Stigma from professional helpers toward survivors of intimate partner violence

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Abstract:

The authors explored experiences of stigma from professional helpers toward survivors of intimate partner violence in two related studies with a combined sample of 231 participants. Qualitative interview and quantitative survey data were analyzed with content analysis procedures using an a priori coding strategy. Results suggest that survivors felt stigmatized by mental health professionals, attorneys and judges, health care professionals, law enforcement, professionals in the employment or education systems, parenting-related professionals, as well as friends and family. The most frequently occurring stigma categories were feeling dismissed, denied, and blamed. Participants cited the most common sources of stigma occurred from interactions with professionals in the court system and law enforcement officers. Implications for future research and practice are discussed.

Keywords: stigma | intimate partner violence | domestic violence | professionals | professional helpers

Article:

> The day I feel I have overcome the stigma associated with being a survivor of an abusive relationship will be the day that once again I trust my own judgment to be sound and wise, without feeling I need affirmation from others. I long for the day that I trust myself again.
>
> (Domestic violence survivor)

Stigma occurs when groups of people are marginalized based on negative labeling, stereotyping, and discrimination resulting in a loss of status in relation to more powerful groups within the population (Link & Phelan, 2001). Previous research suggests that women who have been battered within intimate relationships (hereafter referred to as *battering survivors*) experience stigma in several ways. For example, victims can be stigmatized by mental health professionals overpathologizing presenting symptoms related to the abuse (e.g., Brosi & Rolling, 2010; Humphreys, 2008), by members of their communities judging them (e.g., Merritt-Gray & Wuest,

1995), and by their abusers labeling them with damaging self-images (e.g., stupid, slut; Merritt-Gray & Wuest, 1995). Even the term *victim* can have a stigmatizing effect for battering survivors because of negative connotations associated with the label (Dunn, 2005).

Although attitudes about intimate partner violence (IPV) have been studied because they originate from the general population (Worden & Carlson, 2005), there is less literature that explores these topics as they originate from professionals toward battering survivors. The following is an overview of stigma and how it negatively impacts those experiencing it, a review of literature on public and professionals' attitudes and behaviors toward battering survivors, and a description of our research study that explored the stigma that IPV survivors experienced from professionals when seeking support.

STIGMA

Various types of stigma exist, each with negative consequences. Self-stigma describes self-imposed negativity, blame, or labels that a person feels about oneself. Also mentioned in the literature is associative stigma, or the discrimination that family, friends, or those somehow linked with the person feel from others by virtue of association with the person (Mehta & Farina, 1988). Internal consequences of stigma may include decreases in self-esteem and increases in shame, fear, and avoidance (Byrne, 2000; Corrigan, 2004; Link, Struening, Neese-Todd, Asmussen, & Phelan, 2001; Perlick et al., 2001), whereas external consequences are exclusion, discrimination, prejudice, stereotyping from others, and social distance (Byrne, 2000; Corrigan, 2004; Link et al., 2001).

Although the exact term *stigma* is not found commonly in literature on battering survivors, existing research demonstrates that they may experience many facets of stigma as defined earlier. For example, battering survivors may question themselves by asking "Why me-what's wrong with me?" resulting in damaged self-statements such as "I must have done something to bring this on" or "I will never have a healthy relationship" (Wuest & Merritt-Gray, 2001, p. 84). There has been a historical tendency to blame battering survivors at both societal and individual levels (Bryant & Spencer, 2003). Also referred to as *public justification*, this form of blame has been associated with whether a perpetrator commits an act of violence, whether the victim reports, and whether a third party responds (Waltermaurer, 2012). Also important are the direct and indirect messages from society that battering survivors hear about IPV, such as "You could have 'fixed' the relationship by being more caring or obedient" (Wuest & Merritt-Gray, 2001, p. 84). Furthermore, society has viewed IPV as a private, closed door matter rather than a phenomenon that others could or should become involved in. Authors (e.g., Bryant & Spencer, 2003) have called this victim blaming and posit that these views result in public stigma (Gover, Paul, & Dodge, 2011). A particularly dangerous consequence of stigma for battering survivors includes staying in the abusive relationship rather than believing that a life free of violence can be established (Patzel, 2006).

RESEARCH ON ATTITUDES TOWARD SURVIVORS

Attitudes that others hold toward battering survivors contribute to the stigma surrounding IPV. Negative attitudes are important to uncover because such responses from victims' families and

friends can encourage them to return to their abusers (Goodkind, Gillum, Bybee, & Sullivan, 2003) and/or stay in the relationship rather than attempt to leave at all. In this case, the victim may believe that a life free from violence is unattainable (Patzel, 2006). Research has focused on public perceptions of IPV (Bryant & Spencer, 2003; Waltermaurer, 2012; Yamawaki, Ochoa-Shipp, Pulsipher, Harlos, & Swindler, 2012). In a recent study investigating victim blaming, participants in the study who believed domestic violence (DV) myths (e.g., any woman who really wants to leave her abuser if she really wants to) were significantly more likely to blame the victim and minimize the incident (Yamawaki et al., 2012). A similar study on university students' attitudes revealed that male students were more likely to attribute blame to a victim of IPV than female students. Significant differences were also found between students with and without a prior history of violence in their family of origin, in that students who indicated a history of violence were more likely than those who did not have violence in their history to ascribe blame to societal factors rather than individual factors (Bryant & Spencer, 2003). Other authors have noted that a lack of support from friends and family reduces a woman's ability to leave the relationship (Patzel, 2006). The importance of support cannot be underestimated because it relates to establishing a violence-free life. Chang and colleagues (2010) found that one of the most important factors that led women to successfully leave their abusers was the belief that resources and support from others existed.

PROFESSIONALS' ATTITUDES TOWARD SURVIVORS

Authors (Lauber, Anthony, Ajdacic-Gross, & Rössler, 2004; Nordt, Rössler, & Lauber, 2006; Smith & Cashwell, 2010) have suggested that it is too simplistic to assume that professionals do not have certain stigmas that also are found in the general population. This notion is important to consider because it might impact battering survivors. One question related to stigma from professionals is where it originates. Early researchers hypothesized that stigma stems from feelings of helplessness and futility among professionals (Cohen, 1990). Others believed such attitudes might be associated with feelings of resistance from professionals toward providing services to clients (Cohen, 1990; Minkoff, 1987). Inadequate training and lack of preparedness to work with particular populations and settings before starting in the field might also influence negative attitudes (Hromco, Lyons, & Nikkel, 1995; Minkoff, 1987). In addition, it has been suggested that professionals do not receive adequate support and validation to function successfully in what can be an extremely challenging environment (Minkoff, 1987).

