FACTORS THAT INFLUENCE ATTITUDES, BELIEFS, AND BEHAVIORS OF STUDENTS TOWARD SURVIVORS OF VIOLENCE

Judy L. Postmus
Rutgers University

Corinne Warrener
Rutgers University

Sarah McMahon
Rutgers University

Lisa Macri
Rutgers University

Social workers will inevitably encounter survivors of domestic violence or sexual assault in their work. In this study we explore how education, training, and personal or professional experiences influence students' attitudes, beliefs, and behavior toward survivors. Results indicate that education and/or training decreases students' blaming attitudes and beliefs supportive of myths and increases their screening behavior. Additionally, professional experience and indirect personal experience was found to predict screening behavior, whereas direct personal experience did not show any significance. These results provide much needed information for schools to better prepare students to work with survivors of violence.

MILLIONS OF WOMEN experience physical, sexual, and other forms of violence every year in the United States (Tjaden & Thoennes, 1998, 2006), often sustaining devastating and long-lasting physical, psychological, emotional, and social wounds (Coker, Davis, et al., 2002). Reaching out for help is often the first step to lessen the impact of such violence (Coker, Smith, et al., 2002; Thompson et al., 2000). Most survivors turn to family and friends first and then to formal supports, including social workers, medical providers, law enforcement, and other pro-fessionals (Coker, Derrick, Lumpkin, Aldrich, & Oldendick, 2000; Macy, Nurius, Kernic, & Holt, 2005). Unfortunately, not all of the servic-es or supports are found to be helpful by sur-vivors (Humphreys & Thiara, 2003; Postmus, Severson, Berry, & Yoo, 2009; Zweig & Burt, 2007). Indeed, some researchers use the term "secondary victimization" to describe how for-mal supports may end up revictimizing the victim by creating additional trauma and prob-lems for victims (Campbell, 2008; Macy et al., 2005; Ullman, 1996).

As social workers we are charged with meeting the needs of oppressed and vulnerable groups (National Association of Social Workers [NASW], 1996), in which survivors of violence are certainly included. Because 52% of women in the United States experience some form of interpersonal violence at least once in their lifetime (Tjaden & Thoennes, 1998), one would assume that social workers will encounter survivors of violence in their work whether the abuse is identified or not. Social workers are in a unique position to screen for violence and abuse with clients (Tower, 2003). The practice of screening for domestic and sexual violence has been widely identified as an essential piece of effective prevention and intervention (Family Violence Prevention Fund [FVPF], 1999).

This article explores the factors that influence the attitudes, beliefs, and screening behaviors of MSW students regarding violence against women.[1] Specifically, we examine how education, training, and personal or professional experiences influence students' attitudes, beliefs, and behavior toward survivors of violence. We begin by presenting a review of existing work that provides background and understanding about factors that influence MSW students' attitudes, beliefs, and behaviors. We then present the results from a research study with MSW students attending Rutgers University. We conclude with a discussion of those findings and implications for social work practitioners and educators.

Theoretical Perspective

To better understand the factors that influence MSW students' attitudes, beliefs, and behaviors regarding violence against women, we turn to experiential learning theory, which emphasizes a holistic approach on how adults learn, grow, and develop (Kolb, Boyatzis, & Mainemelis, 2001). By focusing on how experiences shape our learning process, Kolb blends the work of Dewey, Lewin, and Piaget on cognitive and behavioral psychology by including experiential processes. Experiential learning theory posits that knowledge comes from two different modes of grasping experiences through concrete or abstract conceptualization. Knowledge also comes from two additional modes when experiences are transformed through reflective observation or active experimentation. Adults develop a learning style or a preferred method of learning based on social identity, past life experiences, and the current demands of their environment. Learning from experiences then influences behaviors that, in turn, influence experiences in an ongoing cycle.

Hence, using experiential learning theory, we hypothesize that MSW students' attitudes, beliefs, and behaviors regarding violence against women are related to what they have learned, both formally through curricula and informally through other experiences. To understand these attitudes, beliefs, and screening behaviors, experiential learning the-

---

[1]We specifically talk about violence against women in this article because women disproportionately represent victims and males as perpetrators of physical, sexual, and other forms of violence. Hence, we will refer to victims as female and perpetrators as males. This in no way diminishes the experiences of male victims nor absolves females of violence they might inflict on males or other females.

ory suggests that we must (a) consider whether social workers received education or training that prepared them for such screening behaviors, (b) determine their past life experiences (i.e., personal and professional experiences with violence and victimization), and (c) understand the influence of their social identity (i.e., demographic background).

Education and Training on Violence Against Women

Social work education woefully lacks information on topics related to domestic violence and sexual assault in our curricula (Cohn, Salmon, & Stobo, 2002; Danis, 2003). Danis and Lockhart (2003) outline how the two largest professional associations—the Council on Social Work Education (CSWE) and NASW—lack standards, competencies, or policies that specifically address domestic violence or sexual assault unless attached to other family violence statements. Without a dedicated stance or specific requirements, it is no wonder that in 2003 only 18 of the 258 BSW programs and 17 of the 74 MSW programs had a course on family violence, covering adult and childhood victimization; only three BSW and five MSW programs had specific courses on domestic violence (Danis & Lockhart, 2003). For example, one study of medical social workers in Florida found that most (64%) had domestic violence content as part of their professional education; however, only 24% reported taking a separate course, 11% as an elective, and 9% as a required course (Tower, 2003).

