

# Does Intimate Partner Sexual Assault Differ from Other Sexual Assaults? An Exploration of Alcohol Intoxication and Blame

Anna E. Jaffe<sup>1</sup>, Christina Hein<sup>1</sup>, David DiLillo<sup>1</sup>, Kim. L. Gratz<sup>2</sup>, Terri L. Messman-Moore<sup>3</sup>  
<sup>1</sup>University of Nebraska-Lincoln; <sup>2</sup>University of Mississippi Medical Center; <sup>3</sup>Miami University

## Introduction

Recent data show that over 50% of rapes against women are perpetrated by intimate partners (Black et al. 2011; Testa et al., 2007). Intimate partner sexual assaults (IPSA) may be fundamentally different from sexual assaults committed by a stranger or acquaintance in that it may involve a precedence of consent arising from past sexual activities, can include feelings of betrayal, and may be part of a pattern of repeated violence that ultimately jeopardizes the relationship (Kelly & Stermac, 2012; Logan et al., 2013).

IPSA may also differ from other sexual assaults in attributions of victim blame. For example, victims of IPSA may believe their partners' aggressive actions were the result of miscommunication (based on an assumption of consent), leading to less perpetrator blame than victims of other assaults. In addition, prior to an IPSA, victims may have behaved in a typical manner by spending time with their intimate partner, which could involve a greater expectation of safety than spending time with a lesser-known friend or acquaintance. For these reasons, victims of IPSA may also report less self-blame than victims of other sexual assaults. Lastly, it may also be important to consider the use of alcohol in predicting blame attributions, as alcohol-related assaults have been associated with more self-blame (Littleton et al., 2009; Peter-Hagene & Ullman, 2014). Given that alcohol appears to be involved in IPSAs less often than assaults by non-intimate partners (Peter-Hagene & Ullman, 2014), it is possible that perpetrator type and victim alcohol use interact to predict blame attributions.

Despite the high prevalence of IPSA, no known studies have examined victim blame attributions and alcohol intoxication specific to IPSAs. Drawing on prior research and theory, we hypothesized that: (1) victims of IPSA would report less self- and perpetrator blame and (2) victims who report greater intoxication would endorse more self-blame than victims of other assaults.

## Method

### Participants

- Participants were community women recruited at four sites (NE, MS, OH) as part of a larger multi-wave study of sexual revictimization. Of the 491 women who participated in the first assessment, 239 (48.7%) reported a history of a sexual assault in adulthood. Four participants were excluded for incomplete responses. Therefore, a total of 235 women were included in the present study.
- Participant age ranged from 18 to 25 ( $M = 22.3$ ,  $SD = 2.1$ ).
- The majority of participants (70%) were European American, 28% African American, 5% Asian, 3% American Indian, 6% Hispanic, and 1% other (participants could endorse more than one ethnicity).

### Measures

**Sexual assault characteristics.** The Modified Sexual Experiences Survey (Messman-Moore, Walsh, & DiLillo, 2010), an expanded version of the Sexual Experiences Survey (Koss, Gidycz, & Wisniewski, 1987), was used to assess unwanted sexual experiences in adulthood. Participants were asked a number of follow-up questions on the assault they identified as most distressing. For example, participants reported the nature of their relationship to the perpetrator (intimate partner defined as "spouse" or "current steady dating partner" versus a non-intimate partner). Participants also reported on their own perceived level of intoxication prior to the assault using a 5-point scale from 0 (not at all) to 4 (very intoxicated). An assault severity score (0 to 4) was created by adding the most severe perpetrator tactics endorsed (0 = none, 1 = verbal tactics, 2 = physical harm) to the most severe acts endorsed (0 = none, 1 = fondling, 2 = penetration).

**Blame attributions.** The Behavioral Self-Blame and Rapist Blame subscales of the Rape Attribution Questionnaire (Frazier, 2003) each consist of five questions assessing how often the participant has had thoughts regarding specific blame attributions. Responses are indicated on a Likert scale from 0 (never) to 4 (very often). To soften the language for perpetrators who may still be known by the victim, sentence stems in the Rapist Blame scale were modified from "The rapist..." to "The guy..." Mean scores were used in the present study. Alpha coefficients for the Behavioral Self-Blame and Rapist Blame scales in the current study were .893 and .832, respectively.

