142*	—			
6. DVBS Perp.	.051	-.029	-.031	.160*	.176*	—		
7. Perp. Resp. FS	.036	.098	-.078	-.047	-.541**	.089	—	
8. Victim Do Some- thing FS	.043	.113	-.055	-.065	-.106	-.020	.024	—
9. Perp. Do Some- thing FS	.076	-.074	-.015	-.077	-.166*	.034	.242***	-.190**

Note. * $p < .05$. ** $p < .01$. *** $p < .001$.

Participant gender and non-IPV related trauma were believed to be covariates of the dependent and independent variables in this study, so initial correlations were run to test this. Participant gender was correlated with parental IPV exposure, $\tau_b = -.125$, $p = .030$, and the DVBS victim blame subscale, $\tau_b = .146$, $p = .014$, where positive correlations indicated relations to male participants and negative correlations indicated relations to female participants. Total lifetime trauma exposure was correlated with IPV victimization, $r = .438$, $p < .000$, parental IPV exposure, $r = .398$, $p < .000$, depression, $r = .375$, $p < .000$, PTSD, $r = .493$, $p < .000$, and the perpetrator responsibility factor score, $r = .176$, $p = .012$.

Additionally, ANOVAs were run to test if year in school or parent's highest educational level were related to the outcome variables of the DVBS and the vignette factor scores. Group means were not significantly different for any of the outcomes. Therefore, gender and lifetime trauma exposure remained the only covariates that were included in analyses.

Hypothesis Testing

Main effects and the interaction of IPV exposure (both direct IPV victimization and indirect IPV witnessing) and mental health (both depression and PTSD) were hypothesized to

predict victim blame. To test these hypotheses, regressions were run all with gender and lifetime trauma exposure being controlled for, the centered main effects of IPV (direct OR indirect), mental health symptoms (depression OR PTSD), and the centered interaction term as predictors of victim blame. The victim blame outcome was measured in 5 ways: DVBS victim blame, DVBS perpetrator blame, vignette responsibility factor score, vignette victim do something factor score, and vignette perpetrator do something factor score. Tolerance statistics the main effects of all predictors was within normal limits for all regressions.

Hypotheses I and II are both investigating the relationship between direct IPV victimization and victim blame. Hypothesis I stated that increases in direct IPV exposure would predict decreases in victim blame. Hypothesis II stated that current mental health symptoms would moderate the effect of direct IPV victimization. Both hypotheses were tested with two-step regressions where direct IPV scores and mental health (either depression or PTSD scores) were included in the first step of the model (along with covariates), and the second step was the interaction term of direct IPV and either depression or PTSD. Independent models were estimated for DVBS victim blame, DVBS perpetrator blame, vignette responsibility, vignette victim do something, and vignette perpetrator do something as outcomes. Below are the statistics from the best fitting model for each of the regressions that were run.

Using depression as the mental health indicator, the model did not significantly predict DVBS victim blame. Only the main effects of gender ($\beta = .149, t(211) = 2.16, p < .05$) and depression ($\beta = .162, t(211) = 2.21, p < .05$) were significant predictors of variance in DVBS victim blame. Similarly, using PTSD as the mental health indicator, PTSD ($\beta = .247, t(211) = 3.19, p < .05$) was a significant predictor of variance in DVBS victim blame. In contrast, for DVBS perpetrator blame, none of the covariates or predictors from the model with depression as

an index of mental health problems had a significant effect. However, PTSD ($\beta = .185, t(211) = 2.36, p < .05$) was a significant predictor of DVBS perpetrator blame.

Similar regressions were estimated using the vignette factor scores as outcomes. For the model with depression as a mental health indicator, only the main effects of total lifetime trauma ($\beta = .254, t(211) = 3.08, p < .05$) and depression ($\beta = -.158, t(211) = -2.14, p < .05$) were significant predictors of the responsibility factor score. Similarly, in the model with PTSD as a mental health indicator, the main effects of total lifetime trauma ($\beta = .274, t(211) = 3.18, p < .05$) and PTSD ($\beta = -.161, t(211) = -2.06, p < .05$) were significant predictors of variance in vignette responsibility factor score. Neither the main effects of IPV and mental health (either depression or PTSD), or the interaction term were significant predictors of the victim do something or perpetrator do something scores.

Hypotheses III and IV both investigate the relationship between indirect witnessing of IPV and victim blame. Hypothesis III stated that increases in indirect IPV exposure would predict increases in victim blame. Hypothesis IV stated that current mental health symptoms would moderate the effect of indirect IPV victimization on victim blame. Similar to hypotheses I and II, these hypotheses were tested in a two-step regression where lifetime trauma exposure and gender were included in the first step as covariates along with indirect IPV scores and either depression or PTSD scores; included in the second step was the interaction term of indirect IPV and either depression or PTSD.

Results revealed that neither the indirect victimization score or the mental health-by-indirect victimization interaction were significant predictors of DVBS victim blame, DVBS perpetrator blame, vignette responsibility FS, vignette victim do something FS, and vignette perpetrator do something. Otherwise, results mirrored those of the models ran for Hypotheses I

and II: depression was associated with more DVBS victim blame ($\beta = .177, t(211) = 2.40, p < .05$) and less vignette perpetrator responsibility ($\beta = -.171, t(211) = -2.29, p < .05$), PTSD was associated with more DVBS victim ($\beta = .267, t(211) = 3.42, p < .05$) and perpetrator blame ($\beta = .199, t(211) = 2.51, p < .05$), but less vignette perpetrator responsibility ($\beta = -.177, t(211) = -2.24, p < .05$). For covariates, male gender predicted more DVBS victim blame ($\beta = .139, t(211) = 2.02, p < .05$) and lifetime trauma predicted more vignette perpetrator responsibility score ($\beta = .207, t(211) = 2.65, p < .05$).

