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# Assessment for Domestic Violence in Couples Requesting Conjoint Therapy: Current Practice of Assessment among Licensed Therapists

Ilene Grosam  
*St. Catherine University*

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Assessment for Domestic Violence in Couples Requesting Conjoint Therapy:  
Current Practice of Assessment among Licensed Therapists

Submitted by Ilene M. Grosam  
May, 2012

MSW Clinical Research Paper

The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University/University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present their findings. This project is neither a Master's thesis nor a dissertation.

School of Social Work  
St. Catherine University & University of St. Thomas  
St. Paul, Minnesota

Committee Members:  
Jeong-Kyun Choi, MSW, LISW, PhD (Chair)  
Julianne Bulau, MSW, LICSW  
Jeannie Jackson, BSW, LSW

### **Abstract**

Marital therapy with couples is routinely provided by licensed professionals including psychologists, marriage and family therapists, and licensed clinical social workers. Studying assessment practices provides information about how individuals, differing licensing categories, and the overall group assess for domestic violence in couples presenting for conjoint therapy. The present study utilized a survey consisting of both quantitative and qualitative items requesting responses to find out the frequency and methods of assessment for domestic violence when couples present for conjoint marital therapy. Respondents to the survey included 30 Licensed Independent Clinical Social Workers, 19 Licensed Marriage and Family Therapists, five respondents indicating belonging to other categories. The results indicate not all therapists assess for domestic violence in a universal manner, leaving some couples unscreened for violence in the relationship. The methods used to screen for violence in relationships were not always consistent with recommendations from professional organizations and research based literature. Overall therapist responses to working with couples where domestic violence is disclosed indicate safety for the abused partner is considered a foremost concern. Training about assessment processes and the dynamics of violent relationships may increase therapist feelings of competence in their work. More evidence based research is needed to agree what the best methods are to assess and treat violent relationships.

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## **Introduction**

Domestic violence, often referred to by the more inclusive terminology as intimate partner violence, encompasses an array of physical, sexual and psychological acts committed to achieve and maintain control over an intimate partner. Domestic violence was first identified as a social problem in the 1970's (Carlson, 2008). The focus at the time was on women involved in marital relationships, domestic violence happens in all types of intimate relationships. While it is acknowledged both male and female genders may be victims of domestic violence, the overwhelming majority are female. Domestic violence includes acts of physical violence against an intimate partner that are intended to cause harm, such as; pushing, grabbing, shoving, kicking, biting, hitting with fists, choking and threats with a weapon such as a knife or a gun (Carlson, 2008). Emotional and psychological abuse also occur and this includes: verbal attacks, insults, ridicule, name calling, isolation of the victim, denying access to resources such as income, extreme jealousy and possessiveness, monitoring behavior, accusations of infidelity, threats to harm family, children, pets, family members and the destruction of personal property (Carlson, 2008). Sexual abuse occurs in a significant number of abusive relationships in the form of coercive or non-consensual sexual acts (Carlson, 2008).

Gathering accurate statistics for reporting domestic violence is challenging due to victims preferring to keep violence a secret within the family, often there is a fear of retaliation from their partner if the abuse comes to light (Bachman, 1998; Carlson, 2008). Reporting abuse also poses risks to the safety of the victim. The National Crime

Victimization Survey, an ongoing tool for tracking victimization was begun in 1972 and was most recently updated in 1985. The National Resource Center on Violence against Women, from the victimization survey, reports 11percent of the wives surveyed had at least one act of violence perpetrated within the year and three percent of these acts were rated as severe. It may be surprising to note husbands reported violence by wives is nearly identical, however the survey does not account for what led up to the violence, whether it was self-defense or retaliatory in nature due to violence from the spouse (Carlson, 2008). When the annual victimization rates are reviewed, it is clear that females are victimized at significantly higher rates than males by an intimate partner. Rates from the National Crime Victimization Survey of 1992 – 1994 show that 1.8 million women were victimized by their intimate partner and males reported 143,000 assaults by an intimate partner. Questionnaires and clinical interviews reveal over 60percent of couples seeking marital therapy experience physical violence in their relationship and fewer than 10percent of these couples spontaneously report or identify the violence as a presenting problem (Ehrensaft & Vivian, 1996).