We often turn to training or education as a strategy to improve attitudes, beliefs, and behaviors regarding violence against women;

however, little is known about its impact on students. In a recent study of those respondents who had domestic violence as part of their MSW education, 84% reported that the knowledge helped them screen clients for domestic violence (Tower, 2003). Other studies found that when students participate in an experiential learning project on domestic violence or sexual assault they improve their knowledge about violence against women, increase their desire to pursue a career in the field, and feel more empowered to take action to create macro level change (Bent-Goodley, 2007; Carey, 2007; Cheek, Rector, & Davis, 2007).

Whereas research on the impact of formal education on violence against women is limited, more research is available on training. For example, sexual assault training provided to police officers resulted in a greater understanding of sexual assault and a reduction in victim blaming (Campbell & Johnson, 1997; Kinney, Bruns, Bradley, Dantzler, & Weist, 2008; Page, 2008). In contrast, another study found that although training for police officer recruits produced positive behavioral change, there were no changes on cognitive or attitudinal dimensions (Lonsway, Welch, & Fitzgerald, 2001). In studies with health care professionals those who received domestic violence training temporarily improved their skill in screening for domestic violence, their attitudes toward victims of domestic violence, and their knowledge about available resources (Haase, Short, Chapman, & Dersch, 1999; Tower, 2003). Other research with child welfare workers suggests that domestic violence training brings changes in attitudes

about, assessment of, and interventions with families experiencing violence (Humphreys, 1999; Magen & Conroy, 1998; Mills & Yoshihama, 2002; Postmus & Ortega, 2005; Saunders & Anderson, 2000; Waugh & Bonner, 2002). Finally, researchers have demonstrated that one-time seminars or lectures on rape prevention, offered on university campuses, have little to no effect on changing attitudes toward rape survivors (Anderson & Whitson, 2005; Currier & Carlson, 2009).

Professional and Personal Experiences

Professional experiences include those that occur as part of delivering services to survivors of violence as a job or as a volunteer. Findings are inconclusive regarding the relationship between professional experiences and attitudes, beliefs, and behaviors toward victims or survivors of violence. A study found that as exposure to battered women increases, the victim-blaming attitudes of law enforcement professionals decrease (Campbell & Johnson, 1997). In several studies with child welfare workers, those with longer professional careers were less likely to require a woman to leave an abusive situation or remove a child when compared to those with shorter careers (Postmus & Merritt, 2010; Postmus & Ortega, 2005; Saunders & Anderson, 2000). Yet another study indicated that the length of employment in a child welfare agency did not affect workers' interventions with families experiencing domestic violence (Yoshihama & Mills, 2003).

Our understanding of the prevalence and impact of personal experiences with victimization on attitudes, beliefs, and behaviors is limited. A few studies report as little as 11% to as much as 37% of workers in the helping professions have experienced domestic violence, sexual assault, or abuse in childhood (Elliott & Guy, 1993; Hagen & Owens-Manley, 2002; Hansen et al., 1997; Magen & Conroy, 1998; Pope & Feldman-Summers, 1992). A more recent study with practicing social workers found 15%–32% of those responding to the survey had experienced physical, sexual, or emotional abuse as a child (Pooler, Siebert, Faul, & Huber, 2008). Finally, another study with MSW students found that more than half reported experiencing some negative family history (e.g., family violence, alcohol or drug abuse, addictive behaviors; Sellers & Hunter, 2005).

Studies of whether personal experiences with victimization impact attitudes, beliefs, or behaviors of helping professionals are also limited and contradictory. Research with child welfare workers finds no apparent correlations between personal experiences of domestic violence and attitudes toward victims or batterers (Magen & Conroy, 1998; Postmus & Merritt, 2010; Postmus & Ortega, 2005; Yoshihama & Mills, 2003); in contrast, another study found that when child welfare workers relate their own victimization experiences and empathize with battered women, they are less likely to remove children from their home (Yoshihama & Mills, 2003). Similarly, in studies with medical providers, one study found that personal experiences were associated with appropriate responses to domestic violence (Cullinane, Albert, & Freund, 1997). In contrast, several other studies found no relationship (Coleman & Stith, 1997; Moore, Zaccaro, & Parsons, 1998; Parsons, Zaccaro, Wells, & Stovall, 1995).

Personal Demographics

Results from several studies are contradictory when comparing attitudes, beliefs, and behavior about domestic violence by gender. Studies with medical providers indicate that female physicians were more likely to screen for domestic violence (Best, Dansky, & Kilpatrick, 1992; Parsons et al., 1995; Saunders & Kindy, 1993), whereas others found no demographic variable affecting screening behaviors (Hansen et al., 1997; Tower, 2003). Research with child welfare workers found that female workers were more likely than male workers to insist that women leave abusive relationships (Saunders & Anderson, 2000). Studies with psychology students found females had more positive attitudes toward women that, in turn, resulted in their blaming the perpetrator for the physical or sexual violence occurring and less victim blaming (Bryant & Spencer, 2003; Kristiansen & Guilietti, 1990; Locke & Richman, 1999). Finally, several studies on attitudes about rape and rape victims have found men more likely than women to accept or believe rape myths, blame rape victims, and hold negative attitudes about rape victims (see Currier & Carlson, 2009 for an excellent review of the relationship between demographic factors and rape myths). Ethnic differences can also be found in the literature, with Whites being least likely to believe rape myths, Blacks more likely than Whites, and Asians more likely than any other racial group to blame rape victims and believe rape myths (Currier & Carlson, 2009). However, these results must be taken with caution because the measures used may not have been culturally sensitive or may not have captured the subtleties of such rape myths.