Hypothesis V involved the interaction of direct IPV victimization and witnessing indirect IPV. To test this hypothesis, a direct IPV-by-indirect IPV interaction score was created and included in the second step of a regression, with covariates and the main effects of direct IPV and indirect IPV in the first step of the regression. Neither direct IPV, indirect IPV, or their interaction, were significant predictors of DVBS victim blame, DVBS perpetrator blame, vignette perpetrator responsibility score, or vignette perpetrator so something score. Only the main effect of lifetime trauma ($\beta = .196, t(211) = 2.36, p < .05$), significantly predicted the outcome of vignette responsibility FS. However, the interaction term of direct IPV-by-indirect IPV significantly predicted the victim do something factor score ($\beta = .164, t(211) = 2.33, p < .05$). This interaction was plotted in SPSS using PROCESS Hayes (2013). Figure 1 illustrates that participants with the highest levels of direct IPV victimization also had lowest levels of victim blame when they also had low levels of indirect IPV exposure. However, at high levels of indirect IPV exposure with high levels of direct IPV victimization, participants endorsed the highest levels of victim blame. Similarly, participants with moderate direct IPV exposure also expressed more victim blame as their exposure to indirect IPV increased. On the other hand,

participants with no direct IPV exposure had similar levels of “victim do something” scores regardless of their indirect victimization experiences.

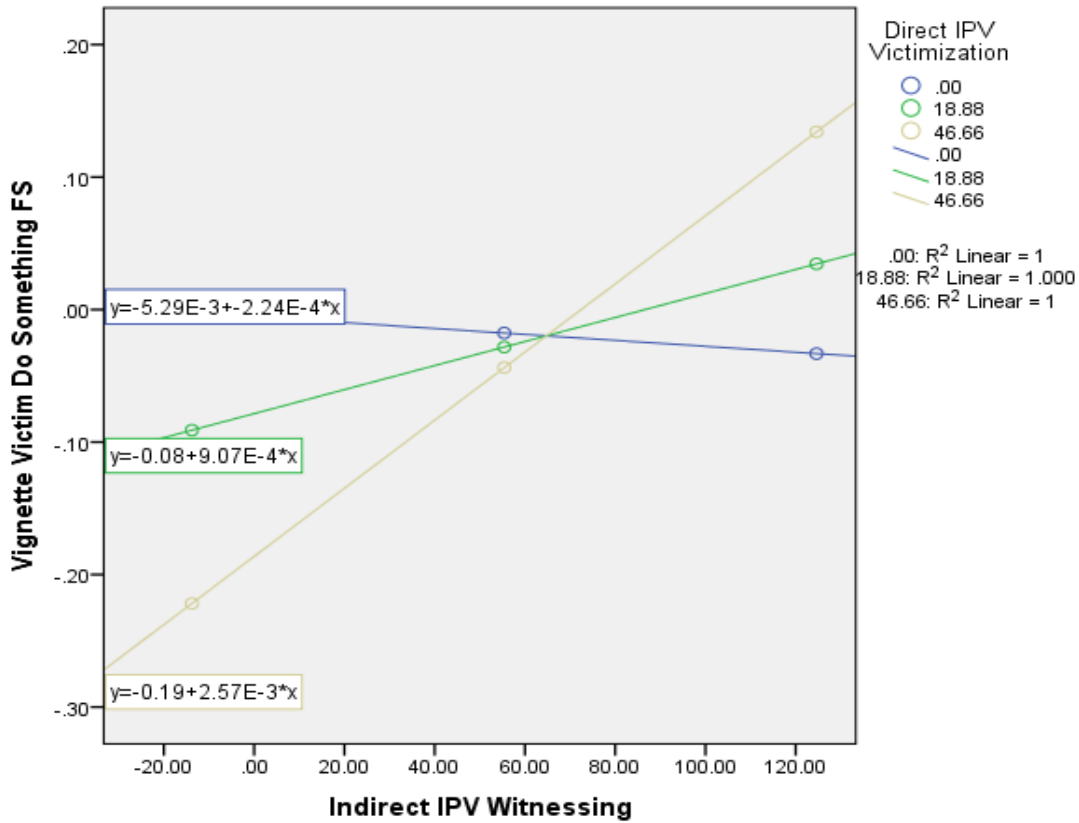


Figure 1. The interaction of indirect IPV and direct IPV victimization on vignette victim do something factor score.

Discussion

The purpose of this study was to explore the effects of direct and indirect IPV exposure and mental health symptoms on victim blame attributions. Past exposure to parental violence while growing up and past and current IPV victimization for each participant was measured along with demographic variables, lifetime trauma, depression and PTSD symptoms in order to explore these how these factors might be related to blame attributions in IPV situations. Direct and indirect IPV victimization were not significant predictors of victim blame. However, direct IPV victimization was found to moderate the relation between indirect IPV witnessing and

victim blame, such that participants with high direct IPV exposure and low IPV witnessing were least likely to say that victims should do something to remedy their abuse, but participants with high direct IPV victimization and high IPV witnessing were most likely to say victims should do something. Hypothesized moderation effects of mental health symptoms on the relationship between IPV exposure (either direct or indirect) and victim blame were not supported; however, the main effects of depression and PTSD were consistently significant, such that more mental health problems were associated with more victim blaming. Last, gender (being female) and more lifetime trauma exposure, included in analyses as covariates, significantly predicted less victim blaming. Findings enhance our understanding of the factors that affect victim blame, provide support for the use of both scale and vignette victim blame measures for college populations, and have the potential to inform future practices and programming related to IPV and victim blame with college students.

Important characteristics of the sample include that all participants were attending DePaul University and the sample was 73% female, 63% identified as Caucasian, and 61% of the sample was 20 years of age or younger. The rates of both forms of IPV exposure were notably higher than population levels reported in the literature for this age group. Eighty percent reported some form of direct IPV victimization within their lifetime and 83% reported witnessing IPV between their parents. These percentages are considerably higher than the estimated 30% prevalence rate for female victimization worldwide of direct IPV victimization (Devries et al., 2013) and 17-58% of parental IPV witnessing that has been found in previous studies (Overbeek et al., 2013; Black et al., 2010). A possible explanation for this is that any lifetime IPV was considered for the prevalence rates within the sample whereas other research has used the cutoff suggested by the authors of the CTS2, which is within the last year (Straus,

Hamby, Boney-McCoy, & Sugarman, 1996). Participants' responses indicate that during the last year 56% experienced psychological aggression, 20% experienced physical assault, and 22% experienced sexual coercion which is more similar to previous reports. Also, prevalence rates may be higher within this sample because college years are a high-risk time for IPV victimization; other research that has focused specifically on the college population has reported similarly high rates of IPV victimization (Black et al., 2011; Fincham, Cui, Braithwaite, & Pasley, 2008).