The investigation of attitudes from professionals toward IPV dates back to Field's (1978) article exploring the attitudes toward rape of law enforcement, crisis counselors, the general population, and perpetrators. In the study, 1,448 professionals were surveyed on attitudes toward rape, and demographic characteristics were explored as they related to these attitudes. Some of the study's findings offer early insight into professionals' attitudes toward women impacted by violence. White police officers were more likely ($p < .001$) than African American officers to perceive rape as being caused by the victim's appearance or behavior. Rape crisis counselors' attitudes also were examined and one finding worth noting is that participation in training programs was related to a woman's responsibility in rape prevention, $r(116) = .23$, $p < .05$; victim precipitation of rape, $r(116) = .22$, $p < .05$; and resistance as a woman's role during rape, $r(116) = .26$, $p < .01$. These results, although dated, suggest a longstanding history of potentially negative attitudes among professionals toward violence against women.

Law Enforcement Officers

Many survivors do not report IPV incidents for fear that law enforcement will be unwilling and unable to act on their behalf (Gover et al., 2011). Furthermore, officers report frustration when assisting IPV incidents; however, the primary source of such frustration remains unknown (Johnson, 2004). There is a dearth of literature on law enforcement officers' perceptions of IPV (Gover et al., 2011; Johnson, 2004; Sinden & Stephens, 1999). However, authors (Gover et al., 2011) have suggested that general attitudes and beliefs about IPV inevitably shape how law enforcement officers respond to incidents. A recent exploration of police officers' perceptions of IPV demonstrated both positive and negative attitudes from the officers (n = 309) who responded to the survey. Most of the officers (84%) felt that IPV calls took up too much of their time and effort and reported a high level of frustration with repeat calls from the same address (93%). Officers also believed that too many calls were received for only verbal arguments (93%). A series of other questions revealed that only 24% of officers believed that more training on IPV would help them assess IPV scenes. Male officers and older officers were more likely to describe IPV calls as problematic. Positive responses included officers disagreeing that IPV is a private matter (87%) and officers agreeing that IPV offenders need to be arrested even when the other party involved in the violence does not want the person to be arrested (64%). One of the largest implications from the study was the need for continued DV training, even if it is viewed from the officers as unnecessary.

Physicians

Physicians play a vital role when screening for IPV because women make an estimated 694,000 visits to the health care system every year because of physical assault, most of these because of IPV (National Institute of Justice and Centers for Disease Control and Prevention, 1998 as cited in Gerbert et al., 2002). Because of this, recommendations have been made for screenings; however, only 1 in 10 physicians screen their patients for IPV (Gerbert et al., 2002). When physicians have been asked about the barriers that get in the way of asking about IPV, responses ranged from practicalities such as lack of time, training, and resources to fears of offending the patient, inability to "fix" the problem, doubt that the patient will change, as well as a fear of opening "Pandora's box" (Gerbert et al., 2002, p. 83). Most recently, in January 2013, the U.S. Preventive Services Task Force recommended IPV screening as a routine preventive service to be administered by physicians. This initiative is a cultural shift for the medical profession (McCall-Hosenfeld, Chuang, & Weisman, 2013), and thus it is that much more important that physicians educate themselves on this population to improve services. Some positive considerations about the role physicians can play in the lives of battering survivors includes the notion that those who disclose IPV to a health care provider are more likely to participate in interventions to assist them with leaving the abusive relationship (McCloskey et al., 2006). Also, patients found the process of assessing for violence from their medical doctors therapeutic when the assessment was done in a caring, compassionate way (Gerbert, Caspers, Bronstone, Moe, & Abercrombie, 1999).

Mental Health Providers

It is well documented that many mental health symptoms are associated with IPV, such as depression, posttraumatic stress disorder (PTSD), sleep and eating disorders, and substance abuse (Howard, Trevillion, & Agnew-Davies, 2010). Important though, is how those who are trained to assess and treat mental health issues are screening and treating IPV-related issues and how these issues are differentiated in a mental health setting. Similar to physicians, lack of training, lack of knowledge of community resources, restricted services, and lack of funding have all been cited as barriers to effective treatment for IPV from mental health providers (Warshaw, Gugenheim, Moroney, & Barnes, 2003). The mental health field, in general, has started to understand IPV because trauma has emerged as a concept that explains the impact of such violence as war, rape, and violent crimes. Mental health symptoms, once considered separate from the effects of victimization, are beginning to be conceptualized as adaptations to unbearable conditions, rather than distinct and unique from the abuse. Authors have pointed out, however, that even though the mental health field understands the connection between mental health symptoms and victimization, women are still stigmatized when other systems are not informed about the connections between DV, trauma, and mental health symptoms (Warshaw et al., 2003).

THE CURRENT STUDY

Although the professional literature holds valuable information on the beliefs of various professionals in relation to battering survivors, missing in the research is an exploration of the stigma experienced by survivors from the professionals from whom help was sought. In the following study, we explored self-reported stigma-related experiences battering survivors experienced from professionals. The terms we used to describe stigma came from the mental illness stigma literature (Byrne, 2000) and included shame, blame, secrecy, "black sheep of the family," isolation, social exclusion, stereotypes, and discrimination. This definition was important to our study because in addition to hearing stigma experiences from survivors, we also wanted to investigate how closely this term described the experience of stigma for our participants. The research questions that framed the study were as follows: To what extent do common descriptors of the concept of stigma apply to experiences of abusive intimate relationships? To what extent do survivors experience stigma through their interactions with various sources of potential support? Because this study was the first to investigate various types of stigma associated with survivors of IPV, research questions and hypotheses were exploratory in nature. Although we predicted that victims of IPV would identify with common descriptors of the concept of stigma (e.g., blame, discrimination, loss of status, isolation, shame, dismissed/denied, and blatant unprofessionalism) and apply them to their own experiences of abuse, no hypotheses were made regarding the frequency and extent of the type of stigma most often experienced by victims. We also investigated the extent to which survivors reported experiencing stigma in their interactions with various sources of potential support such as law enforcement; court officials; medical and mental health professionals; DV and parenting agencies; and religious, employment, and educational agencies.

METHODOLOGY

We conducted two related studies that included a combined sample of more than 231 survivors of abusive relationships. The purpose of both studies was to gain a broader understanding of how

battering survivors experienced stigma related to their abuse. The first study was a qualitative interview study, and the second study involved an electronic survey that combined qualitative and quantitative questions. Both studies were approved by both researchers' university institutional review boards prior to data collection.

