Do you see what I see? : testing the effects of race and social class on therapists' recognition of and attributions for intimate partner violence

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Do You See What I See? Testing the Effects of Race and Social Class on Therapists’ Recognition of and Attributions for Intimate Partner Violence

by

Susana Blanco

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Abstract

An estimated 5.3 million intimate partner violence (IPV) victimizations occur among U.S. women each year (Center for Disease Control and Prevention, 2008). Because of the high prevalence, Harway and Hansen (2004) recommended that therapists assume that all women presenting for therapy may be at risk for violence. However, assessment for IPV is not standard practice. In fact, studies repeatedly indicate that therapists tend to under-identify IPV (e.g., Harway & Hansen, 1993).

Based on attribution theory, this analogue study was designed to assess whether therapists would recognize IPV in a clinical vignette and, when they did, if their causal attributions and the perceived severity of the IPV would differ based on the client’s race and socio-economic status (SES). Based on the stereotyping literature, it was predicted that IPV would be disproportionately identified when a client is White rather than Black, and high-SES rather than low-SES.

Results showed that only 55% of participants in the sample listed IPV as one of up to five clinical problems after reading a case vignette in which a female client was “hit in the face.” An additional 18% of participants listed IPV as the cause of a different clinical problem (e.g., depression), but 26% failed to identify IPV altogether.

Among the 74% who did see IPV as a problem and/or cause, recognition was significantly more likely when the client was depicted as White versus Black. However, identification of IPV did not differ based on the client’s SES. In terms of perceived severity, no race or SES bias was evident, but participants who recognized IPV saw it as severe. Likewise, there were no race or SES differences in participants’ attributions for
IPV, which tended to be relatively more external (e.g., due to “husband’s anger and violent behavior”) than internal to the client (e.g., due to “low-self-esteem”).

This was the first investigation based on attribution theory to examine the influence of stereotyping on therapists’ recognition of IPV. The under-identification supports the ongoing need for therapists to be trained to recognize IPV. These results have particularly significance for therapists working with African-American women, who are disproportionately affected by IPV.
Chapter 1

*Statement of the Problem and Review of Literature*

Intimate Partner Violence (IPV) is a pervasive problem that affects men, children, and women worldwide. Despite an increased awareness about the importance of understanding and eradicating IPV, it continues to be a serious problem. Although there is evidence that both men and women are victims of IPV, research has consistently found that women are overwhelmingly more likely than men to suffer from IPV (Tjaden & Thoennes, 2000). In fact, U.S. women between the ages of 16 to 24 are most likely to be victimized by an intimate partner (U.S. Bureau of Justice, 2007). According to the U.S. Bureau of Justice (2007), between 2001 and 2005, non-fatal intimate partner victimizations represented an average of 22% of the non-fatal violent victimizations of girls and women aged 12 and older. An estimated 5.3 million IPV victimizations occur among U.S. women each year, resulting in nearly 2 million injuries, of which more than 550,000 require medical attention (Center for Disease Control and Prevention, 2008).

The general purpose of the present study was to assess therapists’ recognition and assessment of IPV based on client race and socio-economic status (SES). The terms *domestic violence, domestic abuse, spousal abuse, child abuse, family violence,* and *elder abuse* broadly define a pattern of abusive behaviors by one or both participants in an intimate relationship (i.e., marriage, dating, family, friends or cohabitation). Because of the overlap in definitions, IPV is often used interchangeably with these other terms. However, *intimate partner violence* refers specifically to violence between current and former spouses or dating partners. Furthermore, although IPV can be considered a subset of domestic violence that is specific to a romantic partner, it does not necessarily need to
occur in a shared domestic dwelling. IPV includes (a) physical violence, such as slaps, punches, kicks, and assaults with a weapon (which may lead to homicide); (a) sexual violence, such as sexual coercion, rape, verbal threats, harassment, etc.; and (c) psychological violence, such as insults, intimidation and withholding resources (sometimes referred to as intimate terrorism) (Center for Disease Control and Prevention, 2008).

Like other forms of domestic violence, IPV is typically accompanied by emotional or psychological abuse, (Tjaden & Thoennes, 2000), which often leads to serious physical and psychological consequences, including depression, anxiety, suicidality, drug addiction and decreased immune system functioning (Center for Disease Control and Prevention, 2008). Research suggests that women who are victims of IPV also experience more mental health problems such as alcohol abuse (Lipsky & Caetano, 2008) and depression (Campbell & Gary, 1998). Furthermore, an association was reported by Campbell (2002) between the severity of IPV and (a) alcohol abuse and (b) mental health difficulties in victims of IPV.

Over the past two decades, scholars have emphasized the importance of training psychotherapists to assess their clients for IPV (Bograd, 1984; Hansen, Harway, & Cevantes, 1991; Harway & Hansen, 1993; McClowsky & Grisby, 2005). Because of the high prevalence of IPV (U.S. Bureau of Justice, 2007), it has been recommended that therapists assume that all women who present for therapy may be at risk for violence; however, this assumption is not standard practice (Harway & Hansen, 2004).

IPV is an abuse of power that deprives individuals of their physical safety and psychological health. Despite increased awareness about the need to assess and address
IPV in psychotherapy, therapist recognition of IPV continues to be problematic (Hansen et al., 1991; Harway & Hansen, 1993; McCloskey & Grigsby, 2005). Despite repeated attention to this problem in the literature, many therapists appear to lack the necessary skills to recognize or assess IPV and, therefore, have a tendency to under-identify it (Harway & Hansen, 2004). Although little is known about whether therapists’ stereotypes contribute to the under-recognition of IPV, there is some evidence that stereotypes about IPV affect the ability of lay people (Donovan, 2007) and helping professionals (Peterson-Lewis et al., 1988) to recognize IPV as problematic.

Regardless of treatment intervention modality, identifying risk factors and maximizing the safety of clients is central to ethical practice. However, studies indicate that regardless of theoretical approach, therapists tend to under-identify IPV (Harway & Hansen, 1993; Hansen & Harway, 2004). Douglas (1991) suggested that violence may go undetected in a therapeutic context because therapists tend to have preconceived ideas about perpetrators and victims of violence. Furthermore, therapists may fail to recognize or assess for violence when their client does not fit the therapist’s preconceived ideas and conceptual framework (Bograd & Mederos, 1999). Even in cases where IPV is detected, service providers, including therapists, have been criticized for inadequate intervention (Harway & Hansen, 2004).

Although research suggests that a therapist’s explicit assessment of IPV significantly increases the likelihood of disclosure (Aldarondo & Straus, 1994), many victims of violence express reservations about disclosing abuse to therapists, fearing that they may be blamed for their victimization (Hathaway, Willis, & Zimmer, 2002). According to Bograd (1999), stereotypes about race and class can give rise to victim
blaming. Victim blaming refers to a self-protective stance that stems from the need to see the world as just, to protect oneself from blame, and to feel a sense of control over the world (Hansen, Harway & Ceventes, 1991; Harway & Hansen, 2004). That is, believing that an individual characteristic, like a victim’s race or SES, low-self esteem, lack of self-worth, poor coping skills causes victimization may be easier than believing that violence can occur in any intimate relationship.

Therapists’ ability to identify IPV and their appraisals of IPV are not only relevant for treatment planning but also because if therapists’ stereotypes are conveyed implicitly or explicitly to clients, they may damage the therapeutic relationship. Indeed, it has been noted that the outcome of treatment can be affected by the manner in which violence is identified and addressed (Aldarondo & Straus, 1994) and that failure to address IPV may place a victim at risk of further harm (Douglas, 1991; Hansen et al., 1991).

Because stereotypes and myths about IPV are likely to influence how individuals attribute responsibility and blame, therapists have been encouraged to challenge their biases in order to avoid victim-blaming when assessing and treating victims of IPV (Bent-Goodley, 2007). Although some evidence suggests that many women do not trust mental health providers because of the biased views they are assumed to hold about IPV (Gillum, 2008) and a tendency to blame the victim (Walker, 1979), many victims of IPV also report wanting to discuss the violence they have experienced (Nabi & Horner, 2001). In one study, victims of IPV reported being in favor of screening within the context of a health care environment and that screening practices led them to realize that violence was present and problematic in their relationships (Chang et al., 2003).
The present analogue study examined whether therapists and therapists in training recognize IPV in a clinical context and, when they did, if the severity of the IPV and the appraisals they make about the causes of the IPV differ based on the client’s SES and race. Specifically, it was hypothesized that therapists’ stereotypes about victims of IPV (i.e., the stereotype that African-American women are expected to be victims of IPV) would be evident if significantly more therapists identified IPV as problematic with a White client than with a Black client. In other words, therapists would be more likely to notice IPV in a White client because IPV does not fit the stereotype of White women, whereas when the client is African-American, IPV fits the stereotype (and thus may be overlooked). Similarly, SES stereotypes and biases were reasoned to be evident if therapists identify IPV as problematic only with a high-SES client but not with a low-SES client (i.e., based on the stereotype that IPV is expected in lower-SES couples).

In this study, hypotheses about how perceptions (including biases and stereotypes) may influence therapists’ recognition and appraisals of IPV were based on attribution theory (Heider, 1958). Attribution theory was originally developed to study causal attributions for achievement, but it has subsequently been applied to various social behaviors, including child abuse (e.g., Graham, Weiner, Cobb & Henderson, 2001) and marital violence (e.g., Holtzworth-Monroe, 1988). According to attribution theorists (Heider, 1958; Kelley, 1983; Ross, 1979), causal beliefs give rise to inferences about personal responsibility (cognitive), which then provoke emotions (affective) that ultimately guide a person’s behavioral responses to a specific event. According to this theory, people attribute the causes of events to external (situational) or internal (dispositional) factors. External attributions include chance, fate, or sociocultural factors
like oppression, discrimination, and racism. Internal factors may be dispositional or demographic, such as a person’s educational level, socioeconomic status, race, or characteristics that imply personal responsibility for an event or situation.

It was reasoned that therapists who lack knowledge of IPV would make more internal (e.g., “She is dependent”) than external attributions (e.g., “Her husband is abusive”) about victims of IPV. Similarly, therapists who are influenced by racial and social class stereotypes (e.g., “African Americans are a violent race” or “IPV only occurs in poor families”), were predicted to make more internal attributions about an African-American or a lower-class IPV victim than about a White or upper-class victim. It was thus reasoned that a disproportionate frequency of internal attributions about IPV for an African-American or a lower-class client, as compared with a White or upper-class client, would provide evidence of stereotyping.

**Intimate Partner Violence Among Lower-SES and African-American Women**

The danger of therapists’ under-recognition of IPV for lower-SES and African-American women is underscored by the seriousness of this problem in these client populations. Notably, women from racial and ethnic minority groups are more likely to face barriers associated with increased risk of IPV, such as low SES. In particular, African-American women between the ages of 16 to 24 are at greater risk than women of any other race in the U.S. and often experience more difficulty escaping violence (Campbell & Gary, 1998). Furthermore, African-American women tend to experience more severe IPV than women from other groups (Rennison & Planty, 2003). Not only is severity of abuse positively associated with high rates of substance abuse and other mental health problems for the victim, but severe violence can have deadly consequences.
(Campbell et al., 1998). Notably, IPV is the fourth leading cause of death for African-American women between the ages of 25 and 34 and the second leading cause of death for African-American women aged 15 to 24 (Centers for Disease Control and Prevention, 2008).

IPV occurs across all social strata (Bograd, 2005; Goodman & Epstein, 2008). However, because poverty increases a person’s vulnerability to abuse and abuse increases vulnerability to poverty, IPV tends to be concentrated in economically-disadvantaged communities (Benson, Fox, DeMaris, & Van Wyk, 2003). A recent study (Pavao, Alvarez, Baumrind, Induni, & Kimerling, 2007), based on a nationally representative sample of women in California found that women who reported being a victim of IPV in the previous year were four times more likely than women who did not report IPV to identify difficulty (a) paying their rent or mortgage, (b) maintaining housing stability (i.e., moving more frequently or living in overcrowded conditions with friends or family), and (c) meeting the financial demands of daily living (e.g., paying utility bills). Longitudinal data have also shown that the relationship between IPV and SES influences the prevalence of violence as well as the likelihood that violence will continue once it starts (Goodman, Dutton, Vankos, & Weinfurt, 2005).

Thus, the risk of experiencing health and psychological problems associated with IPV is greater for women who live in poverty. Some studies suggest that poverty places women at higher risk for IPV than any other single demographic factor (Rennison & Welchans, 2000). In fact, racial differences in rates of partner abuse frequently disappear, or become less pronounced, when economic factors are taken into consideration (Rennison & Planty, 2003). Furthermore, numerous authors (e.g., Jacobson & Gottman,
1998) indicate that economic dependence and limited resources contribute to the likelihood of a woman remaining in or returning to an abusive relationship.

Since African-American women are disproportionately affected by poverty, they are likely to be at greater risk for IPV and, consequently, at greater risk for health and psychological difficulties, than other women. Given the high incidence and risks associated with IPV for African-American and low-SES women, research is needed to determine whether therapists tend to under-identify IPV in their work with these two populations.