In summary, we know very little about the educational, training, professional, or personal experiences of MSW students regarding violence against women. Nor do we know how or whether those experiences influence their attitudes, beliefs, or behaviors. As such, the research study described in the following paragraphs provides an initial view of those experiences among a cohort of MSW students in graduate school at Rutgers University. Specifically, we seek to answer the following research questions:

- What is the prevalence of education and training received by social work students?
- How does that education or training influence students' attitudes, beliefs, or behaviors toward survivors of violence?
- What is the prevalence of professional experiences with violence against women?
- How do those experiences influence students' attitudes, beliefs, or behaviors toward survivors of violence?

Based on the limited research available, we hypothesize that MSW students with educational, training, professional, or personal experiences will be less likely to believe myths about survivors, less likely to blame them, and more likely to screen for victimization with their clients.

Methods

Sample and Data Collection

This exploratory study invited all students enrolled in the MSW program at the School of Social Work at Rutgers University to participate in an online survey about their experiences

with violence against women. All MSW students (N=1,116) received an e-mail from the research team and received flyers from faculty encouraging participation. After completing the survey students were invited to go to another website to enter a raffle to win gift certificates tó the university bookstore. The raffle website was separate from the survey, ensuring that the surveys could not be linked to particular students.

Of the 1,116 full- and part-time MSW students who were invited to participate in the study, a total of 301 completed the survey. After eliminating those surveys with missing data, the final sample of 283 (25% response rate) includes 93% female, 66% White, 61% between the ages of 21–30, and 60% full-time students. These results are similar to the entire MSW study body at this particular program.

Independent Variables

Personal experiences. Seven items were altered from a condensed version of the Revised Conflict Tactics Scale (Straus, Hamby, Sugarman, & Boney-McCoy, 1996) asking about students' personal experiences with domestic and sexual violence. The original scale has reliability ranges from .79 to .95 with evidence of construct validity; however, not all items in the scale were used in this study. The items were divided into two categories: direct and indirect experiences. Direct experiences were assessed asking one Likert-type question (1–5) on the extent they had ever been pushed, slapped, kicked, or otherwise physically hurt by a current or previous intimate partner. Additionally, two questions on sexual violence were asked, including the extent they had been forced into fondling,

kissing, sexual touching, or the extent they were forced into sexual intercourse. A mean score from these three questions was used as the "direct personal experience" variable.

Indirect experiences were measured by four items asking whether the participant knew friends or family members who had ever experienced physical or sexual assault. One item asked the extent one of their parents threatened, pushed, slapped, or physically hurt the other with a Likert scale (1–5) similar to the questions about direct personal experiences. The remaining three items asked whether (1) friends had experienced physical domestic violence, (2) friends were forced to have sexual intercourse, and (3) family members had ever experienced physical domestic violence. A mean score of these four items was used as the "indirect personal experience" variable.

Professional experiences. Professional experience was determined by the student's exposure to working with clients who were victims of domestic violence or sexual assault. Two questions asked to what extent students had worked or volunteered with survivors of domestic violence or sexual assault using a Likert scale of 1 (*never*) to 5 (*four or more times*). A mean score was created from the two questions to be used in the analysis.

MSW education. This variable was assessed by asking whether participants had ever received information on sexual assault or domestic violence in their MSW coursework. Four questions asked about specific exposure, such as reading articles, writing a paper, or learning about treatment or prevention. A mean score created the "education" variable used in the analysis.

Training received. This variable was assessed by asking seven questions about whether participants had ever received information on sexual assault or domestic violence through training outside of their MSW coursework (e.g., community presentations, conferences, or in-service training). The mean score of these seven items was used in the analysis.

Age, race, and gender. Age was coded as a continuous variable, ranging from 1–6 based on categories used in the original instrument. (The categories are 21–25, 26–30, 31–40, and every decade up to 61 and older.) Race was modified into a dummy variable, with 0=White and 1=non-White. Gender included male or female options as well as other.

Dependent Variables

Attitudes. The Attitudes Toward Victims variable was created from the mean score of 12 items that asked questions about participants' views about victims. These items were collected from the following scales: the Domestic Violence Blame Scale (Petretic-Jackson, Sandberg, & Jackson, 1994), the Health Care Provider Survey for Domestic Violence (Maiuro et al., 2000), the Domestic Violence Myth Acceptance Scale (Peters, 2003), the PREMIS tool (Short, Alpert, Harris, & Surprenant, 2006) and the Illinois Rape Myth Acceptance Scale (Payne, Lonsway, & Fitzgerald, 1999). Exploratory factor analysis was conducted with 30 items; two factors accounted for most of the variance, including the attitudes toward victims variable and the beliefs about victims variable (see following paragraph for a description of beliefs about victims variable). Twelve items were loaded on one factor, becoming the attitudes toward victims variable, which focused

on the participant's victim-blaming attitudes (α=.78). A mean score of the 12 items was created, ranging from 1–5 (from *strongly disagree* with blaming attitudes to *strongly agree*). An example of a question on the scale indicating a blaming attitude is: "If a woman is raped while she is drunk, she is at least somewhat responsible for what happened."