Study 1: Qualitative Interview Study

The first study involved in-depth interviews with 12 women across two study sites. For Study 1, we limited our participant pool to only females. To be eligible to participate in the study, participants must have met the following criteria: (a) they were at least 21 years old, (b) they reported having been in a previous relationship in which they were battered by a former intimate partner, (c) they reported that they have been out of any abusive relationship for at least 2 years and reported no experiences of physical or emotional victimization by their former or current partners in the past 2 years, (d) they had sufficient English language proficiency to participate in an interview in that language, and (e) during an initial telephone screening, they indicated that they were willing and able to discuss their past history of abuse in the interview process.

To address participant safety, we conducted initial telephone screenings to verify that prospective participants met the inclusion criteria. The following questions were asked, and participants needed to answer "yes" to both questions to participate: (a) "We are interested in stigma and how well it applies to the experiences of battering survivors. To study this phenomenon, we will ask you to talk about topics related to your past experience with abuse. Do you feel comfortable talking about your past experience?" and (b) "In the event that this topic is too difficult to discuss, will you feel comfortable letting us know that you'd like to withdraw from the study?" At the end of the interviews, all participants received contact information for local counseling agencies in the event of any unanticipated emotional distress that occurred following the interviews. Any prospective participants screened out through the telephone screening were offered this information about local resources over the phone.

Participants were recruited (a) through snowball sampling (i.e., asking personal contacts to forward e-mailed information to others who may qualify); (b) by distributing fliers through local agencies that serve clients impacted by current or former IPV, in addition to posting fliers on campus bulletin boards (e.g., in student unions) and in the community (e.g., coffee shops and bookstores); and (c) by including information in newsletters (e.g., in our local communities) and other medial channels (e.g., the campus newspapers). Participants were given a $10.00 store gift card as an incentive for participation.

Interviews were conducted in the researchers' offices. All participants completed a brief demographic form at the start of the interview. Most interviews lasted approximately 1 hr to 1 hr and 30 min. The interviews were audio-recorded and transcribed, and they were based on a semistructured interview guide. We began each interview by asking participants to tell us about their current lives. Then, we asked them to share their past experiences with IPV, including the timing and type of the relationship(s) in which IPV occurred, the types of abuse they experienced, and how they left the relationships. Next, we asked participants to look at a list of terms that researchers previously have used to describe stigma (e.g., blame, discrimination, isolation, and stereotypes) and share the extent to which they believed that stigma applies to their

experiences of IPV. Next, we asked participants to discuss more specific aspects of their abuse-related stigma experiences, including how stigma impacted them at different times and the sources of stigma (e.g., from professionals). The final questions addressed the extent to which participants believed stigma is conveyed in the media and their views about what is needed to overcome the stigma surrounding abuse both individually and at a societal level. Follow-up questions were used as needed for clarification and elaboration.

Study 2: Electronic Survey

As a follow-up to Study 1, we assessed a larger sample to gain a more complete picture of the extent to which the interview participants' experiences occurred within a broader population of battering survivors. Therefore, we created an electronic survey that included a demographic questionnaire, quantitative rating questions, and open-ended questions. The survey was hosted on the electronic survey-hosting platform, Qualtrics, and responses were collected anonymously. This study was open to individuals who (a) were at least 21 years old, (b) were formerly abused by an intimate relationship partner (e.g., a boyfriend/girlfriend, life partner, spouse), (c) had been out of any abusive relationship for at least 2 years, and (d) spoke English. Participants were required to complete an eligibility questionnaire reflecting these criteria before gaining access to the survey, and participants who were not eligible were excluded from the study.

The sample recruited for this study was a convenience sample. We used various sampling strategies including e-mails to personal contacts (i.e., snowball sampling), distributing a recruitment e-mail over relevant LISTSERVS, and posting a notice about the study on Internet message boards and Facebook pages that are relevant to the target population. Participants were provided with an anonymous website link to the survey. We offered a drawing for two $50 store gift cards as an incentive for participation. For participants to participate anonymously and also provide their contact information to enter the incentive drawing, participants who completed the survey were instructed to send an e-mail to the researcher's e-mail address. This method offered no identifying information linked to participants' survey responses. At the end of the survey, we provided a list of website links to national IPV-related organizations so that participants who wanted to seek additional resources could contact these organizations if needed.

The survey began with the demographic questionnaire, which also asked participants questions relating to their past experiences with IPV in one or more relationships. Next, participants were asked to describe their stigma-related experiences. Participants rated the extent to which they felt that a list of 12 stigma-related terms (e.g., blame, discrimination, and being labeled) applied to their experiences of abuse. Participants were asked to rate these items on a scale from 1 (*does not apply at all*) to 5 (*completely applies*). As a follow-up to these ratings, participants were asked to qualitatively describe their experiences related to each term that they rated as at least *somewhat applies* or 3 on the scale from 1 to 5.

The next portion of the survey asked participants to rate the extent to which they experienced stigma from various sources of potential support services. The sources of support we included were mental health professionals, attorneys, health care professionals, the police, the court system, the victims' workplaces, parenting-related resources, friends, family members, DV agencies, and an open-ended "other" category. We asked participants to rate their experiences on

a scale from 1 (*did not experience stigma at all*) to 5 (*experienced stigma completely*), and we also included a *not applicable* response option (i.e., "I did not attempt to access or use this resource."). Participants were instructed to provide open-ended responses for any of the sources of stigma that they rated 3 (i.e., "experienced stigma somewhat") or higher on the scale from 1 to 5. The final survey section included a list of other open-ended questions about overcoming stigma, including the process of overcoming stigma related to abuse, the changes they made in their lives to overcome that stigma, and messages they would like to send to people currently in an abusive relationship.

Study Participants

Across both studies, we had a combined 231 participants when we began the data analyses. (Note: Although the survey remains open, data collected after October 30, 2012 are not included in the analyses described herein.)

Qualitative Interview Participants. There were 12 females who participated in the interviews. Participants ranged in age from 21 to 68 years, with an average age of 45.1 years old (SD = 12.4). Nine participants were White, two were African American, and one was multiracial. Participants' current relationship statuses were as follows: dating/boyfriend/girlfriend (n = 5), single (n = 3), married (n = 3), and divorced (n = 1). Several children that participants had ranged from 0 to 4 years of age, and all but one of the participants' children were older than the age of 12 years. One participant's highest level of education was a high school diploma, five had completed some college, two had completed bachelor's degrees, and four had graduate educations.