**Assessing IPV in Psychotherapy**

Although many victims and survivors of IPV seek psychotherapy, they often do not voluntarily disclose the violence they have experienced or are experiencing. The Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE) conducted a study that found that, of 262 families presenting for therapy, only 12% initially reported IPV as the presenting problem, even though IPV was occurring in at least 40% of the families (Stith, Rosen, Barasch, & Wilson, 1991). Similarly, in another study (O’Leary, Vivian & Malone, 1992), only 6% of women seeking counseling indicated violence as an issue on their intake form; however, when asked to complete a standardized assessment, 53% reported having been assaulted by their partner.

It is estimated that 50% to 70% of couples presenting for treatment reported aggression in their romantic relationships (Vivian & Malone, 1997). In fact, the prevalence of violence is so high that in 1992 the *American Medical Association* encouraged medical physicians to screen universally. The *National Consensus Guidelines on Identifying and Responding to Domestic Violence Victimization in Health Care*
Settings (Family Violence Prevention Fund, 2004) also recommends IPV screening for all adult women and adolescent girls. Similarly, the American Psychological Association (APA, 1996) recommends screening and assessment of IPV and offers specific guidelines for mental health practitioners. Furthermore, the Committee on Divisions/APA Relations’ (CODAPAR) report, *Intimate partner abuse and relationship violence*, (Geffner et al., 2001) refers to IPV screening as a form of secondary prevention, and states the following about the importance of understanding and assessing IPV:

“The prevalence of intimate partner abuse and relationship violence, combined with the severity of its impact at many levels, argues for the need for psychologists who are already engaged in their career, as well as those still in training, to be knowledgeable about a wide variety of issues related to partner violence. It is the ethical and moral imperative of all mental health professionals, whether or not they intend to specialize in working with this population, to be informed and trained in appropriate assessment and intervention techniques” (p. 5).

Despite the high prevalence of violence, mental health practitioners generally lack training in assessing for and discussing IPV (McCloskey & Grigsby, 2005). In a study of 362 members of the American Association for Marriage and Family Therapy (AAMFT) who were asked to conceptualize a written case vignette where IPV was implicated, 40% of the participants failed to indicate family violence as a problem (Hansen, Harway, & Cervantes, 1991). Among participants who addressed the violence, 55% indicated that they would not take immediate action to intervene against the violence, and only 11% indicated that they would obtain protection for the victim.
In a follow-up study, Harway and Hansen (1993) sampled 405 members of the American Psychological Association. Participants were asked to read the description of an actual clinical case that ended in a woman’s death following a family visit to a therapist. Approximately 50% of respondents indicated that safety management was the correct intervention for the woman and her children, 27% indicated needing more information before acting, and 11% indicated that they would focus on increasing the partners’ communication. These results showed that roughly half of the therapists who participated did not accurately identify or assess the lethality of IPV. However, generalizing to actual practice must be made cautiously because participants were only asked to read a case description, not interact directly with a client.

In another study, Geiss and O'Leary (1991) asked 250 members of AAMFT to describe areas that damage marital relationships as well as issues that they found most difficult to treat successfully. Not surprisingly given the previous evidence, physical violence was not rated among the areas most damaging to relationships. However, respondents rated physical violence as one of the top 10 issues that are most difficult to treat successfully. Despite these authors’ call for training in IPV, a subsequent study of 415 licensed mental health professionals found that only 59% of respondents had received training in domestic violence (Campbell, Raja & Grining, 1999).

Subsequent studies also found an under recognition of IPV. Agar and Read (2002), for example, examined therapists’ treatment plans of abuse survivors to determine if there was a clear identification of abuse. The authors found that only 36% of clinical summaries and 33% of the treatment plans mentioned abuse, and only 22% of the abused clients whose treatment plans were reviewed received psychotherapy that directly
addressed their victimization. Similarly, in a study of 112 mental health practitioners who reviewed a written case vignette where IPV was indicated (Dersh, Harris, & Rappleyea, 2006), 44% of respondents failed to identify IPV as a significant clinical problem. More recent, a replication of Harway and Hansen’s (1993) study (Dudley, McClosley, & Kustron, 2008), indicated that while there were improvements in therapists’ overall recognition of IPV in a case vignette (i.e. 85% of participants identified IPV as a problem), therapists tended to minimize the severity of the problem and attribute blame to the victim.

Taken together, the available research suggests that IPV is consistently under-identified by therapists. Little is known, however, about the factors that interfere with therapists’ ability to recognize IPV. One factor may be stereotyping, in as much as research on IPV and violence against women in the general population suggests that observers’ stereotypes, myths, and attributions tend to interfere with their identification of IPV as problematic. The current study was the first to investigate the effects of race and SES stereotyping on therapists’ recognition and assessment of IPV.

Stereotypes and Attribution Theory

Research on social cognition, specifically attribution theory, can contribute to exploring our understanding of IPV. According to attribution theorists (Heider, 1958; Kelley et al., 1983; Ross, 1979; Shaver, 1983), people are motivated to search for the cause(s) of their own and other people’s behavior. When a cause is complex or difficult to understand, people draw an inference, which is termed an attribution. Simply stated, an attribution is an inference, derived from insufficient information and cognitive analysis, about the causes of one’s own or another person’s behavior (Kelley, 1983). By
making attributions, individuals can rapidly categorize and interpret human interactions and behavior, thereby seeing the world as predictable and safe, even when safety may not actually exist (Shaver, 1983).

Heider (1958) theorized that when an individual observes a target actor’s behavior, the observer’s perception and the actor’s features remain relatively constant. Heider further suggested that the impressions formed by an observer of a target are based largely on dispositional characteristics (i.e., stable causes located within individual, such as race). That is, an individual’s behavior is likely to be judged based on characteristics that are perceived by the observer to be consistent, regardless of inconsistencies that are noticed in that person’s behavior or circumstances. This tendency to over-value dispositional characteristics and under-value situational explanations for behavior is known as the fundamental attribution error (Ross, 1977).

Attribution researchers (Plous, 1993) discussed the impact of attribution on clinical perceptions and treatment recommendations. Plous (1993) suggested that treatment recommendations are likely to differ based on whether a clinician attributes the cause of a client’s behavior to situational factors or to the client’s disposition. More specifically, Plaus suggested that when the clinician ascribes causality to a situation (i.e., less stable causes that are external to the individual, such as racism or classism), the clinician makes greater efforts to change the client’s circumstances. However, when a client’s disposition is judged to be the cause of behavior, greater effort is placed on changing aspects of the client. In fact, research has shown that therapists in training displayed significantly less dispositional bias (i.e., they were less likely make a fundamental attribution error by attributing the cause of a problem to the client’s
dispositional or internal factors) when they were specifically trained to become aware of their use of biases and attributions, as compared with therapists who were not trained (Chen, Froehle & Morran, 1997). These findings shed light on the importance of therapists recognizing the potential effect of their personal biases and stereotyped beliefs on their work with clients.

In attribution theory, stereotypes are conceptualized as cognitive schemas that automatically and rapidly provide information and expectations about new people and situations. Again, stereotype-consistent behavior is more likely to be attributed to dispositional causes, whereas stereotype-inconsistent behavior tends to be attributed externally (i.e., to situational causes). Consistent with attribution theory, research has consistently found that observers are more likely to attribute a target actor's (or a victim’s) behavior to dispositional causes than to situational causes (e.g., Jones & Nisbett, 1972; Kelley, 1983).

Racial stereotypes are one of the most frequently examined stereotypes in the psychological literature (Harrison & Esquida, 1998). A significant amount of research concerns the prevalence of negative stereotypes of African Americans (Buzawa & Buzawa, 1990). For example, in a random digital phone survey of 686 Connecticut residents (Plous & Williams, 1995), most participants endorsed at least one stereotypical difference in the inborn abilities of African Americans as compared to Whites. Specifically, in comparison to Whites, African Americans were believed to have superior athletic and rhythmic abilities, but diminished artistic and abstract thinking abilities. This survey also revealed common attitudes about biological differences between the races. For example, many participants reported that black skin is thicker than white skin,
making African Americans less sensitive to pain and extreme temperatures (Plous & Williams, 1995).

Similar stereotypes were found in the General Social Survey (GSS; 2000) data, which was collected by the National Opinion Research Council (NORC; Davis, Smith, & Marsden, 2001). The survey was administered to a cross-section of approximately 1,200 Americans. Fifty-seven percent (57%) of non-African Americans rated African Americans as less intelligent than Whites, and 30% of African Americans rated themselves as less intelligent than Whites. Sixty-two percent (62%) of the entire sample rated African Americans as lazier than Whites, and more than 75% of survey respondents said that African Americans are more inclined than Whites to prefer welfare over work.

Because stereotypes direct the interpretation of social information (Bodenhausen & Lichtenstein, 1987; Fiske & Taylor, 1991), racial stereotypes were expected to influence therapists’ attributions about African-American women who are victims of IPV. Support for this reasoning is found in experimental research with lay people and helping professionals on attributions of African-American rape victims (Willis, 1992), in which African-American victims were believed less frequently and blamed more frequently than European-American victims. These results may be due to the fact that African-American women tend to be portrayed in the media as matriarchs (Moynihan, 1965), which stereotypes them as tough, aggressive, unfeminine, and strong (Collins, 2000; Donovan & Williams, 2002; Taylor, 1999). In fact, many police officers endorse the “matriarchal myth” (Hampton & Gelles, 1994), and are less likely to identify incidents of violence involving African-American women and their partners as IPV (Peterson-Lewis et al., 1988). Similarly, research has found that violence tends to be
considered more serious when the victim is a White woman than an African-American woman (Willis, Hallinan, & Melby, 1996), and observers tend to attribute less blame to White women who physically resist IPV than to their African American counterparts (Harrison & Esqueda, 1999).

Thus, racial stereotypes often negatively influence the attributions individuals make about the behavior of African-American men and women. As a result of these stereotypes and myths, African-American women are often blamed for the negative experiences they face (such as rape or IPV), and racism, sexism, and classism (Donovan & Williams, 2002; Taylor, 1999) tend to be ignored. These findings suggest that stereotyped beliefs that African Americans are inherently aggressive, if also held by therapists, may influence their attributions about clients who are victims of IPV (Tedeschi & Felson, 1994) as well as their recognition of IPV as a problem to be treated in therapy.

Because interpersonal violence is often perceived as a phenomenon of the poor (Baig, Shadigian, & Heisler, 2006), it was expected that stereotypes about social class would also influence how therapists view victims of IPV. Social class stereotypes are extremely common in the U.S. (Bullock, Wyche, & Williams, 2001). For example, according to the Gallup Poll Social Audit (1998), 43% of the Americans surveyed believed that people are poor due a lack of effort. Similarly, poor women are often portrayed in the media as lazy, uninterested in their children’s education or well-being, associated with dysfunctional families, unintelligent, dependent, unmotivated, and irresponsible (Bullock, Wyche, & Williams, 2001). This stereotyping was supported in a study by Lott and Saxon (2002,) who found that when rating a woman who was running
for vice president of the Parent Teacher Organization the woman who was portrayed as from the working class was consistently rated as meeker, cruder, more irresponsible and more unsuitable than the woman who was portrayed as from a higher-SES. Furthermore, sociological research on stereotyping indicated that welfare recipients were the only social group that was universally perceived as low in warmth and competence, as well as disliked and disrespected (Fiske, Xu, Cuddy, & Glick, 1999).

No studies in the psychological literature were located that examined therapists’ SES stereotypes or the impact of SES stereotypes on the assessment of victims of violence. Nevertheless, psychology theorists and researchers are paying increased attention to social class as an important factor that influences the assessment of clients’ problems (Hays, 2008). Thus, it was important to study whether therapists held stereotyped attitudes toward lower class clients.

**Summary and Hypotheses**

The above literature review suggests that IPV tends to be under-recognized by therapists, yet little is known about why therapists often fail to assess their clients for IPV. Understanding whether racial or class stereotypes influence therapists’ blaming of IPV victims is an important next step in research on IPV and on clinical judgment in general.

This study was expected to improve on the existing literature in three ways. First, although previous studies have examined therapists’ recognition of IPV using written case vignettes (Harway & Hansen, 1991; Hansen & Harway, 1993; Dersh, Harris, & Rappleyea, 2006), all of the previous studies were atheoretical, with no conceptual basis for explaining participants’ responses to the case description. By contrast, the present
study was based on attribution theory. It was reasoned that if the hypotheses were supported, results would help explain why many therapists fail to address IPV with at-risk women. Second, no studies have examined therapists’ causal attributions for IPV. This study asked participants to explain their attributions about IPV, providing an understanding of the types of attributions that therapists tend to make about victims of IPV. Because attributions have been shown to influence how therapists intervene with clients (Chen et al., 1997), this knowledge is an important step for the prevention and intervention of IPV. Finally, no studies to date have examined how information about a client’s race and social class affect therapists’ recognition and assessment of IPV. Because of the high prevalence of IPV among African-American women and the known stereotypes about African-Americans, this study used a Black/White race manipulation to determine if race affected participants’ recognition and appraisal of IPV. Additionally, social class was experimentally manipulated (high versus low SES) because IPV disproportionately impacts people of lower SES. Thus, based on previous findings in the relevant literature, it was hypothesized that when reading a clinical case vignette in which violence is mentioned, many therapists would fail to recognize IPV as a primary concern. Furthermore, it was predicted that the client’s race and social class would influence therapists’ appraisal of the severity and cause of the IPV. This hypothesis was based on attribution theory research, which suggests that individuals tend to attribute dispositional causes to interpersonal violence (e.g., Witte, Schroeder, & Lohr, 2005).