Additionally, reports of mental health symptoms were notably higher within this sample. In this sample 50% of participants scored above clinical cutoff for depression and 26% scored above the clinical cutoff for PTSD (and most of these participants also had clinical levels of depression). Similar rates of depression have been previously reported for college samples (Garlow et al., 2008), but published studies often report considerably lower prevalence rates of PTSD among college students (Bernat, Ronfeldt, Calhoun, & Arias, 1998). It is possible the nature of the study attracted participants that were trauma-exposed or experiencing more trauma-related psychological symptoms due to the title of the study, "Attitudes Towards Partner Violence." It is also possible that this sample of students is more generally at risk due to the urban environment of the university from where they were recruited. The risks regularly faced by urban students have been found to lead to an increase in psychological symptoms (Breslau, Wilcox, Storr, Lucia, & Anthony, 2004), and previous studies have often used national samples (Black et. al, 2011; Hamby, Finkelhor, Turner, & Ormrod, 2011) within which the additionally stressors of an urban environment are neutralized. Last, the online nature of the study which could have fostered more honest responses due to the anonymity of the survey, and the high rates

found could be more accurate estimates of the struggles that college students face than rates reported by previous studies that used in person or phone data collection.

Because there is no gold standard for measuring victim blame of IPV, this study contributed to the understanding of how victim blame can be measured quantitatively within research. The DVBS has been used often with the general population as well as with college samples (Black et al., 2009; Bryant & Spencer, 2003; Postmus et al., 2011), but the modified version using the words “boyfriend” and “girlfriend” to be more relatable to the college population has not yet been validated. The results suggest that the structure of the scale was maintained with these modifications. Additionally, this study utilized vignettes that were modeled after previous studies that have used vignettes to explore respondents’ victim blaming tendencies (Carlson, 1999; Reddy et al., 1997; Sylaska & Walters, 2014; Taylor & Sorenson, 2005). Exploration of the structure of this is additional measure showed that participants’ responses when asked about responsibility loaded together onto one factor, while responses when asked who should do something did not. In terms of correspondence between the questionnaire and vignette methods, there was a strong negative correlation between the DVBS victim blame score and the vignette perpetrator responsibility FS, $r = -.541, p < .000$, and a negative correlation between DVBS victim blame and vignette perpetrator do something FS, $r = -.166, p < .05$. These findings suggest that, in addition to face validity, the DVBS has good criterion validity because it correlates highly with less overt measures of victim blame. Also, using the vignette questions added to the understanding of participants’ blame attributions and results suggest that “responsibility” and “do something” are fundamentally separate constructs. Therefore, the utilization of vignettes with the responsibility and do something questions allows

the researcher to gain a broader understanding of how participants rate different aspects related to blame in scenarios of IPV.

Direct and indirect IPV exposure did not predict any of the victim blame indices that were used in this study: DVBS victim blame, DVBS perpetrator blame, vignette perpetrator responsibility FS, vignette victim do something FS, or vignette perpetrator do something FS. Results did support the hypothesis that adult IPV victimization moderated the relationship between indirect IPV witnessing and the vignette victim do something factor score. The vignette victim do something factor score was considered an indicator of victim blame because indicating the victim should do something places a sense of fault onto that person by suggesting the IPV would cease if they were to do something about it. An all too familiar example within victim blame in IPV situations is “why doesn’t she leave?” which indicates that in an abusive relationship, the victim is at least partially to blame because her inaction has resulted in the abuse continuing. Participants with high direct IPV victimization had the lowest scores of the vignette victim do something score when they experienced low levels of indirect victimization but, if they experienced high levels of indirect witnessing, this group had the highest scores on this outcome. For participants with no direct IPV victimization, their responses on vignette victim do something questions had no significant changes whether they had low, medium, or high levels of indirect IPV witnessing. These findings suggest that indirect and direct IPV exposure interact to influence victim blame attributions, which is significant to consider because there is an increased likelihood of experiencing adult IPV victimization for people who witness IPV during childhood (Jin et al., 2007; Schewe et al., 2006). These results also are consistent with the literature because victims of high levels of direct IPV may be more empathetic or relate to the victim more

leading to less victim blame unless the individual also witnessed high levels of IPV which can lead to desensitization of violence which could, in turn, lead to increased victim blame.

Notably, only the vignette victim do something score was associated with IPV experiences, while none of the other outcomes were. The victim do something questions were included in data collection to measure a less overt form of victim blame compared to the victim responsibility questions. The inclusion of these items allowed participants to report their belief that the victim should act to end the IPV, which is a form of victim blame. The DVBS victim blame subscale and the vignette responsibility questions were much more overt in blaming the victim for the IPV, and these types of questions may be more susceptible to social desirability biases. Therefore, the significant finding with only the subtlest form of victim blame in this study supports the role of social desirability in these blame attributions which has been found in judgments involving interpersonal violence previously (Abrams, Viki, Masser, & Bohner, 2003). Additionally, the perpetrator blame scores (DVBS and the vignette perpetrator do something factor score) were not strongly correlated with victim do something scores, indicating that participants' ratings of victim do something are distinct from perpetrator blame.