Electronic Survey Participants. The survey sample consisted of 219 participants. Their mean age was 39.3 years (SD = 10.5). This survey was open to both male and female participants, although most (n = 212, 96.80%) were female (4 were male, and 3 did not report their gender). Participants' current relationship statuses were as follows: single (n = 31, 14.16%); married (n = 61, 27.85%); separated (n = 10, 4.57%); divorced (n = 48, 21.92%); dating, but not in a committed relationship (n = 14, 6.39%); in a committed relationship, not living together (n = 19, 8.68%); in a committed relationship, living together (n = 33, 15.07%); in a legally-recognized civil union/domestic partnership, not married (n = 1, 0.46%); and other (n = 2, 0.91%). Most (n = 189, 86.30%) participants were from within the United States, although 27 (12.33%) participants were from other countries, and the remaining participants did not report their geographic location. Of the participants, 158 (72.15%) had children and 62 (28.31%) did not. The racial/ethnic composition of the sample was as follows: African American/Black (n = 24, 10.96%), Asian (n = 2, 1.00%), White (n = 171, 78.10%), Hispanic/Latino/Latina (n = 5, 2.30%), Native American (n = 11, 5.00%), and other (n = 10, 4.60%). (Note: Participants could select more than one racial/ethnic category.) Participants' highest levels of education were as follows: high school diploma/general educational development (GED; n = 38, 17.35%), associate's degree (n = 32, 14.61%), bachelor's degree (n = 60, 27.40%), graduate degree (n = 55, 25.11%), and other (n = 34, 15.53%).

Data Analyses

For this article, we are reporting only on the data analyses specific to participants' experiences of stigma from professionals from whom they attempted to seek help. The results of the other study components will be reported elsewhere because of the expansive dataset collected through both studies, a full report of all sections of the study is beyond the scope of a single article. The descriptive statistics for participants' quantitative ratings of experienced stigma from various sources are found in the "Results" section.

The qualitative analyses included data from both the interviews (i.e., the transcripts of the interviews) and the survey (i.e., the qualitative responses to open-ended questions). Our research team identified all statements within the qualitative data that addressed any aspect of stigma from professional or organizational sources. We grouped these statements into the following categories: police/law enforcement, court/judge/attorney, medical professionals, mental health professionals, DV shelter/ agency, parenting, church, and employment/education.

We followed Stemler's (2001) content analysis procedures using an a priori coding strategy. Through this approach, we began with a preestablished set of coding categories that were based on both research and theoretical descriptions of stigma that have previously been published. The initial set of codes was revised following our initial rounds of data analysis (Stemler, 2001). Thus, we began with our first draft of the coding system that was drawn from Byrne (2000), Link and Phelan (2001), and the Merriam-Webster dictionary (when definitions of stigma-related terms were not explicitly provided in Byrne [2000] or Link and Phelan [2001]). We applied the initial draft of the coding system to a subset of the data as a pilot test and found that some of the initial categories were redundant. In addition, two new categories of responses emerged through the pilot test (i.e., dismissed/denied and blatant unprofessionalism). In addition, we added an "Other/no code" category for statements that did not fit directly in any of the other categories. The full list and description of codes that were included in the final coding system is as follows:

Blame: To find fault with, to hold responsible, to place responsibility for; this refers specifically to the feelings of others (e.g., the abuser, professionals, friends, and family) directed toward the victim.

Discrimination: Prejudiced or prejudicial outlook, action, or treatment; based on labeling and stereotyping that is oversimplified, prejudiced, or uncritical judgment. "Black sheep of the family" role-a worthless or disgraced member of the family/system; an outcast.

Loss of status: Losing standing as a result of their experiences with abuse, such as in their communities, workplaces, and other social systems; loss of power.

Isolation: "Us and them"; separation from others, whether imposed by the abuser and/or through the person's own choices to separate himself or herself from others.

Shame: A painful emotion felt about oneself caused by consciousness of guilt, shortcoming, self-blame, or impropriety. Can result in secrecy-hiding or concealing, keeping secret, or maintaining privacy or concealment.

Dismissed/denied: When asking for assistance or services, the person is not taken seriously, or the claims of abuse are not believed by the professional. The professional "looks the other way," feels as though this person does not qualify for help, no action is taken by the professional. This can also describe when the professional supports or empathizes with the abuser.

Blatant unprofessionalism: These are statements or actions from the professional that are blatantly unprofessional or unethical, such as name calling, breaches of confidentiality, or blurring of professional boundaries.

Other/no code: We completed a second pilot test of the coding system before applying it to the complete dataset to ensure that the coding system could be applied with sufficient interrater agreement.

The full dataset was coded by three independent coders: the two authors and a graduate research assistant who was trained on the coding system. We included three coders as a built-in check on the validity of the coding system, as well as a built-in process for determining a final code when there were disagreements among the coders. When all three coders agreed, the agreed-upon code became the final code. When only two coders agreed, the final code was the one on which both agreed. Statements that resulted in disagreement between all three reviewers resulted in the statement being coded into the "Other/no code" category. There were 353 statements that were coded by each coder, resulting in 1,059 codings. We calculated the interrater reliability for these codings, and this resulted in an overall percentage of agreement of 73.09% and a Fleiss' kappa statistic of 0.323, indicating fair agreement (Landis & Koch, 1977).

TABLE 1. Participant Ratings of the Extent to Which They Experienced Stigma From Various Sources

Source of Stigma	Number of Participants Rating Each Source	*M*	*SD*
Counselor/mental health professional	142	2.34	1.42
Attorneys	117	2.72	1.62
Health care professionals	111	2.50	1.51
Police/court system	125	3.14	1.65
Employment	135	2.54	1.53
Parenting-related resources	93	2.30	1.55
Friends	167	2.90	1.41
Family members	155	2.87	1.47
Domestic violence agencies	99	1.78	1.27
Other	13	3.08	1.93

Note. Participants rated their experiences on a scale from 1 (*did not experience stigma at all*) to 5 (*experienced stigma completely*), and we also included a *not applicable* response option (i.e., “I did not attempt to access or use this resource”). The stigma sources that participants wrote in for the “other” category included embassy staff, Alcoholics Anonymous, teacher, mentor, housing authority, prosecutor’s office, church, religion, financial assistance, and a priest.

RESULTS

Common descriptors of the concept of stigma did apply to experiences of abusive intimate relationships. Table 1 contains the means and standard deviations of participants' ratings of the extent to which they experienced stigma from various sources and Table 2 contains frequency of

stigma categories according to profession. A full description of stigma experienced from professionals is presented in the following text.