Specifically, the hypotheses were, first, that 40% or more of therapists would fail to identify IPV as a significant clinical issue or problem when presented with a written clinical vignette of a female client who was hit in the face by her partner. This value
(40%) was chosen because previous studies (Hansen et al., 1991; Harway & Hansen, 1993; McCloskey & Grigsby, 2005) consistently found that approximately 40% of therapist participants failed to assess for IPV when it was present in a clinical vignette. Second, based on the stereotyping literature (Bodenhausen, & Lichtenstein, 1987; Harrison, & Esqueda, 1999; Ferguson and Negy, 2004) it was predicted that IPV would be disproportionately identified when a client is White rather than Black, and high-SES rather than low-SES. Third, IPV was expected to be rated as significantly more severe (i.e., needing more clinical attention and intervention) for a White client than for a Black client and for a high-SES client than for a low-SES client. Fourth, based on attribution theory (Graham, Weiner, Cobb, & Henderson, 2001; Holtzworth-Munroe, 1988; Peterson-Lewis, Turner, & Adams, 1988), because IPV is more likely to be expected in African-American families and low SES-families, significantly more internal causal attributions were expected to be made about the IPV with a low-SES and a Black client than with a high-SES or a White client.

**Significance of the Study**

The current study expanded on the current literature by (a) using a theoretical framework to understand why IPV may be overlooked by therapists, (b) manipulating the race and SES of the client, and (c) examining therapists’ causal attributions for the IPV. To date, no other investigations of IPV recognition have examined the effects of race and SES on the casual attributions made by therapists. Because this study is based on attribution theory and research, significant findings were expected not only to contribute to the general knowledge about stereotyping, but also to provide a possible explanation for the under-recognition of IPV by therapists.
Results of the current study were also expected to have practical implications, that is, by helping therapists recognize stereotypes that may affect their work with victims of IPV. If participants were to disproportionately fail to recognize IPV with either the African-American or the lower-class client, this result would support previous findings regarding the stereotyping of IPV victims (e.g., Donovan, 2007). On the other hand if results were to show that more than 40% of participants fail to recognize IPV as problematic regardless of the client’s race or SES, his finding would emphasize a continued need for therapists to be educated about IPV (Harway & Hansen, 2004). Such findings would also highlight the need for early detection and intervention of IPV as a form of secondary prevention, which can reduce the physical and psychological health risks associated with IPV (Geffner et al., 2001)

If, on the other hand, the hypotheses were not supported, these results would suggest that more therapists are able to identify IPV than was reported in previous investigations. Nonsignificant findings would further suggest that, unlike the general population, stereotypes do not interfere with therapists’ ability to identify IPV as problematic with low-SES or Black clients. Although the external validity of these findings may be affected by the analogue nature of the study, nonsignificant results would also suggest that therapists do not tend to hold African-American and low-SES clients responsible for their victimizations.
Chapter 2

Method

The general purpose of the current study was to examine whether therapists were able to recognize IPV in a written clinical vignette and whether the recognition, IPV severity, and attributions participants make about victims of violence differed based on the client’s race and SES. The following sections summarize the sample, design, stimulus materials, procedures, hypotheses, and analyses.

Participants

Volunteers for a study on therapists’ initial assessments were recruited from professional listservs, such as Divisions 17 (Counseling Psychology), 12 (Clinical Psychology), 29 (Psychotherapy), and 43 (Family) of the American Psychological Association (APA). Individual e-mails were also sent to doctoral and master’s training programs, university counseling centers, practicing therapists and community mental health clinics. No effort was made to solicit volunteers based on their gender, race, or SES. Rather, obtaining a heterogeneous sample of practicing psychotherapists was preferred.

A sample of 174 practicing therapists volunteered. Excepting five participants who did not complete the demographic questionnaire, participants were 129 women (76.3%) and 40 men (23.7%), aged 22 - 72 (M = 36.60, SD = 11.38) who had at least one year of clinical experience. The number of clients seen per week ranged from 1 - 40, (M = 13.51, SD = 8.44). Years of post-degree clinical experience ranged from 0 – 35 (M = 6.05, SD = 2). Twenty-eight percent (28%) of participants had earned a Ph.D. (n = 48), 9.5% a Psy.D., (n = 16), 43% a master’s degree (n = 75), 3.4% an MSW (n = 6), 1.7
percent a M.Ed ($n = 3$), and 10% reported having earned a bachelor’s degree and were currently completing on a Ph.D. or Psy.D degree.

The majority of participants (71.6%) self-identified as non-Hispanic, Caucasian ($n = 121$), 12.4% as Hispanic or Latino/a ($n = 21$), 3.4% as African American or Black ($n = 6$), and 4.7% as Asian American or Pacific Islander ($n = 8$). The 7.7% who reported other ethnic and racial descriptors self-identified as Arab ($n = 1$), Asian Indian ($n = 1$), bi-racial Black/White ($n = 2$), bi-racial Asian/White ($n = 2$), South Asian-American ($n = 1$), undisclosed ($n = 1$), White-Jewish ($n = 2$), Native Hawaiian ($n = 1$), and White, non Caucasian/non-Hispanic ($n = 2$).

For the majority of participants (75.2%) the work setting was either an outpatient clinic (45.6%) or a university counseling center (29.6%). Other settings included independent or group practice (13%), inpatient clinics (7.7%) and schools (3%). Twenty-three percent (23%) of the sample described their primary theoretical orientation as cognitive-behavioral ($n = 38$), 19.5% as eclectic ($n = 33$), 13% as interpersonal ($n = 22$), 11.2% as psychodynamic or psychoanalytic ($n = 19$), 8.3% as integrative ($n = 14$), 6.5% as humanistic ($n = 11$), 5.3% as family-systems ($n = 9$), and 4.1% as solution focused ($n = 7$). The remaining 8.9% reported a feminist ($n = 2$), narrative ($n = 2$), Gestalt ($n = 2$) or other ($n = 8$) orientations.

**Power analysis.** A power analysis, based on the methods outlined by Cohen (1988), was conducted to assess the sample size necessary to achieve statistical power $\geq 80$. First, the effect size to be used in the power analysis was determined. Although there were no previous studies that have examined the effects of race and SES on therapists’ recognition of and attributions about IPV, Dersch et al. (2006) reported that among 103
therapists, 57.8% recognized violence as an issue and 45.9% responded to the violence ($r^2$ = .31 and .30, respectively). Regarding race and attributions of blame, in a study of 57 participants, White victims were viewed as more harmed than African-American victims, and White perpetrators were held more culpable ($r^2$ = .21) (Donovan, 2007). The adjusted $r^2$ values ranged from .19 to .30, with a median adjusted $r^2$ = .25. Because $r^2$ = .25 is considered a large effect size (Cohen, 1988) in psychology research, a moderate effect size of $r^2$ = .14 was used, in order be conservative. Thus, with $r^2$ = .14, $df$ = 1, and $\alpha$ = .015, a sample size of 100 participants would yield an estimated power of .90.

Because 174 participants took part in this study, the sample size was considered sufficient to yield an estimated power of .90 for a moderate effect size.

**Design**

This analogue study was a 2 (race) x 2 (SES) between-subjects factorial design. Each participant was randomly assigned to one of four experimental conditions: a high-SES African-American client, a high-SES White client, a low-SES African-American client, or a low-SES White client. The three dependent variables were (a) recognition of IPV (yes or no), (b) perceived severity of IPV, and (c) internality of attributions made about the IPV. Because participants were randomly assigned to conditions, possible confounds (e.g., age, gender, race, and years of experience) were expected to be equally distributed.

One measure was created to assess whether participants recognized IPV as a problem, and if so, to rate its severity. On this measure, participants also listed the cause(s) of each problem that was previously identified. The Cognitive Constructions Coding System (CCCS, Friedlander, 1995) was used to rate the internality and externality
of the causal attributions listed for IPV. Only participants who listed intimate partner violence (or related words, such as “abuse,” “violence,” “maltreated” or “the client being hit/slapped by her husband”) as a problem were included in the analyses of the effects of race and SES on problem severity and attributions.

**Stimulus Materials**

With the exception of race and SES, all other client information was identical (presenting problems, age, and marital status). All participants received the same initial instructions:

“After reading the vignette below, please proceed by pressing ‘Next’ to answer the questions that follow. Note that you will not be allowed to return after you press 'Next,' so please read carefully to obtain the relevant clinical information. Put yourself in the role of the therapist; imagine that you are seeing Linda for the first time and are considering her clinical problems.”

In the high-SES White condition, participants read the following introduction:

“The excerpt you are about to read is taken from the intake session with Linda, a White female in her mid 30’s. Linda has earned her J.D. degree and is a full law professor at a local prestigious university, who is presenting for therapy for the first time.” In the low-SES White condition, participants read, “The excerpt you are about to read is taken from the intake session with Linda, a White female in her mid 30’s. Linda has earned her GED and is a cashier at a local, fast food restaurant, who is presenting for therapy for the first time.” For the high-SES and low-SES African-American conditions all the information provided above was identical except for Linda’s race, which was African-American. The two occupations, cashier and law professor, were selected to manipulate SES based on a
previous study that assessed physicians’ attitudes about screening victims of domestic violence (Baig, Shadigian, & Heisler, 2006).

The vignette (see below) did not explicitly mention the word “violence;” rather, it provided several indicators of violence as informed by the literature (Harway & Hansen, 2004). A moderate level of IPV (“being hit in the face”) was chosen because research suggests that the most frequently reported physical assaults between intimate partners are slapping and hitting (Tjaden, & Thoennes, 2000). Because the vignette was created specifically for this study, two female scholars with experience in IPV research independently reviewed the vignette and agreed that it realistically portrayed a client who was presenting with IPV (a moderate level) as a clinical concern.

The vignette read as follows:

Well….you see…I came here for help. Lately, I have been having a lot of trouble. Things have been really hard at work and at home, and I have been really down. I don’t sleep well or eat well either. I don’t take very good care of myself….I have been drinking a bit more lately. I do not enjoy the things I used to, and to be honest, I am sad and worried all the time. I sometimes get so worried that my heart starts to beat fast, and I get really scared. Nobody knows I’m here. My husband thinks I’m at work right now, and if I told him I’m here, he would be really upset. Actually, I don’t tell him anything. I cry all the time, but he doesn’t know. He wants to have a baby, but I won’t tell him that I won’t have his baby right now. Now that I think about it, there are a lot of secrets in our marriage, I guess. It wasn’t always this way. After three years, we just don’t seem to get along anymore. I never tell him how I feel. I stay quiet and just listen to him. Last
time that I said something to him about being unhappy, he thought I was being disrespectful, so he hit me across the face. It’s weird, because he is mad all the time and I’m sad all the time. I wonder what that means. Anyway, I need to be able to sleep and eat and stop worrying. If I don’t, things are just going to get worse for me at work and at home and, really, I am not sure that I can handle that.

**Instruments**

**IPV recognition and appraisal.** As indicated in Appendix A, participants were instructed, “Please list up to 5 clinical problems you might identify if you were seeing Linda in your practice. After listing each problem, please rate its severity on the 7-point scale (below). For this scale, “severe” refers to the negative impact of the problem on the client. Finally, briefly describe the possible cause(s) of each problem.”

The severity ratings were made on a 7-point scale, where the anchors were 1 = minimal negative impact, 4 = some negative impact, and 7 = extreme negative impact. Previous researchers who investigated therapists’ recognition of IPV (Dersch et al., 2006; Harway & Hansen, 2004) used similar open-ended questions (e.g., “What are the most clinically significant issues in this scenario?”). Although previous studies also included questions about problem severity, the open-ended nature of those questions made it difficult to determine exactly how severe the IPV was perceived by participants. Therefore, for this study, a rating scale response was created to assess participants’ perceptions of IPV severity.

**Cognitive Constructions Coding System.** The responses to the last question, “briefly describe the possible cause(s) of the problem,” were coded using the Cognitive Constructions Coding System (CCCS; Friedlander, 1995; Friedlander & Heatherington,
1998), which was adapted for the present study by its primary author (see Appendix B). The CCCS is an observational coding system that was developed to rate clients' expressed constructions of their individual and family problems on four dimensions: intrapersonal-interpersonal, internal-external, responsible-not responsible, linear-circular. For this study, only the Internal-External (I-E) dimension of the coding system was used. Ratings of causal constructions were made on an ordinal scale from 1 (solely internal) to 5 (solely external), where 3 refers to an equal balance of internal and external explanations. Three studies examining the psychometric properties of the CCCS found that intraclass correlation coefficients for the I-E dimension ranged from .61 to .94, and a known-groups validity test supported the construct validity of the measure (Friedlander & Heatherington, 1998).

Although the CCCS was developed to code clients’ expressed constructions of their problems, for this study it was only used to code therapists’ attributions related to IPV. For example, an internal construction (I-E rating = 1) was, “She was hit because she is disrespectful,” whereas an external attribution was (I-E rating = 5), “She was hit because he is abusive.” Thus, the dependent variable, Internality, could range from 1 (high) to 5 (low). If participants listed more than one attribution for IPV, the internality score for that participant was the mean of the I-E ratings.