Beliefs. The beliefs about victims variable was also created from the exploratory factor analysis of 30 items, as with the attitudes toward victims variable. The beliefs about victims variable consists of four items and focuses on the respondent's belief in statements of myths or stereotypes about victims (α=.73). A mean score of the four items was used in the regression, ranging from 1–5 (from *strongly disagree* with myths to *strongly agree*). An example of a question from the Beliefs scale is: "Domestic violence is more likely to occur in lower socioeconomic neighborhoods."

Behavior. The behavior variable was measured by one question that asked how often the respondent asks questions to screen for domestic violence or sexual assault with the clients he or she serves in field placement. The responses were answered on a five-point Likert-type scale from *never* to *always* (1–5).

Data Analysis

All data were collected through Zoomerang, an online survey program used to anonymously capture answers to the questions. All answers were recorded in an Excel file, which was imported into SPSS 16.0 for data analysis. All data were thoroughly cleaned and double checked for accuracy. Finally, exploratory factor analyses were completed to create the two variables for attitudes and beliefs; reliability

coefficients were calculated for the resulting subscales.

To answer the prevalence research questions, descriptive analyses provided frequencies of the variables included in the study. Additional analyses of variance were run to determine differences between groups on several demographic factors compared to the independent variables. To answer the research questions about the impact of the independent variables (personal and professional experiences, education, and training) on the dependent variables (attitudes, beliefs, and behavior), regression was used to determine strength and direction of the relationships. Gender was not included as part of the regression analysis because the sample was overwhelmingly women (93%).

Results

Table 1 shows the main variables used in analysis. The six items used for personal experiences are listed, with the first three being the indirect experiences and the last three being the direct experiences. Notably, 75% of students in the sample reported having a friend who had been physically or sexually assaulted by a partner. Fifty-seven percent reported a

TABLE 1. Descriptive Statistics of Main Variables (N=283)

	N	%
Personal Experiences with VAW		
Friend physically or sexually assaulted	213	75
Family member physically assaulted by partner	160	57
Parent(s) physically assaulted each other	109	39
Respondent forced into sexual touching	127	45
Respondent physically assaulted by partner	93	33
Respondent forced into sexual intercourse	68	24
Professional Experience	166	59
MSW education: Took a course that included a section on DV/SA	137	48
Training: Received information, training or education about DV/SA outside of MSW coursework?	163	58
Screening: How often do you ask questions to screen for domestic violence or sexual assault? (n=209)[a]		
Never	47	23
Rarely	43	21
Sometimes	36	17
Frequently	33	16
Always	50	24

Note. VAW=violence against women; DV/SA=domestic violence/sexual assault.
[a]n=209 for this group because the screening question was based on whether the respondent was currently working with clients.

family member who had experienced physical domestic violence; and 39% had a parent who threatened, pushed, slapped, kicked, or otherwise physically hurt the other parent. Students also reported their direct experiences with violence, including 33% reporting physical domestic violence, 45% reporting sexual touching experiences, and 24% reporting being forced to have sexual intercourse. Professionally, 59% of students reported working or volunteering with victims of domestic violence or sexual assault. When the independent variables of personal, professional, educational, and training experiences were compared with the demographic variables, no significant differences were found among groups.

Descriptive statistics on education and training show the overall results for whether the respondent had taken a course that included something (i.e., section of a course, assignment, readings) about domestic violence or sexual assault and whether she or he had received training. Less than half (48%) had a class that covered domestic violence/sexual assault, and a little more than half (58%) received information, training, or education about domestic violence or sexual assault from a source outside of the social work program.

Results for frequency of screening indicate a range of responses as to how often MSW students screen for victims of domestic violence or sexual assault. Forty-four percent of students never or rarely screened for violence compared to the 40% who screened frequently or all of the time. The results of the Blame Scale indicate a mean of 1.69 (*SD*=.45) on a 5-point Likert scale with 1 representing *strongly disagree* with blaming attitudes. The Myth Scale has a mean of 2.26 (*SD*=.73) with similar 5-point Likert scale questions.

The results of the regression analysis indicate some of the relationships between independent and dependent variables are significant. Table 2 reports both the standardized and unstandardized coefficients. For attitudes, MSW education, training, and professional

TABLE 2. Results of Regression Analysis

	Attitudes			Beliefs			Behaviors		
	b	SE	*B*	*b*	SE	*B*	*b*	SE	*B*
Direct personal experience	<.01	.03	.01	.05	.04	.07	.04	.10	.03
Indirect personal experience	−.02	.03	−.05	.02	.04	.03	.27**	.11	.18**
Professional experience	−.04*	.02	−.12*	−.08***	.03	−.17***	.19***	.07	.21***
MSW education	−.05***	.01	−.19***	−.02	.02	−.05	.14**	.05	.17**
Training	−.04**	.02	−.16**	−.07**	.03	−.16**	.06	.06	.07
Age	.02	.02	.05	−.13***	.04	−.21***	.07	.09	.06
Ethnicity	.04	.06	.05	−.02	.09	.01	−.26	.22	-.09

*p<.05, **p<.01, ***p<.001

experiences were the best predictors of the dependent variables. As MSW education, training, or professional experiences increased, blaming attitudes decreased. The adjusted R^2 for attitudes was .08, or 8% of the variance was explained by the model.