TABLE 2. Frequency of Stigma Categories According to Profession

	Profession								
Stigma Category	**Law Enforcement**	**Court**	**Medical**	**Mental Health**	**Domestic Violence**	**Parenting**	**Religious**	**Employment and Education**	**Total**
Blame	15	20	4	5	3	3	8	1	59
Discrimination	7	13	4	4	2	1	0	7	38
Loss of status	1	8	0	0	1	0	2	7	19
Isolation	1	0	0	0	1	0	3	3	8
Shame	2	5	0	7	2	1	1	5	23
Dismissed/denied	47	31	3	15	5	1	2	4	108
Blatant unprofessionalism	4	12		3	3	1	0	1	24
Total	77	89	11	34	17	7	16	28	279

Law Enforcement

Seventy-seven statements reflected stigma that participants experienced when they sought help from law enforcement. The most frequently occurring category of stigma that participants experienced with law enforcement was *dismissed*. Forty-seven statements regarding law enforcement agencies were coded into this category. Generally, these statements reflected the perception that law enforcement officers and 911 emergency operators did not take their concerns seriously. An illustrative statement was as follows: "A cop that my abuser knew pulled up next to him at a red light and said . . . I have some papers at the station I need you to come fill out *when you have the time*." Another example was as follows:

> The local police are a joke. In 10 years I called twice. My first call I had a bloodied lip and their response was if he wasn't there, then they could do nothing. My second call was when he yanked me down by my hair with my newborn daughter in my arms. I was told since I had no visible injuries, they couldn't make him leave.

Other elements that seemed to make up the experience of being dismissed by law enforcement included the survivor receiving misinformation: "I called 911. One of the two police officers responding stated, 'It's his house [we were separated, and the house was mine], he can punch a hole in the door if he wants to,'" as well as "They didn't think it was rape because he didn't hold me down or anything. Or at least, he didn't hold me down during the whole time, and I didn't scream or yell," and "The police didn't enforce my protective order. [They] told me they had to witness my ex in the act of violating it-can you believe that one?!?"

Fifteen law enforcement-related statements indicated that participants felt *blamed*. These statements suggested that participants felt at fault or that the abuse was somehow brought about because of something that they did to provoke it. One participant reported such stigma from law enforcement by stating: "From the police who said, 'You need to stop provoking him.'" Another participant who was being stalked by her abuser had this to say:

> I would call and ask someone to remove him from the parking lot across from where I worked-he was just sitting there watching me, and a protective order was in force. Long

> story short, the officer told me "you married him" and was very perturbed about having to tell a man to leave a parking lot.

Four statements reflected blatant unprofessionalism, including the following:

> The final night I left, the officer looked at me and simply asked, "Why didn't you just kill him?" regarding my husband. I do not believe the officer knew what it was like to be in that type of situation.

This unprofessionalism was experienced by participants who noted: "Some of the male officers made unsavory comments," and "I was also asked to go on a date by one of the officers involved at the time."

Seven law enforcement statements were coded into the *discrimination* category. For example, a participant said, "I feel as if I experienced discrimination and stereotyping by professionals (police officers, counselors) when I tried to get help or sometimes by individuals if I told my story. It was like we were labeled THAT HOUSE." Less prevalent categories were *loss of status*, with only the following statement: "It's like they had one opinion of me (young, energetic, bright college student) but then when I disclosed the abuse, none of that other stuff mattered about me." One statement was coded as *isolation* and two as *shame*.

Court System

Eighty-nine statements reflected stigma that participants reported experiencing through the court and legal system. The professionals that participants mentioned having contact with from this category were those in the family court system, attorneys, judges, and court clerks. Twenty of these statements reflected *blame*. For example, one of the participants said:

> The stigma within the court system was the worst. It seemed to me that the judge was yelling at me and blaming me. She often asked me why I hadn't done anything earlier and if I was telling the truth, she would assume I would have done something about the abuse earlier.

For another participant, because she was blamed for so long by the abuser, feeling blamed by professionals was not unfamiliar. The following quote demonstrates this:

> The statement that I "got myself into" it was one I heard from many. My lawyer, my brother- and sister-in-law, and a couple of the very few friends I had left by the time the marriage ended (my husband was very good at isolating me from any support). And I was too wounded and weak at that point to argue. I had heard so often that it was "my fault" from my husband, heard "you brought this on yourself" so many times that hearing it from them was not much different.

Twelve statements in this category were coded as *blatant unprofessionalism* (e.g., "I was told by a judge that if he could have his way and punish me, he would know what to do with me, but since he was to do what was best for the children, he wouldn't go there."). Thirteen statements

were coded as *discrimination* in this system category. Thirty-one statements were coded as *dismissed*. Participants reported various experiences related to feeling dismissed by the court system. One participant felt dismissed when her attorney seemed to sympathize with her abuser: "When she called to let me know that he was being released, she said, 'You know, he just wants to get out of jail.' So, it was like she was almost sympathizing with him."

Eight statements reflected a *loss of status* when dealing with the court system. One participant felt as though her experience with abuse was used against her and resulted in losing custody of her children:

> My first ex-husband took me to court to sue me for child support and used my domestic violence experience as proof of "lack of judgment." So I am now separated from my children, I have definitely lost any power as their mother, same with status.

Five statements were coded as *shame* (e.g., "In the beginning, I was quite proud to be a survivor. After the courtroom experience, I hardly tell anyone due to the shame and the fear of being labeled.").

Medical Professionals

Eleven statements reflected the stigma that participants encountered from medical professionals (e.g., medical doctors, nurse practitioners, nurses, chiropractors). Of these, four were coded into the *blame* category (e.g., "I was made to feel stupid for being in such a relationship"; "Because I was abused as a child without receiving help, I was destined to be abused as an adult"; and "My doctor told me I was stupid if I didn't leave.").

Four statements reflected that participants felt *discrimination* from medical professionals on account of the abuse. For example, one participant said, "The people at the hospital question you and condescend you and act like your [*sic*] making things up for attention." Three statements were coded as *dismissed* in this category. One participant explained that she disclosed her experience of abuse during a medical visit and was not asked to elaborate: "I disclosed [a] history sexual assault in [a] survey of recent health occurrences and was not asked to elaborate-putting it on the survey was my way of trying to open up about it indirectly."

Mental Health Professionals

Thirty-four statements reflected stigma from mental health professionals. Of these, five reflected *blame*. Some of the ways that participants indicated experiencing blame from mental health professionals included being told to ask forgiveness (e.g., "My marital counselor said, 'Make a list of all the sins you committed against him, and ask him for forgiveness'" and "He told me I was 'triggering' my ex's controlling behavior and sexual assaults and encouraged me to focus on my own 'contributions' to the problem rather than find[ing] ways to stay safe.").

Three statements from mental health professionals were *blatantly unprofessional* including the following: "The counselor actually said during our first session that she did not like to or want to work with past victims of IPV," and "One time I went to a counselor because I was having a hard

time with my libido (go figure, who wouldn't after experienced such horrors), and the therapist told me to give my ex more blow jobs." Four statements from participants who sought mental health assistance were coded as *discrimination*. Fifteen statements from participants were coded as *dismissed* in the mental health professional category.