**Demographic questionnaire.** Participants were asked to provide their gender, age, race, theoretical orientation, educational level, type of degree, post-degree years of experience, areas of expertise, and demographic characteristics of clients they serve (see Appendix C). These data were used in the preliminary analyses and to describe the sample.
**Manipulation check.** Participants were asked to answer three questions in order to assess the accuracy of their perceptions of the client (see Appendix D). These questions were be used to determine if participants recognized the client’s race, occupation, and SES.

**Procedure**

A snowball sampling method was used to recruit participants for the present study (Heckathorn, 1997). All data were collected through the internet, and volunteers were self-selected. Recruitment took place by e-mail to professional psychology listservs (such as American Psychological Association, American Psychological Association for Graduate Students) as well as through individual e-mails sent to community mental health sites, doctoral and master’s training programs, university counseling centers, and other mental health service provider sites.

The e-mail letter (see Appendix E), described the study as “an investigation of therapists’ initial assessment of a client’s presenting problem,” and included eligibility criteria, confidentiality, University of at Albany IRB approval certification, and the investigator’s contact information. As an incentive, volunteers were informed that for each completed survey, a $5 donation would be made to Child Find of America, Inc. a national not-for-profit organization dedicated to the prevention and resolution of child abduction.

Voluntary participation was emphasized, and participants were clearly informed of their right to discontinue participation at any time. Informed consent was assumed when participants clicked on the link to the survey.
Participants were then directed to the brief introduction and the vignette. After reading the vignette, participants were asked to continue by clicking ‘next.’ Upon completion of the primary measure developed for this study and manipulation check questions, participants were debriefed (see Appendix F). They were reminded of the investigator’s contact information for follow-up questions, comments, or concerns. Finally, participants were asked to forward the letter or link to eligible therapists of their acquaintance.

**Cognitive Constructions Coding System.** Two doctoral students (one male and one female) in psychology were trained in the use of the I-E scale. These raters were chosen based on their previous research experience, which included coding qualitative data. Raters were unaware of the hypotheses; however, they were told that they would be rating causes of IPV. The raters met with the investigator to review the I-E rating manual and to practice hypothetical examples of internal and external IPV attributions. Fifty practice examples were rated jointly to ensure that the raters understood the manual. The raters then independently judged 50 practice statements. The intraclass correlation coefficient of .85 with the investigator on the practice examples was considered adequate to proceed with the actual ratings.

Once trained, raters independently coded the participants’ attributions, and intraclass correlation coefficients were calculated after each 20% of the sample had been rated. The plan was that coders were not to be given the next 20% of the data until they reached an intraclass correlation reliability of .80 or more. However, raters achieved an adequate intraclass correlation coefficient after each 20% of the coding so that recalibration was unnecessary.
In this way, a total of five intraclass correlation coefficients were calculated, $r_s = .86, .85, .90, .89$ and $.90$, respectively. Discrepancies between the raters were negotiated after each 20% of the sample was completed. Unresolved discrepancies were discussed with the investigator, and a consensus was reached.

**Hypotheses and Analysis**

The following three hypotheses were tested:

**Hypothesis 1:** At least 40% of participants will not list IPV in the client’s top 5 clinical problems, regardless of the client’s race or SES.

**Hypothesis 2:** There will be a significant main effect for race, such that participants in the Black client condition will be less likely to recognize IPV (Hypothesis 2a) and will rate the IPV as significantly less severe (Hypothesis 2b) and as significantly more internally caused (Hypothesis 2c) than will participants in the White client condition.

**Hypothesis 3:** There will be a significant main effect for SES, such that participants in the low-SES client condition will be less likely to recognize IPV (Hypothesis 3a) and will rate the IPV as significantly less severe (Hypothesis 3b) and as significantly more internally caused (Hypothesis 3c) than will participants in the high-SES client condition.

To test Hypothesis 1, frequencies were computed, i.e., the number of participants who did versus did not list IPV as a clinical problem. Chi squares were used to test Hypotheses 2a and 3a based on (a) client race and (b) client SES. That is, the 2 x 2 chi square was (a) recognition (yes/no) by race (black/white) and (b) recognition by SES (low/high). To meet the assumptions of a chi-square analysis, cell size frequencies need
to exceed five. Because each variable only had two categories, the Yates continuity correction was used to determine if the chi-square test was significant, and phi was observed to determine the level of significance. Effect sizes under .05 were considered negligible and therefore not interpreted.

Only the participants who did list IPV as a problem were used in the tests of Hypotheses 2b, 2c, 3b, and 3c. To test these four hypotheses, 2(SES) x 2(race) ANOVAs, were used, with each $\alpha = .025$. The dependent variables were perceived severity (1 = no negative impact to 7 = extreme negative impact) and internality (1 to 5, where 1 = completely internal, 5 = completely external). Preliminary analyses were conducted to insure that the ANOVA assumptions of normality and homoscedasticity were met. Effect sizes under .05 were considered negligible and not interpreted.
Chapter III

Results

This chapter presents the preliminary and major analyses, as well as several post hoc analyses. The chapter concludes with a summary of the major findings.

Preliminary Analyses

First, analyses were conducted to determine whether randomization resulted in an equal distribution of demographic characteristics across the four conditions for the subsample of participants who identified IPV as one of the five clinical problems in the case vignette. Results of the chi-square and ANOVAs were nonsignificant for gender, race, education, age, years of experience, and number of clients seen weekly. In other words, the analyses showed that these participant characteristics were equally distributed across conditions. Results are shown in Tables 1 and 2.

Next, a series of analyses was conducted of responses to the two manipulation check questions based on that same subsample (i.e., participants who identified IPV as a problem). These questions asked participants to indicate the client’s race and occupation. Frequencies showed that 82.4% (n = 42) of the participants in the White condition, compared to 97.7% (n = 43) in the Black condition, accurately identified the client’s race; and 17.6% (n = 9) in the White condition, compared to 2.3% (n = 1) in the Black condition, identified the client’s race as "unknown." To determine if these differences were significant, a 2 (White, Black) x 2 (correct, did not know) chi squared was conducted. A significant difference was found, such that participants in the Black condition were more likely than those in the White condition to identify the client’s race
Table 1

*Randomization Checks by Experimental Condition: Categorical Variables*

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<tr>
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<td>1</td>
<td>0</td>
<td>1</td>
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</tbody>
</table>

Note. $n = 95$. To analyze differences based on race/ethnicity, the African-American, Latino/a, Asian, and “other” participants were compared with Caucasian participants. To analyze differences based on education, the master’s and bachelor’s participants (including those with a bachelor’s degree who were enrolled in a Ph.D. program) were compared with participants who had a doctoral degree. Expected cell sizes for theoretical orientation and work setting were too small to analyze.
### Table 2

**Randomization Results by Experimental Condition: Continuous Variables**

<table>
<thead>
<tr>
<th></th>
<th>High SES</th>
<th></th>
<th>Low SES</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
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<tr>
<td></td>
<td>White</td>
<td>Black</td>
<td>White</td>
<td>Black</td>
<td>White</td>
<td>Black</td>
<td>F(2, 95)</td>
<td>p</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td></td>
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<td>Age</td>
<td>36.88</td>
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<td>12.16</td>
<td>36.61</td>
<td>12.16</td>
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<td>Exp</td>
<td>8.00</td>
<td>8.95</td>
<td>6.58</td>
<td>9.12</td>
<td>6.83</td>
<td>8.30</td>
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<td>8.73</td>
<td>.15</td>
<td>.93</td>
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<tr>
<td>Clients</td>
<td>12.76</td>
<td>10.02</td>
<td>16.08</td>
<td>8.37</td>
<td>13.96</td>
<td>9.64</td>
<td>13.56</td>
<td>8.18</td>
<td>.57</td>
<td>.63</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Note. n = 95. Exp = years of clinical experience. Clients = approximate number of clients seen per week.*
correctly, Yates $\chi^2(1, 95) = 4.41, p = 0.036, \phi = -0.25$. To determine the strength of this effect, $\phi$ was examined and indicated a small effect ($\Phi = -0.25$).

Second, 93% ($n = 88$) of participants correctly identified the client’s occupation and 7.4% ($n = 7$) of participants reported not knowing the client’s occupation. The 7 participants who did not correctly identify the client’s occupation were evenly distributed between groups, such that 4 were in the high SES condition and 3 were in the low SES condition. A 2 (high, low SES) x 2 (correct, did not know) chi squared indicated a nonsignificant difference, Yates $\chi^2(1, 95) = .046, p = .83, \phi = .06$. This result indicated that the SES manipulation (which was based on occupation, as previously used in the literature; Baig, Shadigian, & Heisler, 2006), was successful.

The third question, which asked whether the client was from a low, middle, or high SES, the majority (57.9%) of participants reported being unclear or unsure. Slightly fewer than half (i.e., 46.7%) of participants in the low-SES condition, compared to 20% in the high-SES condition, correctly identified the client’s SES. This difference was significant, Yates $\chi^2(1, 95) = 6.50, p = 0.01, \phi = -0.28$. To determine the size of the effect, $\phi$ was examined and indicated a small effect ($\Phi = -0.28$).

Descriptive analyses were also used to assess for potential violations of the assumptions for the chi squared and ANOVA analyses used in the major hypotheses. First, for the chi-square analyses (Hypothesis 2a and 3a), expected cell frequencies need to exceed 5; each of the four cells contained 20 participants or more. Thus, the assumption for the chi-square analyses was met. The Severity and Internality scores were assessed for independence, normality and homoscedasticity. A normal probability plot of the studentized residuals indicated that, for both variables, the errors were normally
distributed. Levene’s test of Error Variance was greater than .05 for both Severity ($p = .61$) and Internality ($p = .58$), indicating that the homogeneity of variance assumption was met. The overall means, standard deviations, skewness and kurtosis values were:

Severity, $M = 6.05$, SD = 0.93, skewness = -0.91, kurtosis, 0.56; Internality, $M = 3.77$, SD = 1.13, skewness = -0.57, kurtosis = -0.46. Table 3 lists means and standard deviations for Severity and Internality by experimental condition.

**Major Analyses**

**Recognition of IPV.** Of the 174 participants, 54.6% ($n = 95$) listed IPV (or related words such as “abuse,” “violence,” “maltreated” or “the client being hit/slapped by her husband) as one of the client’s five clinical problems, whereas 44.8% ($n = 78$) did not do so. This finding supports Hypothesis 1, which stated that at least 40% of participants would not list IPV in the client’s top five clinical problems regardless of the client’s race or SES.

**Recognition of IPV based on race.** As shown in Table 4, 29.3% ($n = 51$) of participants in the White condition, compared to 25.3% ($n = 44$) of participants in the Black condition. This difference was not statistically significant, $\chi^2(1, 95) = 1.17, p = 0.28$, phi = -.09. Because client race did not influence participants’ recognition of IPV, Hypothesis 2a was not supported.

**Recognition of IPV based on SES.** Results showed that 28.7% ($n = 50$) of participants in the high-SES and 25.9% ($n = 45$) of participants in the low-SES condition identified IPV as a problem (see Table 4). This difference was not statistically significant,
Table 3

Descriptive Statistics for Severity and Internality

<table>
<thead>
<tr>
<th></th>
<th>Severity</th>
<th></th>
<th>Internality</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<tr>
<td>Experimental condition</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>High-SES/White</td>
<td>5.93</td>
<td>0.96</td>
<td>3.58</td>
<td>1.12</td>
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<tr>
<td>High-SES/Black</td>
<td>5.96</td>
<td>1.04</td>
<td>3.71</td>
<td>1.20</td>
</tr>
<tr>
<td>Low-SES/White</td>
<td>6.35</td>
<td>0.83</td>
<td>4.02</td>
<td>0.97</td>
</tr>
<tr>
<td>Low-SES/Black</td>
<td>5.95</td>
<td>0.83</td>
<td>3.81</td>
<td>1.25</td>
</tr>
<tr>
<td>Total</td>
<td>6.05</td>
<td>0.93</td>
<td>3.77</td>
<td>1.13</td>
</tr>
</tbody>
</table>

Note. n = 95 (the subsample of only participants who identified IPV as a clinical problem).
Table 4

Recognition of IPV as a Problem by Client Race and SES

<table>
<thead>
<tr>
<th>Recognition of IPV</th>
<th>Client Race</th>
<th></th>
<th>Client SES</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>White</td>
<td>Black</td>
<td>High</td>
<td>Low</td>
</tr>
<tr>
<td>Yes</td>
<td>51</td>
<td>44</td>
<td>50</td>
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<tr>
<td>No</td>
<td>35</td>
<td>44</td>
<td>37</td>
<td>45</td>
</tr>
</tbody>
</table>

Note. n = 95. Cell sizes represent frequencies. Race Yates $\chi^2(1, 174) = 1.17$, $p = 0.28$, phi = .05. SES Yates $\chi^2(1, 174) = .0001$, $p = 1.00$, phi = .09.
Yates, $\chi^2(1, 95) = .0001, p = 1.00, \phi = .05$. Because client SES had no effect on participants’ identification of IPV, Hypothesis 3a was not supported.

**Severity of IPV based on race and SES.** As shown in Table 5, the mean and standard deviation for Severity indicated that overall, participants who listed IPV as a problem saw it as severe, $M = 6.05, SD = 0.93$ (Severity could range from 1 = minimally to 7 = extremely). Among these participants, only one individual rated the IPV Severity = 3 and six participants rated Severity = 4. Thirty-four participants (19.5% of those who recognized IPV) rated it extremely severe (i.e., = 7).