Adult partners are not the only people impacted by violence in the family, each year, approximately 15.5 million children are exposed to violence in the home (McDonald, Jouriles, Ernest, Ramisetty-Mikler, Caetano, & Green, 2006). Aldarondo and Sugarman (1996); Capaldi and Clark (1998); Hattendorf and Tollerud, (1997) found that the history of violence in the family of origin, witnessing violence between parents, or being violently punished as a child are all risk factors for perpetrating violence toward an intimate partner, carrying forward violence into another generation. A continuing controversy within the domestic violence advocacy community is the provision of mental



health services for victims due to a belief that professional counselors do not adequately understand domestic violence and stigmatize the victim with a diagnosis of mental illness (Carlson, 2008). This belief carries through to the provision of conjoint therapy for intimate partners seeking counseling services when adequate assessment for domestic violence is not done or the signs of emotional abuse are not fully recognized by a professional providing service (Goldner, 1998). Another dilemma in the treatment of violent relationships is the failure of traditional feminist models to address that violence in relationships occurs on a continuum from minimally abusive to an extreme of severe violence (Todahl & Walters, 2011). These less severe forms are the cases which do not receive mandated court services or services from shelter programs. Whether violence occurs in the relationship as a reaction to violence of another, or it is used as a tool for control and intimidation, it is not helpful to the promotion of peaceful family environments and should not go unaddressed when encountered.

Marital therapy with couples is routinely provided by various professionals in several licensing categories, including psychologists, marriage and family therapists, and licensed clinical social workers. The importance of studying the assessment practices of this group was to provide information about how individuals, differing licensing categories, and the overall group assess for domestic violence in couples presenting for conjoint therapy and what they do in their practice when domestic violence is identified. The method for the present study utilized a survey consisting of both quantitative and qualitative items requesting responses to find out if assessments for domestic violence are occurring within settings that provide conjoint marital therapy and if the therapists provide therapy or refer for other services depending upon the severity of the abuse.

Demographic information was collected to determine the licensing category of the respondent, experience in providing services and any specific education received about domestic violence. It was be useful to gain data from licensed clinical social workers since the literature does not indicate this group has been included in previous studies of assessment practices.

Implications for social work practice include making sure therapists have the knowledge needed to make appropriate decisions about providing therapy to couples that have been violent in their relationship. Domestic violence has the potential to affect how services are provided and the typical method of conceptualizing what treatment strategies are useful and what the goal of therapy is. There are also ethical considerations to take into account as licensed clinical social workers are expected to help people in need and address social problems, from the feminist perspective, victims of violence are an oppressed and vulnerable population and social workers are bound to provide access to needed services and resources. Since an intimate partner relationship is an important human relationship, there is a need for the social worker to provide, as part of the helping process, an effort to restore, maintain and enhance the wellbeing of these relationships whenever possible. The social worker is also bound to seek out appropriate supervision when areas of concern arise.

Indications are that the process of screening couples presenting for conjoint therapy is an important part of uncovering the presence of violence which impacts a significant number of intimate partner relationships. From the feminist perspective, therapists who do not have adequate knowledge of domestic violence or do not adequately screen for violence, potentially decrease safety and increase risk for the

victim. The possibility of encountering a couple seeking conjoint therapy and wanting help from a therapist for maintaining the relationship and stopping the violence places the therapist in a situation that relies on their expertise and training around domestic violence. Ethical implications may also arise as the therapist may struggle to meet the needs of the partners and ensure safety and risk reduction for the abused partner. The purpose of this study was to determine the prevalence of universal pre-counseling assessments for domestic violence among couples seeking conjoint therapy in clinical settings and the methods used for assessment. Additional information was collected about factors that therapists may consider in making a decision if conjoint therapy is appropriate, ethical implications for working with couples involved in violent relationships and therapist training in assessment practices and domestic violence.

### **Literature Review**

Domestic violence, often referred to by the more inclusive terminology as intimate partner violence, encompasses an array of physical, sexual and psychological acts committed to achieve and maintain control over an intimate partner. The recognition of domestic violence as a social problem has evolved over the past forty years. Estimates indicate domestic violence is a national problem and common among couples seeking therapy. From one half to as high as two thirds of clients have experienced some form of aggression in the year before coming to therapy (Holtzworth-Munroe, 1992; O'Leary, 1999). There are indications in spite of the high incidence of domestic violence, it is still possible therapists may not identify intimate partner violence presenting in a relationship (Hansen, Harway & Cervantes. 1991). This is particularly significant when domestic violence has been severe and is ongoing in the relationship. Geiss and O'Leary (1981) surveyed members of the American Association of Marriage and Family Therapists about what issues they found were most damaging and domestic violence was not even in the top ten, it was well behind communication issues and unrealistic expectations.