Professional experience, training, and age were significant predictors for beliefs. All had a negative impact on beliefs, indicating that as professional experience, training, or age increased, the belief in myths about victims decreased. The adjusted R^2 for beliefs was .10, or the model explained 10% of the variance.

For the behavior of frequency of screening, indirect personal experience, professional experience, and MSW education were significant. All three variables are positively correlated with the dependent variable. As indirect personal experience, professional experience, and MSW education increased, the frequency of screening for victims of domestic violence and sexual assault increased. The adjusted R^2 for behavior was .13, or the model explained 13% of the variance.

Discussion

The purpose of this exploratory study was to learn about how the educational, training, and professional or personal experiences of MSW students related to violence against women as well as learn what influences students' attitudes, beliefs, and behavior toward survivors. The results indicate that this sample of students had high rates of personal experience with domestic violence or sexual assault as indicated by 57%–75% of students reporting knowing a family member or friend who experienced abuse. These rates are similar to the 66% of the general population study who indicated knowing someone experiencing domestic violence (Carlson & Worden, 2005). Additionally, one third of the students in this sample experienced physical domestic violence and one fourth experienced rape—numbers that are a little higher than normal population studies but in the same range as those studies on professionals in the human service fields (Elliott & Guy, 1993; Hagen & Owens-Manley, 2002; Hansen et al., 1997; Magen & Conroy, 1998; Pope & Feldman-Summers, 1992). These rates of personal experiences remind us that not only must we prepare our students to effectively work with survivors, but that we must also be cognizant that there are many survivors among our student population. It is incumbent on social work educators to integrate materials on violence into our curricula while also being sensitive to the needs of our students. Progressing through a graduate program and learning about the myriad of social problems clients face can possibly bring up reminders or unresolved feelings students may have about their own experiences with victimization. As social work educators we must be mindful of students' histories, acknowledge such histories, and provide appropriate referrals to those needing help. Indeed, schools of social work are not immune to outside challenges or experiences students bring to the classrooms; however, we must be cautious about material we present or discussions we prepare, providing outlets for unresolved or ongoing feelings. We must be especially mindful of students currently or recently involved in abusive relationships and sensitive to struggles those individual students endure as well as how their classmates and

peers react to such struggles. One recommendation is to partner with the department on campus that provides services for survivors of violence or local service providers and invite them to provide a brief presentation at a faculty meeting to increase awareness not only of the problem but also of the resources available for survivors.

Other results from this study indicate that 47% of students in this sample had taken a stand-alone course or learned about violence against women in at least one of their courses through readings, lectures, or assignments. Unfortunately, the survey did not ask whether the student took a course that focused primarily on violence against women but instead only measured exposure within other courses; more research is needed to capture potential differences. This finding may be a reflection of the availability of stand-alone courses at this particular university as well as opportunities provided to the faculty to incorporate such topics in their classes. For example, the Rutgers Office of Violence Prevention and Crime Victim Assistance sponsors a "Don't Cancel Class" program in which they will cover any class at the university and provide content on violence against women in any discipline. Many faculty members at the School of Social Work have taken advantage of this program, incorporating the presentation into their classes. Additionally, Rutgers is committed to addressing violence against women as reflected by the creation of an academic center dedicated to providing research, teaching, and training on violence against women and children. Hence the opportunities for students to learn about violence against women in this particular graduate program are high. How-ever, with such opportunities for exposure, 47% of students might be considered low. Further research is needed to fully understand the amount and type of education received by students. Additionally, the fact that 47% of the sample received education on the issue of domestic violence and/or sexual assault may indicate that the sample was self-selected, and those students who had learned more about the issue were more likely to participate in a survey. Further research is also needed at other institutions to gather a better understanding of the number of students who are exposed to content on domestic violence and sexual assault. Given the high prevalence of victimization in our society, it is likely that all social workers will encounter clients who have experienced abuse. Therefore, we argue that ideally, all MSW students should receive some educational content on sexual assault and domestic violence.

In addition to providing information about the prevalence of victimization among a sample of MSW students, this study provided preliminary findings about their attitudes and behaviors toward survivors. Our hypothesis (i.e., MSW students with educational, training, professional, or personal experiences are less likely to believe myths about survivors, less likely to blame them, and more likely to screen for victimization with their clients) is partially proven. Results from this study indicate that education and/or training as well as professional experience working with survivors decreases students' blaming attitudes toward survivors; however, the model predicting attitudes is not particularly strong, with the R^2 accounting for less than 8% of the variance. With several studies indicating

negative responses from service providers toward survivors (Campbell, 2008; Macy et al., 2005; Ullman, 1996), this finding supports the need to encourage more education and training that specifically addresses blaming attitudes.

Additionally, professional experience, age, and training were found to significantly impact students' beliefs about violence against women as well as their willingness to believe myths commonly regarding survivors. However, the model predicting attitudes is not particularly strong, with the R^2 accounting for less than 10% of the variance. More research is needed to fully understand how training can specifically affect beliefs as well as attitudes with social workers. After formal education, training provides opportunities for social workers to learn about working with survivors of violence. If licensed, most social workers are required to take continuing education workshops; unfortunately, only one study exists on this topic, reporting that 50% of social workers who responded to the Governor's Task Force survey in Florida took a continuing education course in domestic violence (Tower, 2003). However, Florida requires licensed professionals to obtain domestic violence training, suggesting that the results mentioned previously are probably higher than those states that do not require such training. We must encourage our licensing boards to require training on violence against women as part of maintaining licensure.