Previous research documents strong connections between IPV exposure and mental health symptoms (Campbell, 2002; Cohen et al., 2013; Exner-Cortens et al., 2013) as well as mental health symptoms and constructs related to victim blame such as self-blame, negative cognitions, and empathy (Beck et al., 2015; Cusi et al., 2011). Results showed that depression was positively associated with DVBS victim blame and negatively associated with vignette perpetrator responsibility FS (i.e., less perpetrator and more victim blame). Similarly, PTSD was positively associated with DVBS victim blame and DVBS perpetrator blame and was negatively associated with vignette perpetrator responsibility FS (i.e., less perpetrator and more victim

blame). These findings support that mental health is associated with victim blame but the relationship with mental health and perpetrator blame is more complicated and that the DVBS and the vignette questions tapped into different constructs because of the opposing relationships comparing PTSD with the DVBS perpetrator blame and the vignette perpetrator responsibility FS. This is consistent with previous research that states that increased mental health symptoms lead to negative cognitions (Beck et al., 2015) and this research has furthered the connection to show correlations with victim blame. However, the hypothesized model of mental health moderating the relationship between IPV and victim blame was not supported, suggesting there are other mechanisms involved. Empathy (Osman, 2014) and observer similarity to victim (Sylaska & Walters, 2014) have been connected to victim blame and these factors were not investigated for this study. It is possible one of these mechanisms, or other unexplored mechanisms such as social or cultural values, would better predict victim blame.

Gender and lifetime trauma exposure were analyzed as covariates because both constructs have been shown in the literature to be related to victim blame, IPV exposure, and mental health symptoms (Romano & De Luca, 2001; Sylaska & Walters, 2014; Ullman & Filipas, 2005). Results were consistent with existing literature and supported the relationship between both gender and lifetime trauma exposure with victim blame outcomes. Generally, males endorsed more victim blame in the DVBS questionnaire. The covariate of gender was not associated with perpetrator blame or any of the vignette factor scores. This could suggest that males and females only vary on the amount of overt victim blame they endorse through the DVBS but are fairly similar on levels of perpetrator blame and on levels of the more covert forms of victim and perpetrator blame as measured by the vignette questions. Lifetime trauma exposure was negatively associated with DVBS victim blame and positively associated vignette

perpetrator responsibility FS, indicating if a person has experienced more trauma in their life, they are less likely to attribute responsibility to the victim but more likely to indicate that the victim should do something about the IPV.

Taken together, the findings could impact clinical practice by showing that multiple factors are interrelated with lifetime trauma, IPV victimization, and mental health outcomes. Clinically, it would be important to take into consideration a person's entire history in addition to any exposure of direct or indirect IPV in order to more fully understand how a person might be processing the trauma of IPV. Also, due to the high amount of exposure to both direct IPV and indirect IPV, it would be beneficial to make resources and treatment more readily available for these types of trauma exposures. Prevalence rates for both direct and indirect IPV were very high for this population of college students which is a seemingly high functioning group of person within the general population, therefore, treatment and resources may be underutilized within the population because these IPV-exposed students are overlooked when assessing need.

The limitations within this study also need to be considered. Using an online survey with undergraduate students who were required to participate in research for course credit allowed for convenient and quick data collection. However, the quality of the data is harder to assess as it possible that students were not answering the survey with complete accuracy or seriously. Additionally, the vignettes and vignette questions were included for exploratory analyses, therefore, the conclusions that can be drawn from them are limited until further research can support this method and its findings. As is, the vignette questions about whether the victim should "do something" could be capturing both victim blame, with higher levels indicating that the violence is the victim's fault for not doing something to end the violence, and victim advocacy, with higher endorsement indicating empowerment and use of resources that the victim

could use. Other limitations include the demographic makeup of the sample, which was mostly female and the large majority identified as heterosexual. Also, the nature of the scales included in the study required retrospective self-reports of IPV and trauma which are not always accurate. However, this study was the first one to integrate the effects of indirect and direct IPV exposure and mental health problems. Future research should continue to investigate the relationship of direct and indirect IPV considering both types of victimization simultaneously instead of separately. Additional research is also needed to further investigate the mechanisms related to victim blame in the context of IPV and to explore these concepts outside of the college population to make results more generalizable to the general public.

To conclude, this study supports existing findings that gender, lifetime trauma exposure, recent IPV victimization, and mental health symptoms for depression and PTSD are related to victim blame attributions while adding to the overall understanding of mechanisms involved in predicting victim blame. Direct and indirect IPV were found to have an interaction effect that predicted victim blame with the direct victimization group having the highest levels of the victim do something factor score when there was also a high level of indirect IPV exposure but this group also had the lowest levels of the victim do something factor score at low levels of indirect IPV exposure. The findings of this study are important for furthering the understanding of victim blame because indirect IPV exposure increases the likelihood that a person will experience direct IPV victimization. This study also highlights the high prevalence rates of IPV, both direct and indirect, as well as mental health symptomology, both depression and PTSD, within a college sample. Recognizing the high rates of IPV and mental health symptoms will hopefully encourage further research and resources be devoted to this population which is at risk for further victimization and mental health problems.

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Appendix A—Demographics Questionnaire

1. Please enter your age:_____
2. What year are you in school:
 - a. Freshman
 - b. Sophomore
 - c. Junior
 - d. Senior
 - e. Other
3. Please select how you identify:
 - a. Female
 - b. Male
 - c. Write-in:_____
4. What is the highest level of education completed by your mother (or other guardian)?
 - a. Did not complete high school
 - b. High school/GED
 - c. Some college
 - d. Bachelor's degree
 - e. Master's degree
 - f. Advanced graduate work or Ph.D.
 - g. Not sure
5. What is the highest level of education completed by your father (or other guardian)?
 - a. Did not complete high school
 - b. High school/GED
 - c. Some college
 - d. Bachelor's degree
 - e. Master's degree
 - f. Advanced graduate work or Ph.D.
 - g. Not sure
6. Please check all that apply:
 - a. African American/Black
 - b. Asian or Pacific Islander
 - c. Caucasian/White
 - d. Hispanic or Latino
 - e. Write-in:_____
 - f. Would rather not say
7. Please select how you identify:
 - a. Heterosexual
 - b. Homosexual
 - c. Bisexual
 - d. Write-in:_____

Appendix B—Life Stressor Checklist-Revised (LSC-R)

READ THIS FIRST: Now we are going to ask some questions about events in your life that are frightening, upsetting, or stressful to most people. Please think back over your **whole life** when you answer these questions. Some of these questions may be about upsetting events you don't usually talk about. Your answers are important, but **you do not have to answer any questions that you do not want to.**