From the feminist perspective, domestic violence is viewed in terms of male dominance in a patriarchal system that supports the oppression of women and other groups with marginal or minority status. Feminists were at the forefront, working to develop policies around how to help women affected by violent relationships, this led to policies and laws designed to hold batterers accountable for violence, including mandatory arrest and prosecution (Jenkins, 1990; Stith & McCollum, 2011). Jenkins saw domestic violence as based in the gender inequalities evident in society with the unequal distribution of power to its male members leading to violence. Almeida and Durkin

(1999) discuss the role of culture in violence against women as the accumulation of social traditions in our society that are oppressive and maintain the dominance of men over women along with patriarchal customs.

Attempts to remediate offenders, or attendance at programs targeted towards the treatment of offenders is often mandatory. This has led to a one size fits all response to domestic violence therapy, in particular for the couple involved in a violent relationship, couples counseling still is not the recommended course of action because it is felt the female partner will be re-victimized by being held responsible for making changes in the relationship and joint counseling provides a platform for the batterer to blame his victim for causing him to be violent (Jenkins, 1990; Hattendorf & Tollerud, 1997). When empowerment means allowing a victim to make her own choices, and that choice is to remain with a partner who has been abusive, for whatever reason, it is not within the power of a domestic violence advocate or therapist to change her mind for her (Hattendorf & Tollerud, 1997). The victim of domestic violence faces a myriad of cultural, economic, religious, individual values and mores that make remaining in a relationship that is potentially dangerous, what she believes is best at the time (Stith & McCollum, 2011; Goldner, 1998).

### **Conjoint Marital Therapy**

The main reasoning behind offering only gender specific treatments for domestic violence is that joint therapy is usually based upon each person taking responsibility for problems in the relationship, this makes it very easy for a perpetrator of domestic violence to shift blame to his victim and enhances, for the victim, feelings of being responsible for the violence of her partner (Stith & McCollum, 2011; Goldner, 1998).

There is concern that using a systems approach to therapy absolves the violent partner of accountability for their actions and puts the spouse in the position of being responsible for helping to bring the violence under control. In therapy sessions, it is usually necessary for the therapist to remain neutral in their position of working with both clients, but it is critical to be very clear with the abusive partner that the violence must stop and the perpetrator of the violence must take responsibility and be accountable for their role (Stith & McCollum, 2011). Another concern expressed is increased danger to the victim if the abuse is revealed and discussed during therapy because the perpetrator may inflict retribution upon their partner after the session and the victim often does not feel safe to bring this to the therapy sessions (Jory, 1997; Jory, Anderson and Greer, 1997).

Despite the negative implications expressed here, Jory, Anderson and Greer (1997) conceptualize therapists helping couples learn: accountability for change on the part of the abuser, respect and restoring freedom for their partner, putting responsibility for change on the shoulders of the offender, and ensuring the abused partner does not experience self-blame and risks to their safety.

There may be situations and ways to work with certain types of abusive relationships. Ehrensaft, Langhinrichsen-Rohlin, Heyman, O'Leary and Lawrence, (1990), identified a broad web of personal, interpersonal, social, situational and cultural factors in play, broadening the traditional patriarchal, male dominant aggressor model. Goldner (1998) supports marital therapy because there will always be those couples who will not want to try anything else. Research has been conducted which identifies several types of patterns within abusive relationships (Holtzworth-Monroe & Stuart, 1994; Johnson, 1995). Johnson (1995) referred to the most severe form of domestic violence as intimate

terrorism, (initially, he used the term patriarchal terrorism) which he categorized as including for the most part, males who use power and control tactics to dominate all aspects of their partner's life with physical violence being the most used tactic, resulting in the creation of intense fear on the part of the abused as well as an increased risk for more frequent abuse and severe injuries.

This is in contrast to Johnson's description of common couple violence which appears to not be due to a pervasive pattern of control, is relatively intermittent and usually due to a specific argument or conflict which limits the control to a single situation. Other characteristics include the violence is often mutual, does not escalate over time and is less likely to involve severe violence (Johnson, 1995). Johnson defined situational violence as revolving around violence being used in a specific situation, and not as part of controlling all aspects of their partner's life; usually this does not create the same type of fear on the part of their significant other. This type of violence may have the tendency to be mutual, with both partners using some form of physical aggression.

Simpson, Doss, Wheeler and Christensen (2007) conducted research to determine if there was support for Johnson's theory of different types of violence being present in relationships and found there is support for different typologies, with the likelihood couples involved in a relationship with severe violence need treatment that is significantly different from what a couple involved with common couple violence needs. This once again points to the need for thorough assessments for violence in relationships up front so the therapist may make informed decisions about going forward.

When the decision has been made to stay in the relationship and use marital therapy as a means to determine if the relationship will continue, the experience of the

abused partner having their feelings validated about not being responsible for the violence or not having to be the only person who needs to change, may be helpful in accepting the relationship is not viable and boost confidence in ending the relationship (Stith & McCollum, 2011). Goldner (1998) asserts due to attachment bonding the parties together, it is safer to have the therapist, who is joined with both parties available to mediate through what is statistically the time the abused partner is in the most danger, and furthermore, since it is often the choice of the parties to remain together in spite of safety concerns, they are better off for having some tools learned in therapy.