Finally, education, professional experience, and indirect personal experience was found to predict screening behavior; however, the model predicting attitudes is not particularly strong, with the R^2 accounting for less

than 13% of the variance. Curiously, direct personal experience did not show any significance with any of the models. It seems logical that students with greater exposure to working or volunteering with survivors (58% of this sample) would be more comfortable to ask the "difficult" screening questions; additionally, those that have indirect experiences may be more sensitized and willing to screen. Yet in this sample of students, 44% never or rarely screened for domestic violence or sexual assault in their field placements. It is possible that although students might be willing to screen for violence, the organization in which they are placed may not allow or may even discourage such screening. Unfortunately, students were only asked one question about whether they screened for violence against women with their clients; they were not asked any specifics about their screening methods or questions used. Further research is needed to uncover screening protocols at the organizations that take MSW students for field practica and determine the contextual environment that may encourage or inhibit open dialogue about including such screening if not present. Social workers are in a unique position to screen for domestic violence and sexual assault and, therefore, further research on this topic is critical.

There are some limitations that warrant attention when interpreting the results. First, this convenience sample of MSW students does not represent the rest of their classmates nor any other students at other MSW programs. Indeed, with a 25% response rate, self-selection bias may be in play, with students who have more personal or professional experience with violence against women more willing to com-

plete the survey. Future research must attempt to address such bias by taking random samples and comparing results with other schools before any generalization to all MSW students in the United States can be made. Second, the instrument used in this study needs further attention and validation, determining the most effective and reliable method to ask sensitive questions of students. Finally, the R^2 accounts for less than 13% of the variance in the model predicting behavior with lower amounts (8% and 10%, respectively) in the model predicting attitudes and beliefs; further research is needed to test these models. Regardless, the information generated by this exploratory study should provide a starting point for further research as well as provide much needed information for schools to begin communicating about how to adequately and sensitively prepare students, who may have their own personal experiences, to work with survivors of violence in their practice.

Implications and Conclusion

As social workers we will encounter survivors of violence in our work whether the abuse is identified or not, and hence are in a unique position to screen for such violence with clients (Tower, 2003). National associations for physicians, nurses, and other professions have recommended screening for domestic violence as a routine part of practice (American Medical Association, 1992; American Nurses Association, 1992; FVPF, 1999). Because social workers can serve as a critical point for intervention with clients experiencing abuse, it stands to reason that social workers should receive appropriate education and training on how to screen, assess, and inter-

vene with women experiencing physical, sexual, and other forms of violence and not perpetuate further problems for these survivors.

There are several ways to screen for violence or victimization including direct or indirect questioning or posting information around the office. The health care field has developed excellent models for direct screening that can be borrowed and adapted by social workers. For example, FVPF (1999) produced a series of clinical guidelines on routine domestic violence screening (available online at http://new.vawnet.org/Assoc_Files_VAW net/screpol.pdf). Their recommendations include screening all girls ages 14 and older, using culturally competent screening tools, and maintaining confidentiality. The Centers for Disease Control compiled a report including the strengths and weaknesses of available tools to assess domestic violence and sexual assault in healthcare settings and provides many of the actual assessment tools free of charge (Basile, Hertz, & Back, 2007; available online at http://www.cdc.gov/NCIPC/pub-res/images/IPVandSVscreening.pdf). As educators we must provide social work students with the information needed to dispel myths, improve attitudes toward survivors, and teach screening techniques to prepare students when they encounter survivors of violence.

References

American Medical Association. (1992). American Medical Association diagnostic and treatment guidelines on domestic violence. *Archives of Family Medicine, 1*(1), 39–47.

American Nurses Association. (1992). Position statement on physical violence against women. *American Nurse, 24*(4), 8.

Anderson, L. A., & Whitson, S. C. (2005). Sexual assault education programs: A meta-analytic examination of their effectiveness. *Psychology of Women Quarterly, 29*, 374–388.

Basile, K. C., Hertz, M. F., & Back, S. E. (2007). *Intimate partner violence and sexual violence victimization assessment instruments for use in healthcare settings: Version 1.* Atlanta, GA: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control.

Bent-Goodley, T. B. (2007). Teaching social work students to resolve ethical dilemmas in domestic violence. *Journal of Teaching in Social Work, 27*(1), 15.

Best, C. L., Dansky, B. S., & Kilpatrick, D. G. (1992). Medical students' attitudes about female rape victims. *Journal of Interpersonal Violence, 7*, 175–188.

Bryant, S. A., & Spencer, G. A. (2003). University students' attitudes about attributing blame in domestic violence. *Journal of Family Violence, 18*(6), 369–376.

Campbell, R. (2008). The psychological impact of rape victims' experiences with legal, medical, and mental health systems. *American Psychologist, 63*(8), 702–717.

Campbell, R., & Johnson, C. R. (1997). The role of work experience and individual beliefs in policy officers' perceptions of date rape: An integration of quantitative and qualitative methods. *American Journal of Community Psychology, 23*, 249–277.

Carey, L. A. (2007). Teaching macro practice. *Journal of Teaching in Social Work, 27*(1), 10.

Carlson, B. E., & Worden, A. P. (2005). Attitudes and beliefs about domestic violence: Results of a public opinion survey. *Journal of Interpersonal Violence, 20*, 1197–1218.