1. Have you ever been in a serious disaster (for example: an earthquake, hurricane, large fire, explosion)?
 - a. Yes
 - b. No
2. Have you ever seen a serious accident (for example: a bad car wreck or an on-the-job accident)?
 - a. Yes
 - b. No
3. Have you ever had a very serious accident or accident-related injury (for example: a bad car wreck or an on-the-job accident)?
 - a. Yes
 - b. No
4. Was a close family member ever sent to jail?
 - a. Yes
 - b. No
5. Have you ever been sent to jail?
 - a. Yes
 - b. No
6. Were you ever put in foster care or put up for adoption?
 - a. Yes
 - b. No
7. Did your parents ever separate or divorce while you were living with them?
 - a. Yes
 - b. No
8. Have you ever had serious money problems (for example: not enough money for food or place to live)?
 - a. Yes
 - b. No
9. Have you ever had a very serious physical or mental illness (for example: cancer, heart attack, serious operation, felt like killing yourself, hospitalized because of nerve problems)?
 - a. Yes
 - b. No

10. Have you ever been emotional abused or neglected (for example: being frequently shamed, embarrassed, ignored, or repeatedly told that you were “no good”)?
 - a. Yes
 - b. No
11. Have you ever been physically neglected (for example: not fed, not properly clothed, or left to take care of yourself when you were too young or ill)?
 - a. Yes
 - b. No
12. Have you ever been responsible for taking care of someone close to you who had a severe physical or mental handicap (for example: cancer, stroke, AIDS, nerve problems, can't hear, see, walk)?
 - a. Yes
 - b. No
13. Has someone close to you died suddenly or unexpectedly (for example: sudden heart attack, murder, or suicide)?
 - a. Yes
 - b. No
14. Has someone close to you died (do NOT include those who died suddenly or unexpectedly)?
 - a. Yes
 - b. No
15. When you were young (before age 16) did you ever see violence between family members (for example: hitting, kicking, slapping, or punching)?
 - a. Yes
 - b. No
16. Have you ever seen a robbery, mugging, or attack taking place?
 - a. Yes
 - b. No
17. Have you ever been robbed, mugged, or physically attacked (not sexually) by someone you did not know?
 - a. Yes
 - b. No
18. *Before age 16*, were you ever abused or physically attacked (not sexually) by someone you knew (for example: a parent, boyfriend, or husband hit, slapped, choked, burned, or beat you up)?
 - a. Yes
 - b. No
19. *After age 16*, were you ever abused or physically attacked (not sexually) by someone you knew (for example: a parent, boyfriend, or husband hit, slapped, choked, burned, or beat you up)?

- a. Yes
 - b. No
20. Have you ever been bothered or harassed by sexual remarks, jokes, or demands for sexual factors by someone at work or school (for example: a coworker, a boss, a customer, another student, or a teacher)?
- a. Yes
 - b. No
21. *Before age 16*, were you ever touched or made to touch someone else in a sexual way because he/she forced you in some way or threatened to harm you if you didn't?
- a. Yes
 - b. No
22. *After age 16*, were you ever touched or made to touch someone else in a sexual way because he/she forced you in some way or threatened to harm you if you didn't?
- a. Yes
 - b. No
23. *Before age 16*, did you ever have sex (oral, anal, genital) when you didn't want to because someone forced you in some way or threatened to hurt you if you didn't?
- a. Yes
 - b. No
24. *After age 16*, did you ever have sex (oral, anal, genital) when you didn't want to because someone forced you in some way or threatened to harm you if you didn't?
- a. Yes
 - b. No
25. Are there any events we did not include that you would like to mention?
- a. Yes. Fill in: _____
 - b. No
26. Have any of the events mentioned above ever happened to someone close to you so that even though you didn't see it yourself, you were seriously upset by it?
- a. Yes. What was the event? _____
 - b. No.

Appendix C—Revised Conflicts Tactics Scale (CTS2)

No matter how well a couple gets along, there are sometimes when they disagree, get annoyed with the other person, want different things from each other, or just have spats or fights because they are in a bad mood, are tired, or for some other reason. Couples also have many different ways of trying to settle their differences. This is a list of things that may happen when you have differences. Please mark how many times a partner had done these things to you during your entire life by selecting from the following options: 1 = once, 2 = twice, 3 = 3-5 times, 4 = 6-10 times, 5 = 11-20 times, 6 = more than 20 times, or 0 = I have never experienced the behavior from a partner. If you indicate that a specific experience has happened to you (by choosing any option other than 0), a follow-up question will be asked: Has this happened within the last year? (Yes, No answer options).

0= This never happened

1= Once

2= Twice

3= 3-5 times

4= 6-10 times

5= 11-20 times

6= More than 20 times

How often has this happened in your life?

1. My partner showed care for me even though we disagreed
(If 1-6 is selected, indicating this has happened): Has this happened within the last year?
 - a. Yes
 - b. No
2. My partner explained his or her side of a disagreement to me
(If 1-6 is selected, indicating this has happened): Has this happened within the last year?
 - a. Yes
 - b. No
3. My partner insulted or swore at me
(If 1-6 is selected, indicating this has happened): Has this happened within the last year?
 - a. Yes
 - b. No
4. My partner threw something at me that could hurt
(If 1-6 is selected, indicating this has happened): Has this happened within the last year?
 - a. Yes
 - b. No

5. My partner twisted my arm or hair
(If 1-6 is selected, indicating this has happened): Has this happened within the last year?
 - a. Yes
 - b. No
6. I had a sprain, bruise, or small cut because of a fight with my partner
(If 1-6 is selected, indicating this has happened): Has this happened within the last year?
 - a. Yes
 - b. No
7. My partner showed respect for my feelings about an issue
(If 1-6 is selected, indicating this has happened): Has this happened within the last year?
 - a. Yes
 - b. No
8. My partner made me have sex without a condom
(If 1-6 is selected, indicating this has happened): Has this happened within the last year?
 - a. Yes
 - b. No
9. My partner pushed or shoved me
(If 1-6 is selected, indicating this has happened): Has this happened within the last year?
 - a. Yes
 - b. No
10. My partner used force (like hitting, holding down, or using a weapon) to make me have oral or anal sex
(If 1-6 is selected, indicating this has happened): Has this happened within the last year?
 - a. Yes
 - b. No
11. My partner used a knife or gun on me
(If 1-6 is selected, indicating this has happened): Has this happened within the last year?
 - a. Yes
 - b. No
12. I passed out from being hit in the head by my partner in a fight
(If 1-6 is selected, indicating this has happened): Has this happened within the last year?
 - a. Yes
 - b. No
13. My partner called me fat or ugly
(If 1-6 is selected, indicating this has happened): Has this happened within the last year?
 - a. Yes
 - b. No