## Data Analysis

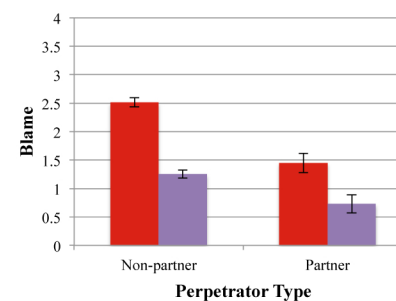
The impact of victim intoxication and perpetrator type on behavioral self-blame and rapist blame was examined using a multivariate model in SAS PROC MIXED with maximum likelihood estimation. The most parsimonious model was determined by removing non-significant predictors and examining reductions in model fit with likelihood ratio tests.

## Results

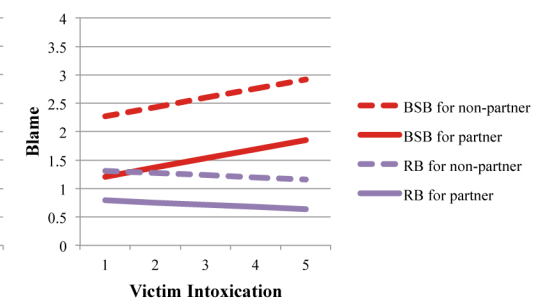
A total of 50 (21%) participants identified their perpetrator as a current intimate partner and 115 (49%) reported being intoxicated prior to the assault. The most parsimonious model included perpetrator type (current partner vs. other), victim intoxication, severity of the assault, and an interaction between perpetrator type and severity of the assault.

Results reveal that, controlling for assault severity and victim intoxication, participants reported higher self-blame than rapist blame ( $p < .0001$ ). Those who were assaulted by a partner reported less blame overall than those assaulted by other perpetrators ( $p < .0001$ ). There was a significant interaction between blame type and perpetrator, such that the difference between self- and rapist-blame was greater for non-partners than partners (see Figure 1). Victim intoxication level was positively related to self-blame, but not significantly related to rapist blame (see Figure 2). There was not a significant interaction between intoxication and perpetrator type.

**Figure 1. Predicted blame scores, holding assault severity constant at 3 and victim intoxication constant at 1.5.**



**Figure 2. Predicted blame scores, holding assault severity constant at 3.**



## Discussion

In support of Hypothesis 1, victims of IPSA endorsed less self- and rapist blame than victims of other assaults. Consistent with Hypothesis 2 and prior findings (e.g., Littleton et al., 2009), victims who reported greater intoxication endorsed more self-blame. However, an interaction between perpetrator type and victim intoxication did not contribute to predictions of blame, indicating that these mechanisms operate separately.

Given that victim intoxication did not moderate the relationship between perpetrator type and blame, alternative explanations for differences in perpetrator type on blame are needed. Although a precedence of consent and the woman's assumption of safety with a partner may contribute to reduced blame, another possible explanation relates to our operationalization of IPSA as an assault by a spouse or current dating partner. Women who endorsed IPSA in the current study may still be engaged in an intimate relationship with the perpetrator. Acknowledging that their partner sexually assaulted them could lead to cognitive dissonance and distress associated with remaining in the relationship. To reduce such dissonance and maintain the relationship, victims of IPSA may downplay the significance of the assault, and therefore assign less blame for the assault.

Overall, these findings highlight the unique nature of IPSAs and help to shed light on this relatively understudied topic. Future research informed by literatures on sexual assault and intimate partner violence is needed to better understand the distinct dynamics involved in IPSAs (Logan et al., 2013). For example, although self-blame for a sexual assault has generally been associated with distress (Frazier, 2003), more research is needed to determine whether the lower levels of self-blame from IPSAs in the current study translate to differences in mental health outcomes. Such research may be vital for informing IPSA-specific interventions.