A two-way, between-groups ANOVA was conducted to test the effects of race and SES on ratings of severity. Only the 95 participants, who identified IPV as a problem, i.e., 54.6% of the total sample, were included in this analysis. The main effects for Race, $F(3, 95) = 1.04, p = 0.31$; partial eta squared = .011 and SES, $F(3, 95) = 1.99, p = 0.16$; partial eta squared = .021, were not significant. Thus, Hypotheses 2b and 3b were not supported.

**Internality based on race and SES.** Table 5 shows the Internality means and standard deviations. (Appendix H lists all of the causal attributions made by participants, with the corresponding I–E ratings.) Results indicated that, on average, participants saw the cause of the client’s IPV to be relatively more external than internal, $M = 3.77, SD = 1.13$ (Internality could range from 1 to 5, where 1 = completely internal, 5 = completely external). Although 14 participants (15%) attributed the cause mostly to the client, (I-E score ≤ 3), 78% of the I-E scores were ≥ 3. More specifically, 31.7% participants received a score of 3, which means that they attributed IPV equally to the client and
Table 5

 Severity and Internality Ratings by Client Race and SES

<table>
<thead>
<tr>
<th></th>
<th>Race</th>
<th></th>
<th>SES</th>
<th></th>
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</thead>
<tbody>
<tr>
<td></td>
<td>White</td>
<td>Black</td>
<td>High</td>
<td>Low</td>
<td>Total</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
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<td>M</td>
<td>SD</td>
<td>M</td>
<td>SD</td>
<td>M</td>
</tr>
<tr>
<td>Severity</td>
<td>5.82</td>
<td>1.28</td>
<td>6.14</td>
<td>.92</td>
<td>5.92</td>
<td>.99</td>
<td>3.95</td>
<td>1.09</td>
<td>6.05</td>
</tr>
<tr>
<td>Internality</td>
<td>3.75</td>
<td>1.20</td>
<td>3.72</td>
<td>1.18</td>
<td>3.54</td>
<td>1.24</td>
<td>4.02</td>
<td>.97</td>
<td>3.77</td>
</tr>
</tbody>
</table>

Note. n = 95. No significant differences by race or SES were observed. Severity = severity of IPV (1 = minimal negative impact to 7 = extreme negative impact). Internality = causal attributions of the IPV as rated on the Cognitive Constructions Coding System (Friedlander & Heatherington, 1998) where 1 = completely internal, 3 = internal and external equally balanced, 5 = completely external.
something external, (e.g. “poor communication;” “relationship problems;” “marital discord”), and the majority (53.7%) of participants received an I-E score of either 4 or 5, (e.g., “He hit her” “Husband’s anger and violent behavior,” “His sexist views and insensitivity”).

To explore the influence of race and SES on therapists’ attributions about the causes of IPV, a two-way, between-groups ANOVA was conducted. The dependent variable was Internality, which ranged from 1 = high to 5 = low. Again, only the 95 participants who identified IPV as a problem were included in this analysis. Results showed no main effect for either race, \( F(3, 91) = .036, p = 0.85 \); partial eta squared = .001 or SES, \( F(3, 91) = 1.94, p = 0.17 \); partial eta squared = .021 on Internality. Thus, Hypotheses 2c and 3c were not supported.

**Post-Hoc Analyses**

Although the tests of Hypotheses 2a, 2b, 2c, 3a, 3b, and 3c were not significant, several interesting findings in the preliminary analyses prompted a series of post-hoc tests. Notably, many of the participants who did not identify IPV as a problem did list it as the cause for a different clinical problem, such as “depression.” Because it was reasoned that participants who recognized IPV as a cause would be likely to address it therapeutically, post-hoc analyses were conducted on this broader operationalization of IPV recognition. Thus, the following post-hoc analyses were conducted on the sample of participants who listed IPV as a cause and/or a problem (\( n = 128; 73.6\% \) of the total sample). Because these analyses were conducted post hoc, the results were interpreted with caution.

**Recognition of IPV as a problem or a cause.** Table 6 indicates the frequencies
Table 6

Recognition of IPV as a Problem and/or Cause

<table>
<thead>
<tr>
<th>Recognition of IPV</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>No recognition</td>
<td>46</td>
<td>26.4</td>
</tr>
<tr>
<td>IPV as problem only</td>
<td>63</td>
<td>36.2</td>
</tr>
<tr>
<td>IPV as a cause only</td>
<td>33</td>
<td>19.0</td>
</tr>
<tr>
<td>IPV as a problem and a cause</td>
<td>32</td>
<td>18.4</td>
</tr>
</tbody>
</table>

*Note. n = 174.*
of participants who (a) did not list IPV as either a problem or cause, (b) listed IPV as a problem only, (c) listed IPV as the cause of a different clinical problem, and (d) listed IPV as both a problem and a cause.

As shown in the Table 6, 26.4% of participants did not mention IPV as either a cause or a problem, 19% listed IPV as a cause alone, and 18.4% identified IPV as both a problem and a cause. In other words, 128 participants (74.6%) recognized IPV as a clinical issue (i.e., problem and/or cause). The modal problems for which IPV was listed as a cause were depression \( (n = 38) \), anxiety \( (n = 28) \) and marital problems \( (n = 12) \) (see Appendix I).

**Recognition of IPV based on client race and SES.** Similarly, it was reasoned that whether participants listed IPV (as a problem, a cause, or both) or not at all may be influenced by the client’s race or SES. As shown in Table 7, results based on this subsample \( (n = 128) \) revealed a significant race effect, Yates \( \chi^2 (1, 128) = 5.45, p = .02, \) phi = -.20, such that participants in the White condition identified IPV significantly more frequently than did participants in the Black condition. To determine the strength of this effect, phi was examined and indicated a small effect, \( \Phi = -.20 \). A second 2 x 2 chi-square analysis was used to determine if there was a significant difference by client SES. This result was not significant, Yates \( \chi^2 (1, 128) = .001, p = 1.00, \) phi = -.008.

**Clinical experience, level of education and identification of IPV.** Logistic regression analyses were conducted to determine if IPV recognition (yes or no) was predictive by participants’ experience and level of education. It was reasoned that relatively more seasoned participants (i.e., those with more than 20 years post-degree experience), may have identified IPV at higher rates than participants with less
Table 7

*Recognition of IPV as a Problem and/or Cause by Experimental Condition*

<table>
<thead>
<tr>
<th>Recognition of IPV</th>
<th>Client Race</th>
<th></th>
<th>Client SES</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>White</td>
<td>Black</td>
<td>High</td>
<td>Low</td>
</tr>
<tr>
<td>No recognition</td>
<td>15 (17.4%)</td>
<td>31 (35.2%)</td>
<td>24 (26.1%)</td>
<td>22 (26.8%)</td>
</tr>
<tr>
<td>Problem and/or cause</td>
<td>71 (82.6%)</td>
<td>57 (64.8%)</td>
<td>68 (73.9%)</td>
<td>60 (73.2%)</td>
</tr>
</tbody>
</table>

Note. n = 174. Race Yates $\chi^2 (1, 95) = 5.45, p = .02, \phi = -.20$. SES Yates $\chi^2 (1, 95) = .001, p = 1.00, \phi = .008$. 


experience. Furthermore, because level of education is often associated with greater clinical experience (Dudley et al., 2008), analyses of this variable on the identification of IPV seemed worthy.

Because the dependent variable was categorical, the independent variables were not multicollinear (i.e., Tolerance was ≥ .10) and outliers more than 2 SDs standard deviations above or below the mean were dropped from the model, the assumptions for logistic regression were met. To reduce the likelihood of Type I error a modified Bonferroni correction (Holland & Copenhaver, 1988) was utilized and alpha was set at .025.

These analyses were based on the subsample of 95 participants who identified IPV as a problem (i.e., not including those who listed IPV as a cause). In the first logistic regression, with years of clinical experience, the Hosmer and Lemeshow test was not significant, indicating a good model fit ($p = .133$). The results indicated that 7% of the variance in IPV identification was accounted for by experience, Log Likelihood = 221.19, Nagelkerker $R^2 = 0.07$, $p = .005$. In other words, participants with relatively more experience were significantly more likely to identify IPV as one of 5 clinical problems. In the second regression, education was not predictive of IPV identification, Log Likelihood = 229.13, Nagelkerker $R^2 = 0.21$, $p = .107$.

Logistic regression analyses were re-conducted on the larger sample, i.e., the 128 participants who listed IPV as a problem and/or a cause ($n = 128$) versus those who did not identify IPV. Again, the Hosemer and Lemeshow test was not significant, indicating a good model fit ($p = .30$). Results revealed that neither experience (Log Likelihood =
193.28, Nagelkerker $R^2 = 0.06$, $p = .264$) nor education (Log Likelihood = 194.54, Nagelkerker $R^2 = 0.06$, $p = .397$) significantly predicted IPV recognition.

Table 8 shows the results for all logistic regressions. The average experience level of participants who listed IPV as a problem only was $M = 7.28$ years, $Mdn = 4.0$, $SD = 8.67$. The average of experience of those who listed IPV as a problem and/or a cause was $M = 6.19$ years, $Mdn = 3.0$, $SD = 7.83$. Notably, all 10 participants with at least 20 years of experience identified IPV as a problem, and 5 of them (50%) identified IPV as both a problem and a cause.

Finally, because previous research on IPV and trauma suggests that training in these areas leads to increased assessment and attention to IPV by therapists (Danley, Gansky, Chow, & Gerbert, 2004; Hinderliter, Doughty, Delaney, Pitula, & Campbell, 2003), frequencies were computed to determine if participants who indicated having expertise in these areas (on the demographic questionnaire) were more likely to identify IPV. Among the six participants who indicated having expertise in IPV or family violence (3.4% of the sample), only 1 individual (16%) did not recognize IPV as a problem or a cause. Among the remaining 5 participants, 3 people identified it as a problem (50%) and 2 people (33%) listed it as a cause. Of the 26 participants (14.9% of the total sample) who reported trauma as an area of expertise, 13 (50%) identified IPV as a problem, 7 (27%) identified it as a cause, and 5 (19%) did not identify it at all. These results suggest that participants who reported having expertise (18.3%) in either IPV or trauma, identified IPV as a problem or a cause (81.5%) more frequently than did participants who did not report expertise (73.6%) in IPV, family violence, or trauma.
Table 8

*Contribution of Experience and Education to Recognition of IPV*

<table>
<thead>
<tr>
<th>IPV Recognition</th>
<th>B</th>
<th>S.E</th>
<th>Wald</th>
<th>df</th>
<th>p</th>
<th>Odds Ratio</th>
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</thead>
<tbody>
<tr>
<td>Post-degree experience (problem only)</td>
<td>0.06</td>
<td>0.02</td>
<td>6.91</td>
<td>1</td>
<td>0.01</td>
<td>1.07</td>
</tr>
<tr>
<td>Level of education (problem and/or cause)</td>
<td>-0.12</td>
<td>0.09</td>
<td>1.85</td>
<td>1</td>
<td>0.17</td>
<td>0.89</td>
</tr>
<tr>
<td>Post-degree experience (problem and/or cause)</td>
<td>0.03</td>
<td>0.04</td>
<td>1.16</td>
<td>1</td>
<td>0.28</td>
<td>1.03</td>
</tr>
<tr>
<td>Level of education (problem only)</td>
<td>-0.07</td>
<td>0.09</td>
<td>0.57</td>
<td>1</td>
<td>0.45</td>
<td>0.93</td>
</tr>
</tbody>
</table>

*Note. n = 95 for problem only; n = 128 for problem and or cause.*
Summary

Analysis of responses to the manipulation check questions revealed that of the 95 participants who identified IPV as a problem, the majority of participants in both the White (82%) and the Black condition (98%) correctly identified the client’s race. However, participants in the White condition were significantly more likely to report not knowing the client’s race than did participants in the Black condition. Second, 93% (n = 88) of participants correctly identified the client’s occupation. The 7 participants who did not identify the client’s occupation were evenly distributed among conditions.

In a sample of 174 therapists, IPV was largely undetected. That is, 45% of participants in this study failed to list IPV as a clinical problem. This finding supported Hypothesis 1. Subsequent analyses showed that the majority of participants (74%) did recognize IPV as a problem and/or a cause, whereas 26% failed to identify IPV in any way.

The remaining hypotheses were not supported. That is, among participants who identified IPV as a clinical problem, there were no differences based on race or SES. However, post-hoc analyses showed that among the 74% of participants (n = 128) who listed IPV as a problem and/or a cause, significant race differences emerged. Consistent with the stereotyping hypothesis, these participants were more likely to identify IPV when the client as depicted as White. No differences based on SES were found in this larger subsample, however.