14. My partner punched or hit me with something that could hurt
(If 1-6 is selected, indicating this has happened): Has this happened within the last year?
a. Yes
b. No
15. My partner destroyed something belonging to me
(If 1-6 is selected, indicating this has happened): Has this happened within the last year?
a. Yes
b. No
16. I went to a doctor because of a fight with my partner
(If 1-6 is selected, indicating this has happened): Has this happened within the last year?
a. Yes
b. No
17. My partner choked me
(If 1-6 is selected, indicating this has happened): Has this happened within the last year?
a. Yes
b. No
18. My partner shouted or yelled at me
(If 1-6 is selected, indicating this has happened): Has this happened within the last year?
a. Yes
b. No
19. My partner slammed me against a wall
(If 1-6 is selected, indicating this has happened): Has this happened within the last year?
a. Yes
b. No
20. My partner was sure we could work out a problem
(If 1-6 is selected, indicating this has happened): Has this happened within the last year?
a. Yes
b. No
21. I needed to see a doctor because of a fight with my partner, but I didn't
(If 1-6 is selected, indicating this has happened): Has this happened within the last year?
a. Yes
b. No
22. My partner beat me up
(If 1-6 is selected, indicating this has happened): Has this happened within the last year?
a. Yes
b. No
23. My partner grabbed me
(If 1-6 is selected, indicating this has happened): Has this happened within the last year?
a. Yes
b. No

24. My partner used force (like hitting, holding down, or using a weapon) to make me have sex
(If 1-6 is selected, indicating this has happened): Has this happened within the last year?
a. Yes
b. No
25. My partner stomped out of the room, or house, or yard during a disagreement
(If 1-6 is selected, indicating this has happened): Has this happened within the last year?
a. Yes
b. No
26. My partner insisted on sex when I did not want to (but did not use physical force)
(If 1-6 is selected, indicating this has happened): Has this happened within the last year?
a. Yes
b. No
27. My partner slapped me
(If 1-6 is selected, indicating this has happened): Has this happened within the last year?
a. Yes
b. No
28. I had a broken bone from a fight with my partner
(If 1-6 is selected, indicating this has happened): Has this happened within the last year?
a. Yes
b. No
29. My partner used threats to make me have oral or anal sex
(If 1-6 is selected, indicating this has happened): Has this happened within the last year?
a. Yes
b. No
30. My partner suggested a compromise to a disagreement
(If 1-6 is selected, indicating this has happened): Has this happened within the last year?
a. Yes
b. No
31. My partner burned or scalded me on purpose
(If 1-6 is selected, indicating this has happened): Has this happened within the last year?
a. Yes
b. No
32. My partner insisted on oral or anal sex (but did not use physical force)
(If 1-6 is selected, indicating this has happened): Has this happened within the last year?
a. Yes
b. No

33. My partner accused me of being a lousy lover
(If 1-6 is selected, indicating this has happened): Has this happened within the last year?
a. Yes
b. No
34. My partner did something to spite me
(If 1-6 is selected, indicating this has happened): Has this happened within the last year?
a. Yes
b. No
35. My partner threatened to hit or throw something at me
(If 1-6 is selected, indicating this has happened): Has this happened within the last year?
a. Yes
b. No
36. I felt physical pain that still hurt the next day because of a fight with my partner
(If 1-6 is selected, indicating this has happened): Has this happened within the last year?
a. Yes
b. No
37. My partner kicked me
(If 1-6 is selected, indicating this has happened): Has this happened within the last year?
a. Yes
b. No
38. My partner used threats to make me have sex
(If 1-6 is selected, indicating this has happened): Has this happened within the last year?
a. Yes
b. No
39. My partner agreed to a solution I suggested
(If 1-6 is selected, indicating this has happened): Has this happened within the last year?
a. Yes
b. No

Appendix D—Adult Recall Version of the Revised Conflicts Tactics Scale (CTS2-CA)

No matter how well parents get along, there are times when they disagree, get annoyed with each other, want different things from each other, or just have spats or fights because they are in a bad mood, are tired, or for some other reason. Parents also have many different ways of trying to settle their differences with each other. This is a list of things that might happen when your parents has differences or were angry with each other.

If your mother and father (or step mother or step father) were not living together and you were living with your mother, please answer about your mother and the man she was living with then. If you were living with your father or step father, but not your mother, please answer about your father and the woman he was living with then.

Please circle how many times each of them did the things on this list in your lifetime. If a parent did not do one of these things then please circle “0.” How often did this happen in your lifetime?

0= This never happened

1= Once

2= Twice

3= 3-5 times

4= 6-10 times

5= 11-20 times

6= More than 20 times

1. Mother showed she cared about father even when they disagreed
2. Father showed he cared about mother even when they disagreed
3. Father explained his side of a disagreement to mother
4. Mother explained her side of a disagreement to father
5. Mother insulted or swore at father
6. Father insulted or swore at mother
7. Father threw something at father that could hurt
8. Mother threw something at father that could hurt
9. Mother twisted father's arm or hair
10. Father twisted mother's arm or hair
11. Father had a sprain, bruise, or small cut because of a fight with mother
12. Mother had a sprain, bruise, or small cut because of a fight with father
13. Mother showed respect for father's feelings about an issue
14. Father showed respect for mother's feelings about an issue

15. Father pushed or shoved father
16. Mother pushed or shoved father

17. Mother used a knife or gun on father
18. Father used a knife or gun on mother

19. Father passed out from being hit on the head by father in a fight
20. Mother passed out from a hit on the head in a fight with mother