Some participants suggested that mental health professionals mistook symptoms of abuse for other mental health concerns or did not understand the full impact of the abuse had. Examples of this include the following: "An on-campus counselor was unhelpful and downplayed the abuse," "She told me that my partner was 'controlling.' When I came to hear [*sic*] with what [I know now] are clearly PTSD symptoms, she told me that couldn't be what it was," and "The first counselor I went to completed ignored it when I told him I was raped in my relationship-only wanted to focus on depression symptoms." Seven statements in this category were coded as shame. One participant, in particular, felt shame in several ways related to two different professional counselors:

> My counselor did not believe me in the most recent rape/sexual assault so that was very shaming. Because she "latched" onto this, instead of helping me with my presenting issues, I did not return. Instead, I suffered in fear that he [abuser] would find out I went to a counselor. The other counselor I saw was more accepting but never really addressed it with me. I wanted to hide from it, and she let me.

Domestic Violence Agencies

Seventeen statements reflected stigma participants experienced when they sought help from DV agencies. Five statements regarding DV agencies were coded into the *dismissed* category. Generally, these statements reflected the perception that professionals that participants encountered in these agencies did not take their concerns seriously. An illustrative statement was as follows:

> I did seek help at a local domestic violence agency. I regretted with my entire being going there. I had finally worked up the nerve to seek help. I'd finally agreed to speak with someone. When I got there, I was nervous and scared, and I was greeted by a cold receptionist. I was made to fill out paper work. Then, when I met with one of the women that worked there, she asked me about my situation. I'd begin to explain and she would interrupt. Then she asked me what exactly I wanted or needed from them. I asked about counseling and she said they couldn't help me there, I'd have to go elsewhere.

Three statements indicated that participants felt *blamed* by agency staff members. All three statements suggested that the participants felt that the staff members blamed them for not having left their abusive partners sooner. For example, one participant said, "Employee blamed me for not leaving with my son . . . She smugly told me I should have called their agency or the police all the while acting like I should have known better." Another said, "During our meeting, she asked me why I was just now trying to put a [protective order] on my ex-husband."

Three statements reflected *blatant unprofessionalism* from DV agency staff members, including the following two statements: "I called a domestic violence hotline, in the middle of the night,

crying, and the woman hung up on me," and "The woman assigned to meet with me was made at the receptionist and told her in front of me that she was done for the day and wasn't pleased that she had to help me." Another two DV agency-related statements were coded into the *discrimination* category. For example, one participant said, "Even DV professionals who think they understand are quick to lump you into the 'weak and helpless' category." The categories that were less prevalent in relation to these agencies were *shame*, with two statements (e.g., "I finally for the first time ever got the courage to go to our local domestic assault and violence center."), and isolation and loss of status, with one statement each.

Parenting-Related Resources

Seven statements reflected stigma that participants felt through parenting-related resources and support networks. Three statements reflected *blame*. For example, a participant said, "Every time I tried explaining that I thought the children's behavior problems were caused by witnessing their father beat me . . . I was told that it was my fault for being depressed and anxious." There was also one statement for each of the following categories: *blatant unprofessionalism* (i.e., "Sometimes questions were being asked that maybe weren't on the paper, just because somebody was probing and being nosy."), *discrimination* (i.e., "She made this assumption, you know, that I had . . . a history of being involved with men who beat my children."), *dismissing/denying* (i.e., "I have tried for the last 3.5 years to get help for the kids to deal with their trauma, and it is only now that we have court-ordered therapy for them."), and *shame* (i.e., "Shame-for staying, putting my kids in that situation").

Religious Organizations

Sixteen statements reflected stigma the participants encountered through religious organizations. Of these, eight were coded into the *blame* category. Some of the blame-related statements that participants heard from their religious organizations in relation to their abuse included the following: "You need to submit yourself to God and become a better wife"; "God hates divorce"; "Why don't you let him come back?"; "You need to let your husband come home. You know, God's gonna do so-and-so to you"; and "If DV were grounds for annulment, everyone would be divorced!" Three statements reflected that participants felt *isolated* in their religious organizations on account of their abuse. For example, a participant said, "I was shunned by a few churches who were not willing to have a single/divorced woman staining their perfect aisles." Another said, "This collection of folks find ways to avoid eye contact when our paths have crossed again." Similarly, two statements were coded into the *loss of status* category, indicating that participants felt that their abuse led them to lose standing in their religious organizations. For example, a participant said, "You have an uphill battle to end stigmatization in fundamentalist faith communities because very often they are resistant to hearing anything that contradicts their paradigms."

Finally, two statements reflected participants feeling *dismissed* by their religious organizations (e.g., "It was only when I would share my stories of abuse and saw the 'no talk' rules in place and the minimization taking place consistently in the communities of faith I was in did I realize that I had to leave that as well to grow and make progress. . . I think as long as these communities of

faith stigmatize and revictimize abused people-mainly women-the women involved in abuse will be more intractable."), and one statement reflected feeling *shame* (i.e., "It took a year for me to be comfortable with allowing anyone to know. I didn't want to be judged.").

Employment and Education

Twenty-eight statements reflected stigma through participants' employment and education. Seven statements reflected *discrimination*. Some ways that participants experienced employment- and education-related discrimination included hearing coworkers, classmates, and instructors speak negatively about survivors of IPV; being viewed as "a high risk for calling in"; and being left out from work-related opportunities. Another seven statements suggested that participants experienced work- and education-related *loss of status* related to their abuse. Some statements even indicated that participants lost jobs because of their abuse (e.g., "because he attacked me in the parking lot"; "they knew what was happening and didn't want to deal with it"; "lost my job after losing too much work"; and "I was asked to resign because . . . my first husband . . . was psychotic and he was . . . coming to my work.").

Five employment- and education-related statements were coded in the *shame* category. This included feeling ashamed about job performance problems related to the abuse, fearing taking psychotropic medications to help with depressive symptoms "for fear of drug testing on my job," and feeling shame about how coworkers do or would view them because of their abuse. Four statements indicated that participants felt *dismissed* when seeking help through their work or school. Examples include the following: "I tried to reach out to coworkers but they just handed me an EAP card and tried to ignore my pleas for help" and "At times the education system was not sensitive to what was occurring in our home." Another three statements reflected that participants experienced *isolation* through work or schools. For example, a participant said, "While I did not get fired, it did make things difficult for my work relationship, as I was a nanny and they didn't want to be involved." Finally, there was one statement each in the following categories: *blame* (i.e., "The woman asking me looked at me as if she was disgusted by me and proceeded to tell me that if I was in a bad situation, I needed to be smart enough to get out. She also sent me home because I looked awful.") and *blatant unprofessionalism* (i.e., "The judgment that is passed especially when you tell your supervisor and they tell everyone in the office.").