In terms of participants’ ratings of the IPV’s severity and the attributions listed for the IPV, neither race nor SES influenced participants’ ratings of IPV severity or degree of internality to the client. However, mean scores suggested that among the 55% of
participants who listed IPV as one of up to five clinical problems, IPV was seen as fairly severe and its cause was viewed as more external (e.g., “her husband’s anger”) than internal to the client (e.g., “she’s dishonest)

Post-hoc analyses also revealed that participants with more clinical experience were significantly more likely to identify IPV as a problem, when compared to those with relatively less experience. However, there were no differences based on experience when the analysis included those who identified IPV as a problem and/or a cause. Similarly, no significant results were found based on level of education on participants’ recognition of IPV. Finally, a greater proportion of participants who claimed expertise or exposure to clients who had experienced IPV/family violence or trauma identified IPV as a problem or a cause (81.5%), as compared to participants who did not have exposure or specialized training (73.6%).
Chapter IV

Discussion

This chapter summarizes the results obtained in the present study with respect to their theoretical and practical implications. Limitations are discussed, followed by recommendations for future research.

Theoretical and Practical Implications

Historically, researchers have attributed therapists’ under-detection of IPV to their lack of knowledge regarding the prevalence and negative consequences of IPV (Aldarondo & Straus, 1994; Harway & Hansen, 1993). However, despite the increased attention given to IPV by scholars over the past 30 years (Dudley et. al., 2008), in this study, IPV was undetected as a problem by therapists at an alarming rate (i.e., 45%). Findings from this study support several previous studies (Agar & Read, 2002; Campbell, Raja & Grining, 1999; Geiss & O’Leary, 1991; Hansen et al., 1991; Harway & Hansen, 1993) that consistently reported that therapists tended to under-identify IPV in a similar clinical case vignette.

Interestingly, although the majority of therapists in the present study did not list IPV as a clinical problem, almost 75% saw IPV as part of the overall clinical picture, i.e., as a problem and/or the cause of another clinical problem (e.g., depression). Although it is unclear whether therapists who identified IPV as a problem versus a cause would address IPV differently in an actual therapeutic encounter, the overall identifying of IPV as part of the clinical picture is promising. That is, compared to earlier findings where the majority of therapists ignored IPV entirely (Geiss & O’Leary, 1991; Hansen et al., 1991; Harway & Hansen, 1993), most of the present participants were at least aware that the
client was a victim of IPV. Furthermore, these findings are consistent with recent findings in which therapists were more likely to identify IPV in a written case vignette (Dersh, et al., 2006; Dudley, McClosley, & Kustron, 2008) than they had been in previous studies (Hansen et al., 1991; Harway & Hansen, 1993. Taken together, results of the present study and the recent research by other authors suggest that although the increased attention to IPV may not have reached all therapists, some progress in therapists’ overall awareness of IPV has been accomplished since the original studies on this topic by Hansen, Harway and Cevantes (1991) and Harway and Hansen, (1993).

Although reasons for the repeated finding of under-identification of IPV are largely speculative, previous authors offered the following possible explanations: Most therapists tend to lack experience in the assessment and intervention of IPV (McCloskey & Grigsby, 2005); many therapists have preconceived ideas about the type of person who commits violent acts and the type of person who is likely to be a victim (Douglas, 1991); and many therapists fail to recognize or assess for violence when the client does not fit within the therapist’s pre-existing beliefs about victims (Bograd & Mederos, 1999).

Regarding lack of experience, although the present participants were not asked about specific training in IPV, results showed that those with relatively more clinical experience did tend to recognize the IPV as a clinical problem. This finding is consistent with previous research, which indicates that clinical experience increases the likelihood of IPV recognition (Dersh, et al, 2006; Dudley et al., 2008). However, unlike previous findings (Dersh et al., 2006), education level (i.e., bachelor’s, master’s, or doctorate) did not increase the likelihood of IPV detection. This result suggests that clinical experience may be more relevant to the detection of IPV than level of education. Nonetheless,
among the participants who claimed expertise in IPV or trauma, a slightly greater percentage (81%) identified IPV as a problem and/or a cause than the percentage in the entire sample (74%). Because therapists with more clinical experience or greater expertise in trauma/IPV are more likely to have worked with clients who are victims of IPV, it seems that actual clinical exposure to IPV increases the likelihood of its recognition. Thus, consistent with the recommendations of other authors, the present findings underscore the continuing need for graduate students in the mental health field to receive specific training in IPV.

Regarding therapists’ preconceived ideas or beliefs about victims of IPV, research based on attribution theory has consistently found that stereotyping tends to negatively influence the attributions individuals make about victims of violence (Harrison, & Esqueda, 1999; Holtzworth-Munroe, 1988; Willis, & Melby, 1996). For this reason, the present study was designed to assess stereotypes of Black and low-SES women. With respect to race, the impact of stereotypes about African-American women has been identified as a contributing factor to the disproportionate rates of IPV in the African-American community (Gillum, 2002). That is, stereotypical perceptions of Black women as aggressive, yet immune to the effects of violence, have prevented Black women from receiving adequate treatment from health care providers (Bent-Goodley, 2007; Taft et al., 2008). In fact, it is argued that stereotypes undermine African-American women’s self-esteem and lead to self blame and to being blamed by others for the violence they have endured (Thomas, 2000).

Results from the present study support this literature on the negative effects of stereotyping on Black victims of IPV, in that participants were more likely to identify
IPV (as a problem and/or cause) when the client was depicted as White versus Black. In other words, results suggest that therapists were more likely to notice IPV in the White client because IPV does not fit the stereotype of White women. However, because IPV fits the stereotype for Black women, significantly more participants failed to list it as a clinical problem or cause. These findings are important for practitioners by highlighting potential biases in the assessment of IPV. Furthermore, the findings are consistent with previous research that indicates that therapists bring biases and assumptions to the assessment process (Bent-Goodley, 2007).

It was hypothesized that IPV recognition would occur significantly more often when the client was depicted as high versus low SES. However, no such SES bias emerged in participants’ identification of IPV. This finding may be explained by the recent trends in the IPV literature regarding the relationship between SES and IPV. Until recently, this relationship was under researched and poorly understood (Goodman & Epstein, 2008). In the past, SES was considered a variable to be controlled for in an analysis, and researchers tended not to study SES as a central concern in the risk factors that contribute to IPV. However, a growing body of evidence has emerged over the last decade that has challenged researchers’ understanding of IPV as class-less problem. That is, poverty is a serious risk factor for IPV (Humphreys, 2007). Since clients from lower SES are at greater risk for IPV than clients from higher SES, the present finding of no SES bias in participants’ identification of IPV is promising.

As indicated above, racial bias was evident among participants who identified IPV as a problem and/or a cause. Interestingly, however, if IPV was recognized as one of up to five clinical problems, neither the client’s race nor her SES influenced participants’
ratings of the problem severity or the degree of internality in the attributions made about the causes of the IPV. Notably, among participants who identified IPV identified as a problem, it was generally rated as severe and it was seen as more externally than internally caused. Nevertheless, several participants (15%) attributed the cause of IPV as mostly internal to the client, (e.g., “she’s dishonest,” “low-self-esteem,” “lack of previous healthy relationships”). An even greater proportion of participants (32%) attributed the cause of IPV equally to the client and her husband, (e.g., “marital problems/discord” of “communication issues”). Taken together, these findings suggest that almost half the participants (46%) described the cause of IPV as at least partially due to something internal to the client.

Nevertheless, the majority of participants (54%) tended to see the cause of IPV as external to the client. These external causes tended to be related to the client’s husband’s attitude and abusive behavior towards his wife (e.g., “he hit her” “husband’s anger and violent behavior,” “his sexist views and insensitivity”). These findings suggest that therapists who are more attuned to IPV do understand the risks associated with IPV and place the blame or responsibility outside the victim. Since previous studies showed that students are less likely to make fundamental attribution errors when specifically trained to be aware of their biases and attributions (Chen, Froehle & Morran, 1997), training in IPV should focus on challenging therapists’ tendency to over-emphasize the victim’s disposition as a cause of IPV.

Although the equal distribution of causal attributions between victim and perpetrator was also found in previous studies (Dudley et. al, 2008; Geiss & O’Leary, 1991; Hansen et al., 1991; Harway & Hansen, 1993), the overall findings of this study
related to causal attributions and severity ratings are not consistent with previous research. That is, previous studies reported that therapists tend to minimize the severity of and risks associated with IPV and attribute blame to the victim (Dudley et al., 2008; Geiss & O’Leary, 1991; Hansen et al., 1991; Harway & Hansen, 1993). The present findings show some improvements in this area, which may be result of the continued efforts by scholars in this area to bring attention to the importance of accurately assessing IPV in a clinical context.

Although race and SES biases were not evident in terms of severity or internality, other findings suggest that racial and SES biases may have been present. Analyses of the manipulation check questions indicated that, with respect to recall of the client’s race, significantly more participants correctly identified the client’s race when she was depicted as Black versus White. This finding suggests that therapists may be less likely to pay attention to racial characteristics for White clients than for Black clients, or that in the absence of information to the contrary, the client’s race is assumed to be White.

Notably, two participants in the White experimental condition who reported not knowing the client’s race wrote, “I assumed that the client was White.”

Similarly, therapists were significantly more likely to recall the SES status of the low-SES client than the high-SES client. Furthermore, this difference was more pronounced when the client was Black. That is, participants were most likely to attribute a definitive SES status to the low-SES Black client than to the High-SES Black client or either White client. Although there is no basis for explaining this result, it may be that these participants were more comfortable attributing a SES category to low SES clients, particularly when the client is Black.
Members of marginalized communities have repeatedly identified negative experiences with health care providers based on perceived stereotypical attitudes, and these attitudes have been described as interfering with victims receiving appropriate intervention (Bell & Mattis, 2000). In general, victims of IPV often find it difficult to gain access to services. However, marginalized women (e.g., African American and low-SES) who are victims of IPV face additional barriers that are difficult to overcome (Bent-Goodley, 2005). Therefore, the present results suggest it is imperative for mental health providers to receive specific training in culturally-sensitive practice so that all clients, regardless of SES or racial/ethnic background, receive quality therapeutic care. Similarly, Bell and Mattis (2000) listed four goals that may be particularly useful in developing culturally-sensitive IPV interventions for African-American women: identify, challenge and dispel racial myths; recognize and acknowledge the significance of race; be sensitive to the needs and desires of the client; and adjust for the unique needs and expectations of marginalized clients.

**Limitations**

Several limitations of the present study are worth noting. Analogue research, which involves using materials that approximate or describe reality (e.g., written case vignettes), has long been used to understand client and therapist behavior (Munley, 1974). However, the simulated nature of analogue research has been criticized because of its threat to external validity. Additionally, the use of a brief scenario description of a client’s presenting problem, with one incident of IPV does not approximate a clinical interaction. Furthermore, findings from this study cannot be generalized to IPV within same-sex couples or IPV that involves a type or level of violence other than that depicted
in the study. Nevertheless, although the generalizability of analogue research to real-life settings and situations must be done cautiously, analogue studies do allow for a high level of experimental control, maximizing internal validity so that the results may address theoretically-based questions.

Despite the experimental control in this present study, the race and SES manipulations may not have been as effective in eliciting therapist biases as they would have been in an actual clinical setting. For example, 17.6% of participants in the White condition, compared with 2.3% in the Black condition, reported the client’s race as “unknown.” Similarly, it is unclear whether the manipulation for SES was strong enough to trigger an SES bias in participants’ identification of IPV, severity ratings, or causal attributions. That is, although 93% of participants correctly identified the client’s occupation (which was the SES manipulation used for this study), 62% of participants reported being unclear or unsure of the client’s SES. As such, it is possible that the SES manipulation did not have the intended impact. Nevertheless, because the occupation manipulation was effective (i.e., 93% of participants accurately recalled the client’s occupation), if occupation alone prompts an inference about SES, as suggested by previous research (e.g., Baig, Shadigian, & Heisler, 2006; Lott & Saxon, 2002), it is possible that the SES manipulation was indeed effective. If that were the case, the results would indicate that racial bias outweighed SES bias in the present therapists’ recognition of IPV as a clinical problem.

Although there is no way to accurately determine whether the race and SES manipulations were as effective in eliciting therapist biases as they would have been in an actual clinical setting, there are three potential explanation for these findings. First, the
failure by some participants to correctly answer the manipulation check questions regarding race and SES could have been due to faulty memory. That is, inasmuch as participants were asked to complete three tasks and the demographic questionnaire before answering these questions, some participants may well have forgotten the client’s race and SES. Alternately, race and SES may not have been seen as salient factors in the case vignette and thus were not retained in memory. Finally, responses to the race and SES questions could have been influenced by social desirability response bias.

A second limitation is the sampling procedure, which allowed participants to self-select. The use of snowball sampling has been criticized due to its lack of generalizability and the tendency for in-group recruitment and over-sampling of groups with larger personal networks. Nevertheless, this type of recruitment is valuable for studies where the participants represent a rather narrow subgroup of the general population, for whom adequate sampling frames are not available (Patrick, Pruchno & Rose, 1998; Streton, 2004). In terms of the present sample, the majority of participants were White (71.6%) and women (76.3%). Although these percentages may be representative of the population of therapists in the U.S., the limited racial and gender diversity in the sample did not allow for an examination of how race and SES bias may operate differently based on these therapist characteristics. Similarly, the fact that the majority (63%) of participants had fewer than five years of clinical experience limited the exploration of how experience may influence race and SES biases in the recognition of IPV.