21. Mother called father fat or ugly
22. Father called mother fat or ugly

23. Father punched or hit mother with something that could hurt
24. Mother punched or hit father with something that could hurt

25. Mother destroyed something belonging to father
26. Father destroyed something belonging to mother

27. Father went to a doctor because of a fight with mother
28. Mother went to a doctor because of a fight with father

29. Mother choked father
30. Father choked mother

31. Father shouted or yelled at mother
32. Mother shouted or yelled at father

33. Mother slammed father against a wall
34. Father slammed mother against a wall

35. Father said he was sure they could work out a problem
36. Mother said she was sure they could work out a problem

37. Mother needed to see a doctor because of a fight with father, but didn't go
38. Father needed to see a doctor because of a fight with mother, but didn't go

39. Father beat up mother
40. Mother beat up father

41. Mother grabbed father
42. Father grabbed mother

43. Father stomped out of the room or house or yard when he had a disagreement with mother

44. Mother stomped out of the room or house or yard when she had a disagreement with father
45. Mother slapped father
46. Father slapped mother
47. Father had a broken bone from a fight with mother
48. Mother had a broken bone from a fight with father
49. Mother suggested a compromise to a disagreement with father
50. Father suggested a compromise to a disagreement with mother
51. Father burned or scalded mother on purpose
52. Mother burned or scalded father on purpose
53. Mother did something to spite father
54. Father did something to spite mother
55. Father threatened to hit or throw something at mother
56. Mother threatened to hit or throw something at father
57. Mother still felt physical pain the next day because of a fight with father
58. Father still felt physical pain the next day because of a fight with mother
59. Father kicked mother
60. Mother kicked father
61. Mother agreed to try a solution to a disagreement suggested by father
62. Father agreed to try a solution to a disagreement suggested by mother

Appendix E—Center for Epidemiologic Studies Depression Scale (CES-D)

Below is a list of the ways you might have felt or behaved. Please mark how often you have felt this way during the past week.

During the past week . . .	Rarely or none of the time (less than 1 day)	Some or a little of the time (1-2 days)	Occasionally or a moderate amount of time (3-4 days)	Most of all the time (5-7 days)
1. I was bothered by things that usually don't bother me.				
2. I did not feel like eating; my appetite was poor.				
3. I felt that I could not shake off the blues even with help from my family or friends.				
4. I felt I was just as good as other people.				
5. I had trouble keeping my mind on what I was doing.				
6. I felt depressed.				
7. I felt that everything I did was an effort.				
8. I felt hopeful about the future.				
9. I thought my life had been a failure.				
10. I felt fearful.				
11. My sleep was restless.				
12. I was happy.				
13. I talked less than usual.				
14. I felt lonely.				
15. People were unfriendly.				
16. I enjoyed life.				
17. I had crying spells.				

18. I felt sad.				
19. I felt that people dislike me.				
20. I could not get "going."				

Appendix F—PTSD Checklist—Civilian Version (PCL-C)

Below is a list of problems and complaints that people sometimes have in response to stressful life experiences. Please read each one carefully, then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

- 1= Not at all
- 2= A little bit
- 3= Moderately
- 4= Quite a bit
- 5= Extremely

1. Repeated, disturbing memories, thoughts, or images of a stressful experience from the past?
1 2 3 4 5
2. Repeated, disturbing dreams of a stressful experience from the past?
1 2 3 4 5
3. Suddenly acting or feeling as if a stressful experience were happening again (as if you were reliving it)?
1 2 3 4 5
4. Feeling very upset when something reminded you of a stressful experience from the past?
1 2 3 4 5
5. Having physical reactions (e.g. heart pounding, trouble breathing, sweating) when something reminded you of a stressful experience from the past?
1 2 3 4 5
6. Avoiding thinking about or talking about a stressful experience from the past or avoiding having feelings related to it?
1 2 3 4 5
7. Avoiding activities or situations because they reminded you of a stressful experience from the past?
1 2 3 4 5
8. Trouble remembering important parts of a stressful experience from the past?
1 2 3 4 5
9. Loss of interest in activities that you used to enjoy?
1 2 3 4 5
10. Feeling distant or cut off other people?
1 2 3 4 5
11. Feeling emotionally numb or being unable to have loving feelings for those close to you?
1 2 3 4 5
12. Feeling as if your future will somehow be cut short?
1 2 3 4 5

13. Trouble falling or staying asleep?	1	2	3	4	5
14. Feeling irritable or having angry outbursts?	1	2	3	4	5
15. Having difficulty concentrating?	1	2	3	4	5
16. Being “super-alert” or watchful or on guard?	1	2	3	4	5
17. Feeling jumpy or easily startled?	1	2	3	4	5

Appendix G—Domestic Violence Blame Scale (DVBS):

Listed below are statements sometimes used to account for violence within relationships. The boyfriend will always be the assailant and the girlfriend will be the victim in these statements, however, violence can go in either or both directions or any type of relationship.

Please indicate your agreement/disagreement with or perception of the frequency of these statements based on the six point scale below:

Strongly Disagree 1 2 3 4 5 6 Strongly Agree

- | | | | | | | |
|--|---|---|---|---|---|---|
| 1. The amount of sex and violence in the media today strongly influenced the boyfriend to physically assault his girlfriend. | | | | | | |
| | 1 | 2 | 3 | 4 | 5 | 6 |
| 2. Partner violence is a result of women being regarded as property by society | | | | | | |
| | 1 | 2 | 3 | 4 | 5 | 6 |
| 3. A boyfriend who physically assaults his girlfriend should be locked up for the act. | | | | | | |
| | 1 | 2 | 3 | 4 | 5 | 6 |
| 4. A boyfriend who physically assaults his girlfriend is “mentally ill” or psychologically disturbed. | | | | | | |
| | 1 | 2 | 3 | 4 | 5 | 6 |
| 5. Partner violence can be mainly attributed to peculiarities in the boyfriend’s personality. | | | | | | |
| | 1 | 2 | 3 | 4 | 5 | 6 |
| 6. It is the girlfriend who provoked the boyfriend to physically assault her. | | | | | | |
| | 1 | 2 | 3 | 4 | 5 | 6 |
| 7. Partner violence is the product of a male-dominated society. | | | | | | |
| | 1 | 2 | 3 | 4 | 5 | 6 |
| 8. The girlfriends encourage partner violence by using bad judgement, provoking the boyfriend’s anger, and so on. | | | | | | |
| | 1 | 2 | 3 | 4 | 5 | 6 |
| 9. The girlfriend was physically assaulted by her boyfriend because she deserved it. | | | | | | |
| | 1 | 2 | 3 | 4 | 5 | 6 |
| 10. Partner violence can be avoided by the girlfriend trying harder to please her boyfriend. | | | | | | |
| | 1 | 2 | 3 | 4 | 5 | 6 |
| 11. Partner violence is more likely to occur in unstable relationships. | | | | | | |
| | 1 | 2 | 3 | 4 | 5 | 6 |
| 12. Partner violence is more likely to occur when people have poor interpersonal relationships. | | | | | | |
| | 1 | 2 | 3 | 4 | 5 | 6 |
| 13. The boyfriend’s abuse of alcohol and drugs causes partner violence. | | | | | | |
| | 1 | 2 | 3 | 4 | 5 | 6 |

14. Partner violence occurs because society accepts it. 1 2 3 4 5 6
15. Partner violence is more likely to occur in “slum” or bad areas. 1 2 3 4 5 6
16. As stress on the relationship increased, so did the probability of partner violence. 1 2 3 4 5 6
17. Partner violence is more likely to occur in relationships that are socially isolated from the community. 1 2 3 4 5 6
18. The boyfriend who physically assaulted his girlfriend cannot control his violent behavior. 1 2 3 4 5 6
19. The boyfriend who physically assaulted his girlfriend had a dominant, aggressive father who also engaged in partner violence. 1 2 3 4 5 6
20. The rise of the “women’s movement” and feminism has increased the occurrence of domestic violence. 1 2 3 4 5 6
21. Girlfriends exaggerate the physical and psychological effects of partner violence. 1 2 3 4 5 6
22. In our society, it is a boyfriend’s prerogative to strike his girlfriend in his own home. 1 2 3 4 5 6
23. Boyfriends physically strike their girlfriends because in our society this is defined as acceptable masculine behavior. 1 2 3 4 5 6

Appendix H—Vignettes

Verbal abuse

Martha and Jeff are two college students that have casually dated for a few months and have had sex. One night, they go to a party together and they both drink throughout the night. Jeff notices that Martha is spending a lot of time with another guy at the party. While walking home, Jeff gets angry at Martha because of the other guy at the party. She denies talking to other guys and says that he is imagining things. Martha decides to go back to her dorm instead of spending the night at Jeff's. Jeff calls Martha a "lousy lover" and "an ugly skank." He also says that he never should have brought her to the party and that he could have taken any girl home. Then, Jeff tries one more time to convince Martha to come back to his place but when she refuses, he swears at her and storms off. This kind of thing has happened repeatedly.

Minor injury

Julie and Josh have been dating for about 10 months. They met through a mutual friend who believed they would make the perfect pair and they seem quite happy together. Since the school year started, there has been some tension building in their relationship. Josh has been stressed about his classes and has been starting fights quite frequently because he is jealous that Julie spends much of her time with other guys; Josh genuinely believes that Julie is cheating on him. Josh gets very heated during these fights and, in his anger, has thrown things around the room. One night, after they each had a drink or two in Julie's room after dinner, they started fighting. Josh grabbed Julie and slapped her face after she denied, once again, cheating on him. This is the first time that Josh has ever hit Julie. He leaves the room and calls the next day to apologize.

Severe injury

Susan and Peter attend the same college and have been dating for seven months. One day, Peter's soccer team suffered a season ending loss and afterwards he spent three hours drinking with his teammates. Knowing how bad tempered Peter could be when he had been drinking and his team had lost, Susan tried to avoid upsetting her boyfriend. Peter walked into Susan's apartment and threw the dinner she had made him at her. He then held her in a headlock for a long time while he accused her of not caring about his team. The neighbors in their apartment building called the police when they heard Susan's screams. Peter was taken to the station for the night. He had a blood alcohol content of .32 percent. Susan was hospitalized that night for severe bruising and head injuries and was released three days later. This was the first time that Susan had been injured during a fight with Peter.

Sexual coercion

Teresa and Rick are seniors in college that have been dating for 3 years and live together. One evening, they attended a party together but Teresa decided not to drink because she had to wake up early the next morning to study for a midterm. They spent most of the time at the party with each other hanging out with their mutual friends. At the end of the night, while walking home, Rick accused Teresa of prioritizing academics before their relationship and a heated argument between the two ensued. After arguing the entire walk home, they reached their shared house but the disagreement was far from settled. Instead of communicating, Rick refused to listen to what Teresa had to say despite her repeated efforts to make him understand her side. Then he threatened to hurt her and pressured her to have sex. This was the first time that an incident like this had happened between them.

Appendix I—Vignette Questions:

1. Who do you think is most at fault, that is, who is most responsible, in this situation?
 - a. [Perpetrator's name] is most responsible
 - b. [Victim's name] is most responsible
 - c. They are both responsible
 - d. Neither is responsible

2. Please indicate the degree to which you believe [Victim's name] is responsible:
1 2 3 4 5 6 7 8 9 10

3. Please indicate the degree to which you believe [Perpetrator's name] is responsible:
1 2 3 4 5 6 7 8 9 10

4. Who should do something about this situation?
 - a. [Perpetrator's name] should
 - b. [Victim's name] should
 - c. Both should
 - d. Neither should

5. Please indicate the degree to which you believe [Victim's name] should do something about the situation:
1 2 3 4 5 6 7 8 9 10

6. Please indicate the degree to which you believe [Perpetrator's name] should do something about the situation:
1 2 3 4 5 6 7 8 9 10

7. What is the most important thing that should be done to make things better?
[Open Ended]