Cheek, T., Rector, K., & Davis, C. (2007). The clothesline project. *Journal of Teaching in Social Work, 27*(1), 13.

Cohn, F., Salmon, M. E., & Stobo, J. D. (2002). *Confronting chronic neglect: The education and training of health professionals on family violence.* Washington, DC: National Academies Press.

Coker, A. L., Davis, K. E., Arias, I., Desai, S., Sanderson, M., Brandt, H. M., & Smith, P. H. (2002). Physical and mental health effects of intimate partner violence for men and women. *American Journal of Preventive Medicine, 23*, 260–268.

Coker, A. L., Derrick, C., Lumpkin, J. L., Aldrich, T. E., & Oldendick, R. (2000). Help-seeking for intimate partner violence and forced sex in South Carolina. *American Journal of Preventive Medicine, 19*, 316–320.

Coker, A. L., Smith, P. H., Thompson, M. P., McKeown, R. E., Bethea, L., & Davis, K. E. (2002). Social support protects against the negative effects of partner violence on mental health. *Journal of Women's Health & Gender-Based Medicine, 11*, 465–476.

Coleman, J. U., & Stith, S. M. (1997). Nursing students' attitudes toward victims of domestic violence as predicted by selected individual and relationship variables. *Journal of Family Violence, 12*, 113–138.

Cullinane, P. M., Albert, E. J., & Freund, K. M. (1997). First-year medical students' knowledge of, attitudes toward, and personal histories of family violence. *Academic Medicine, 72*, 48–50.

Currier, D. M., & Carlson, J. H. (2009). Creating attitudinal change through teaching: How a course on "Women and Violence" changes students' attitudes about vio-

lence against women. *Journal of Interpersonal Violence, 24,* 1735–1754.

Danis, F. (2003). Social work response to domestic violence: Encouraging news from a new look. *Affilia, 18,* 177–191.

Danis, F., & Lockhart, L. (2003). Domestic violence and social work education: What do we know, what do we need to know? [Guest editorial]. *Journal of Social Work Education, 39,* 215–224.

Elliott, D. M., & Guy, J. D. (1993). Mental health professionals versus non-mental-health professionals: Childhood trauma and adult functioning. *Professional Psychology: Research and Practice, 24*(1), 83–90.

Family Violence Prevention Fund (FVPF). (1999). *Preventing domestic violence: Clinical guidelines on routine screening.* San Francisco, CA: Author.

Haase, C. E., Short, P. D., Chapman, D. M., & Dersch, S. A. (1999). Domestic violence education in medical school: Does it make a difference? *Academic Emergency Medicine, 6,* 855–857.

Hagen, J. L., & Owens-Manley, J. (2002). Issues in implementing TANF in New York: The perspective of front-line workers. *Social Work, 47,* 171–182.

Hansen, D., Bumby, K. M., Lundquist, L. M., Chandler, R. M., Le, P. T., & Futa, K. T. (1997). The influence of case and professional variables on the identification and reporting of child maltreatment: A study of licensed psychologists and certified masters social workers. *Journal of Family Violence, 12,* 313–332.

Humphreys, C. (1999). Avoidance and confrontation: Social work practice in relation to domestic violence and child abuse. *Child & Family Social Work, 4*(1), 77–87.

Humphreys, C., & Thiara, R. (2003). Mental health and domestic violence: "I call it symptoms of abuse." *British Journal of Social Work, 33,* 209–226.

Kinney, L. M., Bruns, E. J., Bradley, P., Dantzler, J., & Weist, M. D. (2008). Sexual assault training of law enforcement officers. *Women & Criminal Justice, 18*(3), 19.

Kolb, D. A., Boyatzis, R. E., & Mainemelis, C. (2001). Experiential learning theory: Previous research and new directions. In R. J. Sternberg & L. F. Zhang (Eds.), *Perspectives on thinking, learning, and cognitive styles* (pp. 193–210). Mahwah, NJ: Lawrence Erlbaum Associates.

Kristiansen, C. M., & Guilietti, R. (1990). Perceptions of wife abuse: Effects of gender, attitudes toward women, and just-world beliefs among college students. *Psychology of Women Quarterly, 14,* 177–189.

Locke, L. M., & Richman, C. L. (1999). Attitudes toward domestic violence: Race and gender issues. *Sex Roles, 40*(3/4), 227–247.

Lonsway, K. A., Welch, S., & Fitzgerald, L. F. (2001). Police training in sexual assault response: Process, outcomes, and elements of change. *Criminal Justice and Behavior, 28*(6), 695–730.

Macy, R. J., Nurius, P. S., Kernic, M. A., & Holt, V. L. (2005). Battered women's profiles associated with service help-seeking efforts: Illuminating opportunities for intervention. *Social Work Research, 29,* 137–150.

Magen, R. H., & Conroy, K. (1998). *Training child welfare workers on domestic violence: Final report.* New York. NY: Columbia University.

Maiuro, R. D., Vitaliano, P. P., Sugg, N. K., Thompson, D. C., Rivara, F. P., &

Thompson, R. S. (2000). Development of a health care provider survey for domestic violence. *American Journal of Preventative Medicine, 19*(4), 245–252.

Mills, L., & Yoshihama, M. (2002). Training children's service workers in domestic violence assessment and intervention: Research findings and implications for practice. *Children and Youth Services Review, 24,* 561–581.