DISCUSSION

Participants experienced various forms of stigma from the professionals from whom they sought help. In fact, each facet of stigma that we used in this study was endorsed by participants as an attitude they experienced when seeking help from professionals. Although we do not wish to suggest that all professionals stigmatize battering survivors, we do believe that the findings of this study warrant a discussion of the ways in which stigma is experienced by survivors from the professionals with whom our participants came into contact.

The highest levels of stigma were reported when seeking support from the police or court system ($M = 3.14$, $SD = 1.65$). Ninety of the 353 statements were statements made about law enforcement, mainly feeling dismissed and blamed. Stigmatizing attitudes seemed to be present when asking for restraining orders, making emergency phone calls, or other means of seeking

assistance from the legal system. Law enforcement might benefit from education and training efforts so that there is consistency and understanding in responsibilities in IPV situations. Because literature (Patzel, 2006) suggests that the belief that survivors have the ability to live a life without their abuser is related to their successfully leaving, those to whom survivors turn first (i.e., legal professionals) have a critical role in the process of helping a victim break free of an abusive relationship. Prior research related to law enforcement (e.g., Gover et al., 2011) supports this notion that education and training is greatly needed in the area of IPV.

Also in this category was the legal system, including judges, attorneys, and clerks associated with the courts. There were 112 statements that were referred to these experiences. When looking at the types of stigma that participants experienced from the legal system overall, *blame* accounted for 20 statements, and *dismissal* account for 31 statements. Both of these aspects of stigma were the most frequently occurring within law enforcement as well. Similar to the stigma experienced with law enforcement, many of our participants felt that the court system did not serve them, or that they were not important enough to be helped by the courts. Also noteworthy in both law enforcement and court system settings were the experiences that participants felt were blatantly unprofessional.

Across both of our studies, stigmatizing experiences were found for each of the other professional groups we studied, although quantitative ratings indicated that these other groups were less stigmatizing than law enforcement and the court system. Because professionals of many types come into contact with battering survivors and our participants felt stigmatized in some way by many when seeking help, we believe that future research could uncover the source(s) of such stigma related to professionals. Whether these sources of stigma are similar or different according to profession would be important to understand. Perhaps, for example, those in the medical profession are nervous, as previous research suggested to "open Pandora's box" (Gerbert et al., 2002, p. 83) by asking about abuse, and this translates to stigmatizing attitudes, whereas attorneys' stigmatizing attitudes may be a result of less formalized training or education on working with this population on legal matters. Previously, scholars have suggested that it was too simplistic to assume that professionals do not carry some of the same stigmas in the general population toward the very clients they assist (Lauber et al., 2004; Nordt et al., 2006; Smith & Cashwell, 2010). We found, consistent with earlier research, stigmatizing attitudes did indeed exist from professionals.

As Table 1 shows, participants experienced stigma from some groups that we did not include in our qualitative analyses, but these groups are important to address here. First, participants rated friends and family as possible sources of stigma. Also, participants experienced stigma from sources that fell in the "other" category. The stigma sources that participants wrote in for the "other" category included embassy staff, Alcoholics Anonymous, teacher, mentor, housing authority, prosecutor's office, church, religion, financial assistance, and a priest. These sources may have been rated at higher levels because people who chose to write them in chose to do so because of highly stigmatizing experiences with them. All of these additional sources of stigma (i.e., friends, family, and others) warrant attention in future research.

LIMITATIONS AND FUTURE DIRECTIONS

As with any research study, ours includes limitations. First, our study included self-report data and relied on subjective perceptions of experiences from survivors. Still, we were surprised with the degree of honesty, detail, and description that the participants provided, and we believe that our participants had no reason to embellish or fabricate any of the stigmas that they described. We offered a very small incentive for participating (i.e., a drawing for one of two $50.00 gift cards), for which only 36 participants signed up, and an even smaller incentive for participation in study 1 ($10.00 gift cards). To us, this highlighted the strong desire that participants had to share their stories, rather than any tangible reward for participating. Most of our participants were female, so the stigma experiences that males who are battering survivors might face are largely undocumented and understudied. Future research on males' experiences with stigma is warranted. Similarly, our sample included little diversity related to race and ethnicity, sexuality, and socioeconomic status, so future research should include a more diverse sample for generalizability. Interrater reliability for the research was 73.09% and a Fleiss' kappa statistic of 0.323, indicating fair agreement (Landis & Koch, 1977), so results of this study should be interpreted with caution because this is a limitation to the study.

Future research can continue to investigate how the concept of stigma applies to this population. Our studies found support for the notion that the concept of stigma does resonate with battering survivors. Further research can examine the perceptions of others touched by IPV, such as people who are currently being victimized and child witnesses to parental IPV. Because we heard many stigma experiences from various professionals, we also suggest that scholars investigate this phenomenon from the perspective of professionals. Qualitative interviews, focus groups, or other means by which researchers can further understand professionals' experiences would assist scholars with understanding the concept. Further research on stigma and IPV can ultimately assist with the eradication of the experience because we know that the results of feeling stigmatized are so damaging. Eliminating or reducing the stigma surrounding IPV can help survivors receive help more easily and can help them to feel supported as they rebuild their lives after the abuse. Therefore, this line of research can make a valuable contribution to the movement to end IPV.

Clinicians working with survivors of IPV can inquire about any prior stigmatizing experiences associated with professionals, so as not to repeat any negative interactions. We also encourage clinicians to confront any negative attitudes they might hear from other professionals as a way to educate others about stigma and IPV. Education and advocacy efforts are in high demand because, unfortunately, there is evidence that stigma still exists.

REFERENCES

Brosi, M. W., & Rolling, E. S. (2010). A narrative journey for intimate partner violence: From victim to survivor. The American Journal of Family Therapy, 38, 237-250. http://dx.doi.org/10.1080/01926180902961761

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

Byrne, P. (2000). Stigma of mental illness and ways of diminishing it. Advances in Psychiatric Treatment, 6, 65-72.

Chang, J. C., Dado, D., Hawker, L., Cluss, P. A., Buranosky, R., Slagel, L., . . . Scholle, S. H. (2010). Understanding turning points in intimate partner violence: Factors and circumstances leading women victims toward change. Journal of Women's Health, 19, 251-259. http://dx.doi.org/10.1089/jwh.2009.1568

Cohen, N. (1990). Stigma is in the eye of the beholder: A hospital outreach program for treating homeless mentally ill people. Bulletin of the Menninger Clinic, 54, 255-258.