A final limitation was the use of measures developed specifically for this study. For example, although many therapists did not list IPV as one of the five clinical problems, many listed it as the cause of another clinical problem, indicating that they
were aware that the client had been hit by her partner. Given the structure of the recognition measure (and its unknown reliability and validity), it was difficult to ascertain whether participants who identified IPV as a cause would actually have assessed or addressed IPV differently with an actual client. Although the present use of a Likert scale to measure IPV severity revealed that participants who identified IPV as problematic did tend to rate it as severe, it is unclear why these findings differ from previous research, which used open-ended questions to elicit therapists’ perceptions of IPV severity (Dudley et. al, 2008; Geiss & O’Leary, 1991; Hansen et al., 1991; Harway & Hansen, 1993). Nevertheless because no existing measures were located to assess therapists’ perceptions of the severity of IPV, the choice to use this measure seemed justified and, indeed, the results suggest that the variable had some measure of face validity.

Despite these limitations, no previous study has investigated the effects of race and SES biases on therapists’ recognition of IPV, severity ratings, or attributions about the cause of IPV. Given the negative psychological and physical health risks associated with IPV, the present results offer valuable information about factors that may contribute to therapists’ recognition of IPV in a clinical situation.

**Recommendations for Future Research**

IPV is a major public health issue, one that has a negative impact on roughly 25% of women in the U.S. (Centers for Disease Control, 2006). Despite the continued high prevalence of IPV, results of this study, as well as previous research along these lines, indicate that therapists tend to under-identify IPV as problematic. Although the findings show that the majority of therapists did identify IPV as part of the overall clinical picture, roughly 25% did not do so, suggesting that continued training related to IPV assessment
is needed. Because of the high prevalence of IPV, repeated demonstrations of therapists’ under-identification of IPV, and the negative consequences associated with victimization, training programs and state mental health licensing boards should consider including IPV assessment as a mandatory component of therapists’ training.

Evidence indicates that IPV has serious mental and physical health consequences for all women, particularly for African-American women (Taft et al., 2008). Although intimate partner violence against women cuts across all economic, racial, religious, and age groups, women who are members of minority groups and women of lower SES status are disproportionately affected by IPV. Indeed, surveys show that women in the lowest income bracket are seven times more likely to be victims of domestic violence than women in the highest income bracket (Bureau of Justice, 2007). Surveys also suggest that African-American women experience intimate partner violence at a rate 35% higher than White women (Tjaden & Thonnes, 2000). Thus, it is imperative for therapists to understand the prevalence, negative consequences, and need to assess clients for IPV, particularly women who are members of minority groups.

Therapists are often faced with making difficult treatment decisions when their clients are in vague and potentially dangerous situations. Because our current understanding of therapists’ under-identification of IPV (and how biases and stereotypes may interfere with the detection of IPV) is limited, further research on this topic is sorely needed. By expanding this line of inquiry and investigating biases and stereotypes through the lens of attribution theory, researchers can begin to understand the processes by which therapists form clinical judgments about IPV victims. This understanding may
also help practitioners who work with victims of IPV assess how their personal biases and stereotypes limit their understanding of IPV.

Building on the current study, future researchers may well examine if and how multicultural training or self-awareness regarding cultural diversity issues affects clinicians’ recognition of IPV among diverse clients. For example, future research in this area should include a more detailed vignette, with explicit specific information about the client’s socio-economic status. Because of the high prevalence of IPV among women of color, future studies could replicate the present research with a client from other marginalized groups (e.g. Latina.). Additionally, because IPV also affects same-sex couples (e.g., Sorenson & Thomas, 2009), research is needed on stereotyping and bias in the clinical judgment of IPV among these couples. It may be that the use of videotaped (rather than written) vignettes that depict clients with different racial, religious, and SES backgrounds may be more effective in eliciting stereotypes and biases, offering a clearer understanding of how these biases may influence therapists’ assessment of IPV.

Yet another line of inquiry might include a qualitative aspect. That is, asking participants to explicitly identify the problems and or causes that they would address in therapy with an IPV victim, as well as why they think these issues are relevant or important, may offer important information on the reasons for the under-recognition of this serious national problem.
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Department of Justice.


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Appendix A

Clinical Problem, Severity, Attributions

Please list up to 5 clinical problems you might identify if you were seeing Linda in your practice. After listing each problem, please rate its severity on the 7-point scale (below).

For this scale, “severe” refers to the negative impact of the problem on the client. Finally, briefly describe the possible cause(s) of each problem.

1. Clinical problem ________________________________

How severe is this problem?: 1 2 3 4 5 6 7
minimal negative impact some negative impact extreme negative impact

The cause of problem 1 might be: (please describe BRIEFLY, in your own words. Do not worry about spelling or grammar).
____________________________________________________________
________________________________________________________________________

2. Clinical Problem ________________________________

How severe is this problem?: 1 2 3 4 5 6 7
minimal negative impact some negative impact extreme negative impact

The cause of problem 2 might be: (please describe BRIEFLY, in your own words. Do not worry about spelling or grammar).
____________________________________________________________
________________________________________________________________________

3. Clinical Problem ________________________________

How severe is this problem?: 1 2 3 4 5 6 7
minimal negative impact some negative impact extreme negative impact
The cause of problem 3 might be: (please describe BRIEFLY, in your own words. Do not worry about spelling or grammar).
________________________________________________________________________
________________________________________________________________________

4. Clinical Problem __________________________

How severe is this problem?:

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
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<tbody>
<tr>
<td>minimal negative impact</td>
<td>some negative impact</td>
<td>extreme negative impact</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The cause of problem 4 might be: (please describe BRIEFLY, in your own words. Do not worry about spelling or grammar).
________________________________________________________________________
________________________________________________________________________

5. Clinical Problem __________________________

How severe is this problem:

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>minimal negative impact</td>
<td>some negative impact</td>
<td>extreme negative impact</td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

The cause of problem 5 might be: (please describe BRIEFLY, in your own words. Do not worry about spelling or grammar).
________________________________________________________________________
Appendix B

INTERNAL - EXTERNAL DIMENSION

Adapted from the Cognitive Constructions Coding System

(Friedlander & Heatherington, 1998)

This bipolar scale refers to the locus of causal explanations for a problem. Internal explanations are those that attribute causality to the person, whereas external explanations attribute causality outside the person. The person refers to behavior, traits, interests, abilities, or deficits; personality style; physical, emotional, or psychological states; illness or disability; motivation, attitude, beliefs, values, and so forth. Outside the person refers to situations, contexts, events, other people, authorities (including "the system"), divine will, luck, or fate.

It should be noted that factors within the person that are explained by the participant as outside the person's control are nonetheless rated as internal. Examples of these are inherited diseases, an uncontrollable temper, a genetic predisposition to illness, etc.

In selecting a rating on the 1 (highly internal) to 5 (highly external) scale, the judge must first consider each explanation or attribution separately and make a judgment as to its internality (I) vs. externality (E). In making these ratings, the judge should consider all causes given for the identified problem. Thus, if there is more than one cause listed for the identified problem of Intimate Partner violence (IPV), each cause should be identified and rated separately. For example, if the cause of IPV is listed as “Her husband hit her because she is keeping secrets,” both statements should be rated as follows: “Her husband hit her,” would be rated a 5, highly external and “she is keeping secrets” would be rated a 1, highly internal.

---

1 = The speaker implicitly or explicitly attributes causality internally, i.e., to the person.

Examples:

1. Client’s low self-esteem, co-dependency or lack of self-worth

2. Client is keeping secrets

3. Client’s history of trauma or abuse.

4. Client doesn’t realize she’s a victim.

5. Client’s early childhood attachment issues.
6. Her depression, anxiety, alcoholism/substance abuse or personal psychopathology.

7. Client’s lack of assertiveness.

8. Client’s race or SES

2 = The speaker implicitly or explicitly attributes causality mostly internally, i.e., to the person, and the overall construction is primarily internal. This is when there’s some other person or external force involved but it’s mostly internal to the person.

Examples:
1. Client is unhappy with her job/job dissatisfaction.
2. Client feeling marginalized in relationship.
3. Client doesn’t communicate effectively with husband.
4. Client is unhappy with life circumstances.
5. Client doesn’t understand husband’s needs.

3 = The speaker implicitly or explicitly attributes causality equally to the person and to factors or situations outside the person and there is no basis for determining that internal explanations are more important than external ones.

Examples:
1. Poor communication in the couple.
2. Conflicting needs in the relationship
3. Differences in values and expectations.
4. Marital discord
5. They have poor conflict resolution
6. She lies, then he hits her
4 = The speaker implicitly or explicitly attributes causality mostly externally, i.e., to factors or situations outside the person and the overall construction is primarily external but not attributed fully to another person or circumstances.

Examples:

1. Cultural issues and norms
2. Limited support system
3. Intimidation
5. Family concerns.
6. Lack of access to resources.
7. Gender roles and norms

* * *

5 = The speaker implicitly or explicitly attributes causality externally, i.e., to another person, to fate/chance or to external circumstances.

Examples:

1. An abusive partner.
2. Partner’s anger
3. Partner’s lack of self control
4. Partner’s poor coping skills
5. Partner’s sexist views
6. He is trying to control her.
7. He hit her.
8. She is unlucky.
9. Her parents were abusive.
10. Real or perceived threats if client leaves partner.

11. Racial oppression, racism, or sexism
Appendix C

Demographic Questionnaire

Please provide the following demographic information.

1. Gender: ___ Male    ____Female _____ Other (please specify)
2. Age: _____
3. Race/ethnicity: ___African American/Black   ___Caucasian/Non-Hispanic
   ___Asian/Asian American/Pacific Islander   ___Native American
   ___Hispanic/Latino/a   ___Other(please specify)
4. Primary work setting: ____Inpatient   ____ Outpatient   ____College/university
   counseling center   ____Independent practitioner/Group practice   ____ Residential
   treatment   ____ School   ____ Other (please specify)
5. Highest degree: ___Ph. D  ___PsyD. ___M.A.  ___ M.S.   ____B.A./B.S.   ____ other
   (specify)
6. Primary theoretical orientation: ___Psychoanalytic   ___Humanistic ___Interpersonal
   ___Cognitive-Behavioral   ___Family Systems   ___Process-Experiential/Gestalt
   ___Solution-focused   ___Eclectic   ___Other (please specify)
7. Years of post-degree clinical experience: _____
8. Approximate number of clients seen per week: _____
9. What percentage of your current caseload is:
   ______ White
   ______ Black
   ______ Low-SES
   ______Middle SES
   ______ High SES
10. Please list any areas of expertise and training:
Appendix D

Manipulation Check

What was Linda’s race?  ________________________________

What was Linda’s Occupation?  _________________________

What was Linda’s socioeconomic status?
___low
___middle
___high
___unclear
Appendix E

Consent Form

Hello! My name is Susana Blanco and I am a doctoral candidate in the Counseling Psychology program of University at Albany, State University of New York. I would like to invite you to participate in my doctoral dissertation research, which is an investigation of therapists’ initial assessment of a client’s presenting problem. I realize that your time is valuable and that you probably receive many such requests. Participation in my study should take about 15 or 20 minutes, and to show my appreciation, I will donate $5 for every completed survey to Child Find of America. Child Find of America, Inc. is a national not-for-profit organization dedicated to the prevention and resolution of child abduction (http://www.childfindofamerica.org/).

I am looking to sample therapists from a range of disciplines (e.g., Social Work, Psychology, Mental Health, Marriage and Family Therapy), who are currently seeing clients and who have at least one year of face-to-face clinical experience (this includes students who have completed at least one year of practicum). I appreciate receiving surveys from anyone who meets these criteria.

Although my specific hypotheses can’t be revealed until a participant has completed the study, I believe that they will have important implications for practice, training, and supervision. If you agree to be a participant in this study, I will ask you to read a brief written vignette of a client’s presenting problems and answer some questions regarding your perceptions of and reactions to the client.

Participation in this study is voluntary and completely anonymous. Moreover, you are free to discontinue participation at any time.

This project has been approved by the University at Albany Institutional Review Board. Approval of this project only signifies that the procedures adequately protect the rights and welfare of the participants. Please note that absolute confidentiality cannot be guaranteed due to the limited protections of Internet access. Please be sure to close your browser when finished so no one will be able to see what you have been doing. If you have any questions or concerns about this study, please contact me, Susana Blanco, by phone at 305-502-9589 or by e-mail at sb288541@albany.edu. You may also contact the chair of this dissertation project, Dr. Myrna Friedlander, by phone at (518) 442-5049 or by e-mail at mfriedlander@uamail.albany.edu. If you have any questions concerning your rights as a research participant that have not been answered by the investigator or if you wish to report any concerns about the study, you may contact the University at Albany Office of Regulatory Research Compliance at 518-442-9050 (toll free 800-365-9139) or orrc@uamail.albany.edu.

If you would like to participate in the study, please click on "continue to Next page" below. Again, thank you very much for your time!

LINK:
Appendix F

Debriefing Statement

Thank you for your participation in this investigation!

You were randomly assigned by the Psychdata software program into one of four groups: high-SES White client, low-SES White client, high-SES Black client or low-SES Black client. With the exception of race and SES, all other client information remained the same. The three dependent variables were (a) recognition of IPV (yes or no), (b) perceived problem severity of IPV, and (c) internality.