Moore, M., Zaccaro, D., & Parsons, L. H. (1998). Attitudes and practices of registered nurses toward women who have experienced abuse/domestic violence. *Journal of Obstetric, Gynecologic, and Neonatal Nursing, 27,* 175–182.

National Association of Social Workers (NASW). (1996). *Code of ethics.* Retrieved from http://www.socialworkers.org/pubs/code/code.asp

Page, A. D. (2008). Judging women and defining crime: Police officers' attitudes toward women and rape. *Sociological Spectrum, 28*(4), 389–411.

Parsons, L. H., Zaccaro, D., Wells, B., & Stovall, T. G. (1995). Methods of and attitudes toward screening obstetrics and gynecology patients for domestic violence. *American Journal of Obstetrics and Gynecology, 173,* 381–386.

Payne, D. L., Lonsway, K. A., & Fitzgerald, L. F. (1999). Rape myth acceptance: Exploration of its structure and its measurement using the Illinois Rape Myth Acceptance Scale. *Journal of Research in Personality, 33*(1), 27–68.

Peters, J. (2003). *The Domestic Violence Myth Acceptance Scale: Development and psycho-metric testing of a new instrument.* Orono, ME: University of Maine.

Petretic-Jackson, P. A., Sandberg, G., & Jackson, T. (1994). The Domestic Violence Blame Scale (DVBS). In S. K. VandeCreek & T. L. Jackson (Eds.), *Innovations in clinical practice: A source book* (Vol. 13). Sarasota, FL: Professional Resource Press.

Pooler, D. K., Siebert, D. C., Faul, A. C., & Huber, R. (2008). Personal history and professional impairment: Implications for social workers and their employers. *Administration in Social Work, 32*(2), 69–85.

Pope, K. S., & Feldman-Summers, S. (1992). National survey of psychologists' sexual and physical abuse history and their evaluation of training and competence in these areas. *Professional Psychology, 23*(5), 353–361.

Postmus, J. L., & Merritt, D. (2010). When child abuse overlaps with domestic violence: The factors that influence child protection workers' beliefs. *Children and Youth Services Review, 32,* 309–317.

Postmus, J. L., & Ortega, D. (2005). Serving two masters: When domestic violence and child abuse overlap. *Families in Society, 86,* 483–490.

Postmus, J. L., Severson, M. E., Berry, M., & Yoo, J. A. (2009). Women's experiences of violence and seeking help. *Violence Against Women, 15,* 852–868.

Saunders, D. G., & Anderson, D. (2000). Evaluation of a domestic violence training for child protection workers and supervisors: Initial report. *Children and Youth Services Review, 22,* 375–398.

Saunders, D. G., & Kindy, P. (1993). Predictors of physicians' responses to woman abuse:

The role of gender, background, and brief training. *Journal of General Internal Medicine, 8,* 606–609.

Sellers, S. L., & Hunter, A. G. (2005). Private pain, public choices: Influence of problems in the family of origin on career choices among a cohort of MSW students. *Social Work Education, 24,* 869–881.

Short, L. M., Alpert, E., Harris Jr., J. M., & Surprenant, Z. J. (2006). PREMIS: A comprehensive and reliable tool for measuring physician readiness to manage IPV. *American Journal of Preventative Medicine, 30*(2), 173–180.

Straus, M. A., Hamby, S. L., Sugarman, D. B., & Boney-McCoy, S. (1996). The Revised Conflict Tactics Scales (CTS2): Development and preliminary psychometric data. *Journal of Family Issues, 17,* 283–316.

Thompson, M. P., Kaslow, N. J., Kingree, J. B., Rashid, A., Puett, R., Jacobs, D., & Matthews, A. (2000). Partner violence, social support, and distress among inner-city African American women. *American Journal of Community Psychology, 28*(1), 127–143.

Tjaden, P., & Thoennes, N. (1998). *Prevalence, incidence, and consequences of violence against women: Findings from the national violence against women survey.* Washington, DC: National Institute of Justice.

Tjaden, P., & Thoennes, N. (2006). *Extent, nature, and consequences of rape victimization: Findings from the national violence against women survey.* Washington, DC: National Institute of Justice.

Tower, L. E. (2003). Domestic violence screening: Education and institutional support correlates. *Journal of Social Work Education, 39,* 479–494.

Ullman, S. E. (1996). Social reactions, coping strategies, and self-blame attributions in adjustment to sexual assault. *Psychology of Women Quarterly, 20,* 505–526.

Waugh, F., & Bonner, M. (2002). Domestic violence and child protection: Issues in safety planning. *Child Abuse Review, 11,* 282–295.

Yoshihama, M., & Mills, L. (2003). When is the personal professional in public child welfare practice? The influence of intimate partner and child abuse histories on workers in domestic violence cases. *Child Abuse & Neglect, 27*(3), 319–336.

Zweig, J. M., & Burt, M. R. (2007). Predicting women's perceptions of domestic violence and sexual assault agency helpfulness: What matters to program clients? *Violence Against Women, 13,* 1149–1178.

Judy L. Postmus is assistant professor and director, **Sarah McMahon** is assistant professor and associate director, **Corinne Warrener** is a PhD candidate, and **Lisa Macri** is a doctoral student at the Center on Violence Against Women at Rutgers University.

Address correspondence to Judy L. Postmus, Center on Violence Against Women, Rutgers University, School of Social Work, 536 George St., New Brunswick, NJ 08901; e-mail: Postmus@ssw.rutgers.edu.