Corrigan, P. (2004). Target-specific stigma change: A strategy for impacting mental illness stigma. Psychiatric Rehabilitation Journal, 28, 113-121.

Dunn, J. L. (2005). "Victims" and "survivors": Emerging vocabularies of motive for "battered women who stay." Sociological Inquiry, 75, 1-30.

Field, H. S. (1978). Attitudes toward rape: A comparative analysis of police, rapists, crisis counselors, and citizens. Journal of Personality and Social Psychology, 36, 156-179.

Gerbert, B., Caspers, N., Bronstone, A., Moe, J., & Abercrombie, P. (1999). A qualitative analysis of how physicians with expertise in domestic violence approach the identification of victims. Annals of Internal Medicine, 131, 578-584.

Gerbert, B., Gansky, S. A., Tang, J. W., McPhee, S. J., Carlton, R., Herzig, K., . . . Caspers, N. (2002). Domestic violence compared to other health risks: A survey of physicians' beliefs and behaviors. American Journal of Preventive Medicine, 23, 82-90.

Goodkind, J. R., Gillum, T. L., Bybee, D. I., & Sullivan, C. M. (2003). The impact of family and friends' reactions on the well-being of women with abusive partners. Violence Against Women, 9, 347-373. http://dx.doi.org/10.1177/1077801202250083

Gover, A. R., Paul, D. P., & Dodge, M. (2011). Law enforcement officers' attitudes about domestic violence. Violence Against Women, 17, 619-636. http://dx.doi.org/10.1177/1077801211407477

Howard, L. M., Trevillion, K., & Agnew-Davies, R. (2010). Domestic violence and mental health. International Review of Psychiatry, 22, 525-534. http://dx.doi.org/10.3109/09540261.2010.512283

Hromco, J., Lyons, J., & Nikkel, R. (1995). Mental health case management: Characteristics, job function, and occupational stress. Community Mental Health Journal, 31, 111-125.

Humphreys, C. (2008). Problems in the system of mandatory reporting of children living with domestic violence. Journal of Family Studies, 14, 228-239.

Johnson, R. R. (2004). Police officer frustrations about handling domestic violence calls. The Police Journal, 77, 207-219.

Landis, J. R., & Koch, G. G. (1977). The measurement of observer agreement for categorical data. Biometrics, 33, 159-174.

Lauber, C., Anthony, M., Ajdacic-Gross, V., & Rössler, W. (2004). What about psychiatrists' attitude to mentally ill people? European Psychiatry, 19, 423-427.

Link, B. G., & Phelan, J. C. (2001). Conceptualizing stigma. Annual Review of Sociology, 27, 363-385.

Link, B. G., Struening, E. L., Neese-Todd, S., Asmussen, S., & Phelan, J. C. (2001). Stigma as a barrier to recovery: The consequences of stigma for the self-esteem of people with mental illnesses. Psychiatric Services, 52, 1621-1626.

McCall-Hosenfeld, J. S., Chuang, C. H., & Weisman, C. S. (2013). Prospective association of intimate partner violence with receipt of clinical prevention services in women of reproductive age. Women's Health Issues, 23, e109-e116.

McCloskey, L. A., Lichter, E., Williams, C., Gerber, M., Wittenberg, E., & Ganz, M. (2006). Assessing intimate partner violence in health care settings leads to women's receipt of interventions and improved health. Public Health Reports, 121, 435-444.

Mehta, S., & Farina, A. (1988). Associative stigma: Perceptions of the difficulties of college-aged children of stigmatized fathers. Journal of Social Clinical Psychology, 7, 192-202.

Merritt-Gray, M., & Wuest, J. (1995). Counteracting abuse and breaking free: The process of leaving revealed through women's voices. Health Care for Women International, 16, 399-412. http://dx.doi.org/10.1080/07399339509516194

Minkoff, K. (1987). Resistance of mental health professionals to working with the chronic mentally ill. New Direction for Mental Health Services, 33, 3-20.

Nordt, C., Rössler, W., & Lauber, C. (2006). Attitudes of mental health professionals toward people with schizophrenia and major depression. Schizophrenia Bulletin, 32, 709-714.

Patzel, B. (2006). What blocked heterosexual women and lesbians in leaving their abusive relationships. Journal of the American Psychiatric Nurses Association, 12, 208-215. http://dx.doi.org/10.1177/1078390306294897

Perlick, D., Rosenheck, R., Clarkin, J., Sirey, J., Salahi, J., Struening, E., & Link, B. (2001). Stigma as a barrier to recovery: Adverse effects of perceived stigma on social adaptation of persons diagnosed with bipolar affective disorder. Psychiatric Services, 52, 1627-1632.

Sinden, P., & Stephens, B. (1999). Police perceptions of domestic violence: The nexus of victim, perpetrator, event, self and law. Policing, 22, 313-326.

Smith, A., & Cashwell, C. S. (2010). Stigma and mental illness: Investigating attitudes of mental health and non-mental-health professionals and trainees. Journal of Humanistic Counseling, Education and Development, 49, 189-202.

Stemler, S. (2001). An overview of content analysis. Practical Assessment, Research & Evaluation, 7(17). Retrieved from http://PAREonline.net/getvn.asp?v=7&n=17

Waltermaurer, E. (2012). Public justification of intimate partner violence: A review of the literature. Trauma, Violence, & Abuse, 13, 167-175. http://dx.doi.org/10.1177/1524838012447699

Warshaw, C., Gugenheim, A. M., Moroney, G., & Barnes, H. (2003). Fragmented services, unmet needs: Building collaboration between the mental health and domestic violence communities. Health Affairs, 22, 230-234.

Worden, A. P., & Carlson, B. E. (2005). Attitudes and beliefs about domestic violence: Results of a public opinion survey: II. Beliefs about causes. Journal of Interpersonal Violence, 20, 1219-1243. http://dx.doi.org/10.1177/0886260505278531

Wuest, J., & Merritt-Gray, M. (2001). Beyond survival: Reclaiming self after leaving an abusive male partner. The Canadian Journal of Nursing Research, 32, 79-94.

Yamawaki, N., Ochoa-Shipp, M., Pulsipher, C., Harlos, A., & Swindler, S. (2012). Perceptions of domestic violence: The effects of domestic violence myths, victim's relationship with her abuser, and the decision to return to her abuser. Journal of Interpersonal Violence, 27, 3195-3212. http://dx.doi.org/10.1177/0886260512441253