Despite an increased attention in the literature regarding the importance of therapists recognizing intimate partner violence (IPV), many therapists lack the skills necessary to recognize IPV and therefore have a tendency to under-identify it (Hansen & Harway, 2004). In this study attribution theory (Heider, 1958) was used to examine how therapists’ perceptions (including biases and stereotypes) may influence their recognition of and causal attributions for IPV. Based on attribution theory, it is assumed that therapists who lack knowledge about the importance of assessing IPV may make stereotypic attributions (Bodenhausen & Lichtenstein, 1987) about victims of IPV. It is also reasoned that therapists who are familiar with racial and class-based stereotypes associated with IPV (e.g., “African Americans are a violent race” or “IPV only occurs in poor families”) may have emotional reactions to clients whose demographic characteristics prompt those stereotypes, affecting the therapists’ causal attributions about the IPV experienced by the client.

Thus, it is hypothesized that stereotypes associated with race, SES, and IPV will be evident in therapists’ recognition, rating of problem severity, and causal attributions of IPV. More specifically, I hypothesized that 40% of therapists will not indicate IPV as a clinical problem. Of those therapists who recognize IPV as problematic, I hypothesized that IPV will be rated as more problematic for a White and a high-SES client than for either Black or a low-SES client. Similarly, I hypothesized that these therapists will make causal attributions about the IPV that are significantly more internal with a Black and a low-SES client (i.e., locating the cause of IPV within the client herself).

This investigation seeks to further the research in issues involving therapist’s identification of intimate partner violence. It is hoped that the results of my study will further therapists’ work with victims of violence by examining the attributions therapist make about clients.

Again, I sincerely thank you for taking time out of your busy schedule to assist in this research. If you have further questions regarding this study please contact me, Susana Blanco at sb288541@albany.edu or at 305-502-9589 or the chair of this dissertation, Micki Friedlander, Ph.D. at mfriedlander@uamail.albany.edu or (518) 442-5049.
Appendix G

Table 9

*Mean I-E (Internality) Ratings (Causal Attributions for IPV)*

<table>
<thead>
<tr>
<th>I-E Rating</th>
<th>Written Attribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.0</td>
<td>Linda thinking it is ok for her husband to hit her.</td>
</tr>
<tr>
<td>1.0</td>
<td>She's dishonest</td>
</tr>
<tr>
<td>1.0</td>
<td>Could be secondary to the primary MH problems or exist independently</td>
</tr>
<tr>
<td>1.5</td>
<td>Limited communication skills, trouble with intimacy/personal expression</td>
</tr>
<tr>
<td>1.7</td>
<td>Unresolved marital and family of origin issues; stigma, self-esteem</td>
</tr>
<tr>
<td>1.7</td>
<td>Her shame and lack of previous healthy relationships; relationship issues</td>
</tr>
<tr>
<td>1.8</td>
<td>Life situation, marriage, low self esteem, depression</td>
</tr>
<tr>
<td>2.0</td>
<td>Relationship issues, drinking, maybe her job dissatisfaction</td>
</tr>
<tr>
<td>2.0</td>
<td>Possible co-dependency issues, a history of abuse,</td>
</tr>
<tr>
<td>2.3</td>
<td>Interplay of social issues concerning race, gender, SES, and power</td>
</tr>
<tr>
<td>2.5</td>
<td>Abuse history, stress in relationship, poor skills for managing anger, low self-esteem</td>
</tr>
<tr>
<td>2.7</td>
<td>Distrust in relationship, secrets by her, intimidation by him</td>
</tr>
<tr>
<td>2.7</td>
<td>Linda's self-concept, relationship history and dynamics, pattern of abuse/cycle</td>
</tr>
</tbody>
</table>

(table continues)
Table 9, continued

<table>
<thead>
<tr>
<th>I-E Rating</th>
<th>Written attribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.0</td>
<td>Husband gets angry when Linda speaks up</td>
</tr>
<tr>
<td>3.0</td>
<td>This one is the husband's problem; but wife may have come from abusive home as well.</td>
</tr>
<tr>
<td>3.0</td>
<td>Marital problems</td>
</tr>
<tr>
<td>3.0</td>
<td>Couple is caught in cycle of abuse</td>
</tr>
<tr>
<td>3.0</td>
<td>Partner not understanding Linda</td>
</tr>
<tr>
<td>3.0</td>
<td>Somehow maladaptive relationship patterns developed.</td>
</tr>
<tr>
<td>3.0</td>
<td>Husband feeling betrayed and acting out; client not being honest</td>
</tr>
<tr>
<td>3.0</td>
<td>Marital problems</td>
</tr>
<tr>
<td>3.0</td>
<td>Husband; client's past and self-esteem</td>
</tr>
<tr>
<td>3.0</td>
<td>Marital problems</td>
</tr>
<tr>
<td>3.0</td>
<td>Loss of connection and mutual goals between partners, lack of clear communication and trust</td>
</tr>
<tr>
<td>3.0</td>
<td>Her alcohol; his control, their infertility</td>
</tr>
<tr>
<td>3.0</td>
<td>Dysfunctional relationship with husband</td>
</tr>
<tr>
<td>3.0</td>
<td>Living with Abusive Spouse, her lack of understanding of being in a DV situation</td>
</tr>
<tr>
<td>3.0</td>
<td>Relationship difficulties</td>
</tr>
<tr>
<td>3.0</td>
<td>Her husband slaps her when she lies/confronts him</td>
</tr>
</tbody>
</table>

Table continues
<table>
<thead>
<tr>
<th>I-E Rating</th>
<th>Written attribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.0</td>
<td>Their poor skills for managing conflict &amp; stress</td>
</tr>
<tr>
<td>3.0</td>
<td>Long standing poor communication; psychopathology in both parties</td>
</tr>
<tr>
<td>3.0</td>
<td>Personal dynamics, environmental stressors, cultural</td>
</tr>
<tr>
<td>3.0</td>
<td>Poor communication pattern</td>
</tr>
<tr>
<td>3.0</td>
<td>Marital discord</td>
</tr>
<tr>
<td>3.3</td>
<td>Power/control issues, communication problems, cultural expectations of marriage</td>
</tr>
<tr>
<td>3.3</td>
<td>Unhappy marriage, husband's violence/anger, not feeling heard or cared for by him</td>
</tr>
<tr>
<td>3.5</td>
<td>Poor relationship and lack of appropriate communication with husband and his anger issues</td>
</tr>
<tr>
<td>3.5</td>
<td>Feeling marginalized in relationship, being physically abused in relationship</td>
</tr>
<tr>
<td>3.5</td>
<td>Lack of trust in relationship/relationship issues, could be due to early attachment</td>
</tr>
<tr>
<td>3.5</td>
<td>Interpersonal conflict; environmental context of patient</td>
</tr>
<tr>
<td>3.5</td>
<td>Partner abuse, her feeling powerless and helpless in the situation</td>
</tr>
<tr>
<td>3.7</td>
<td>Poor communication; poor conflict management; abusive husband</td>
</tr>
</tbody>
</table>

Table continues
<table>
<thead>
<tr>
<th>I-E Rating</th>
<th>Written attribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.8</td>
<td>Communication and marital problems; possible anger or cultural beliefs</td>
</tr>
<tr>
<td>4.0</td>
<td>Husband's anger, lack of trust in relationship</td>
</tr>
<tr>
<td>4.0</td>
<td>Marital issues, husband battering her</td>
</tr>
<tr>
<td>4.0</td>
<td>Domestic Violence/unhealthy relationship</td>
</tr>
<tr>
<td>4.0</td>
<td>Cultural expectations in marriage</td>
</tr>
<tr>
<td>4.0</td>
<td>Interpersonal communication, mental health issues of husband.</td>
</tr>
<tr>
<td>4.0</td>
<td>Lack of emotional connection, gender roles, husband's own issues</td>
</tr>
<tr>
<td>4.0</td>
<td>Her husband's anger and their lack of communication. She's afraid to tell him anything</td>
</tr>
<tr>
<td>4.0</td>
<td>Marital problems; husband's physical violence towards her</td>
</tr>
<tr>
<td>4.0</td>
<td>It sounds like there is a significant amount of marital discord/abuse by the husband.</td>
</tr>
<tr>
<td>4.0</td>
<td>Marital discord, and abusive husband.</td>
</tr>
<tr>
<td>4.0</td>
<td>Violent, controlling partner; submissive pattern of relating; cultural or religious mores</td>
</tr>
<tr>
<td>4.0</td>
<td>Cultural contextual factors</td>
</tr>
<tr>
<td>4.0</td>
<td>Cultural issues/values influence relationship</td>
</tr>
<tr>
<td>4.0</td>
<td>Abusive behaviors by husband and or slow degradation of communication in marital relationship</td>
</tr>
</tbody>
</table>

*Table 9, continued*
<table>
<thead>
<tr>
<th>I-E Rating</th>
<th>Written attribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.0</td>
<td>Social, cultural, gender related, power</td>
</tr>
<tr>
<td>4.0</td>
<td>Perpetrator's personality and other contextual factors; interaction b/w the perpetrator and victim</td>
</tr>
<tr>
<td>4.3</td>
<td>Abusive relational pattern in marriage, limited social support, lack of access to resources, fear</td>
</tr>
<tr>
<td>4.5</td>
<td>Fear at home, specifically in marriage given she was previously hit by her husband.</td>
</tr>
<tr>
<td>4.5</td>
<td>Her husband hit her and she's afraid to talk to him</td>
</tr>
<tr>
<td>5.0</td>
<td>The husband's maladaptive reaction to the client speaking honestly about their relationship.</td>
</tr>
<tr>
<td>5.0</td>
<td>Her husband being abusive</td>
</tr>
<tr>
<td>5.0</td>
<td>Husband slapped client</td>
</tr>
<tr>
<td>5.0</td>
<td>Her husband</td>
</tr>
<tr>
<td>5.0</td>
<td>Marital discord</td>
</tr>
<tr>
<td>5.0</td>
<td>Client is involved in an abusive relationship which effects her safety.</td>
</tr>
<tr>
<td>5.0</td>
<td>Husband hit her</td>
</tr>
<tr>
<td>5.0</td>
<td>Stressed husband</td>
</tr>
<tr>
<td>5.0</td>
<td>Her husband</td>
</tr>
<tr>
<td>5.0</td>
<td>Abusive Partner</td>
</tr>
</tbody>
</table>

Table continues
<table>
<thead>
<tr>
<th>I-E Rating</th>
<th>Written attribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.0</td>
<td>Husband's inability to express emotions in a healthy manner and/or poor representation of how marriage</td>
</tr>
<tr>
<td>5.0</td>
<td>Husband</td>
</tr>
<tr>
<td>5.0</td>
<td>His sexist views, insensitivity.</td>
</tr>
<tr>
<td>5.0</td>
<td>Her husband's insincerity</td>
</tr>
<tr>
<td>5.0</td>
<td>Husband physically and emotionally abusive</td>
</tr>
<tr>
<td>5.0</td>
<td>Husband's inability to manage his anger responses.</td>
</tr>
<tr>
<td>5.0</td>
<td>Pretty self-explanatory- she is being physically abused by her husband</td>
</tr>
<tr>
<td>5.0</td>
<td>Husband's abuse towards Linda</td>
</tr>
<tr>
<td>5.0</td>
<td>Abusive husband</td>
</tr>
<tr>
<td>5.0</td>
<td>Spousal abuse, verbal and physical</td>
</tr>
<tr>
<td>5.0</td>
<td>Lack of emotional intelligence on husband's side and ability to hear disagreements</td>
</tr>
<tr>
<td>5.0</td>
<td>Spouse’s lack of healthy coping</td>
</tr>
<tr>
<td>5.0</td>
<td>Spouse as DV perpetrator</td>
</tr>
<tr>
<td>5.0</td>
<td>Husband's anger</td>
</tr>
<tr>
<td>5.0</td>
<td>Abusive man's behavior...</td>
</tr>
<tr>
<td>5.0</td>
<td>Husband's anger management problems</td>
</tr>
<tr>
<td>5.0</td>
<td>Husband</td>
</tr>
</tbody>
</table>

Table continues
<table>
<thead>
<tr>
<th>I-E Rating</th>
<th>Written attribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.0</td>
<td>Husband resorts to physical violence toward client during arguments</td>
</tr>
<tr>
<td>5.0</td>
<td>Husband's anger management problem</td>
</tr>
<tr>
<td>5.0</td>
<td>Married to man who is emotionally and physically abusive</td>
</tr>
<tr>
<td>5.0</td>
<td>Husband's anger &amp; violent behavior.</td>
</tr>
</tbody>
</table>

*Note. n = 95.*
Table 10

*Frequencies of Problems in Which IPV was Listed as the Cause*

<table>
<thead>
<tr>
<th>Problem</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td>38</td>
</tr>
<tr>
<td>Anxiety</td>
<td>28</td>
</tr>
<tr>
<td>Marital problems</td>
<td>12</td>
</tr>
<tr>
<td>Alcohol</td>
<td>8</td>
</tr>
<tr>
<td>PTSD or trauma</td>
<td>7</td>
</tr>
<tr>
<td>Possible eating disorder</td>
<td>2</td>
</tr>
<tr>
<td>Sleep difficulties</td>
<td>2</td>
</tr>
<tr>
<td>Work difficulties</td>
<td>3</td>
</tr>
</tbody>
</table>

*Note. n = 100, which includes participants who listed IPV as the cause of one or more other clinical problems.*