The bottom line appears to be either way, gendered treatment or conjoint, each has risk involved for the couple who chooses to remain in a relationship. Debate surrounds the efficacy of batterer only intervention programs that are the standard mandate for court ordered domestic violence offenders. When examining the research of Green and Bogo, and Robie (2004), it was found the perpetrator of domestic violence had a 40 percent chance of remaining nonviolent, while also finding the offender who completes some other form of sentence not including a batterer's intervention program, has a 35percent chance of remaining nonviolent. This may relate to the 50 percent non-completion rate found for these programs (O'Leary, 1999). Babcock and La Taillade (2000), found only about one third of offenders who start a treatment program actually complete. Group attendance for men has no guarantee of safety for women, since in about ten to fifty percent of cases, when follow-up with the female partner has been completed, it was discovered the violence had become worse (Gondolf, 2002).



### **Gender Specific Treatment and Conjoint Treatment**

It is important to remember both sides of the argument in the end want to achieve the same goal, relationships that are safe for both partners. It should not be viewed as only one or the other may accomplish the desired outcome. Careful consideration needs to be given to how we address and stop domestic violence in relationships in a way that meets the needs of the victim and provides her with safety. Almedia and Durkin (1999), in applying a cultural context model, found therapists need to understand the definition of domestic violence, and know that besides physical abuse, the perpetrator uses intimidation and psychological abuse to control their partner. Almedia and Durkin proposed domestic violence is the accumulation of oppressive social traditions and patriarchal customs, which in our society; maintain the dominance of men over women. Women who have had lives impacted by violence are most often taught to claim their own power. Almedia & Durkin felt the therapist should require men to attend individual batterer's intervention groups first, in cases of moderate to severe violence, before attending joint sessions. The initial work in batterer groups is defining accountability for the batterer and typically this has involved the criminal justice system mandating treatment in gender specific groups (Carlson, 2008). When a couple is coming to therapy and the violence is disclosed there, or the violence hasn't been severe enough to come to the attention of authorities, these become situations where the therapist may be the first contact for the couple. Initially, domestic violence may not be presented by the couple as the reason bringing them to counseling, but oppression and power and control based interactions manifest in how finances, child rearing and other issues are played out in the couple relationship. These may be red flags for the therapist to reassess if domestic

violence is present. While the initial interview may be conjoint, it is recommended to then meet with each individually in order to screen thoroughly for violence in an environment safe for the woman. One reason given for not doing individual therapy with men is it reinforces the privacy of the issue and gives men a chance to focus on what has been done to them and portray themselves as a victim and supports their feelings of entitlement. A Cultural Context Model is a three prong approach: Separate cultural context groups for men and women. Then conjoint therapy when progress towards ending battering has been made, with return to individual groups as a support.

Jacobson, Gottman, Waltz, Rushe, Babcock and Hitzworth-Munroe (1994) studied via reporting scales, the roles of batterers and victims in violent altercations. Women categorized as in a relationship with domestic violence present were fearful. Husbands denied responsibility for the violence and did not claim to be afraid of their wives; fear is what gives men the power of social and psychological control and appears to drive the violence present in the family system. Jacobson, al. (1994) found women who use violence in the relationship mainly do so out of a reaction to violence by their spouse, whereas men would use physical violence in response to nonviolent behaviors. Once the violence has begun, men reported there was nothing the women could do to stop it. Jacobson and colleagues proposed a profile of the batterer and victim. Men were more controlling and less likely to acknowledge there was anything wrong with them; women, while often as verbally aggressive as men, showed more fear, tension, sadness and reported helplessness when faced with the violence of their husbands and being fearful of them. Goldner (1998) approached the treatment of violence and victimization in intimate relationships and discussed the oppositional forces present in the dilemma of how to treat

domestic violence in relationships, since Feminist theory holds conjoint therapy is inappropriate, male batterers need to be held accountable and attend suitable batterers treatment programs, joint therapy is unsafe for women as it supports an opportunity for her to continue to be blamed and responsible for change in the relationship. Batterers may use self-justification for their actions to re-victimize partners in therapy. Goldner (1998) supports conjoint therapy from a feminist perspective taking into account justice and safety for the victimized partner. The basic principle of equal responsibility of the individual in a couple does not apply in situations where domestic violence occurs. The balance of power and control in the relationship is one sided, which means therapy must encompass many theoretical and therapeutic approaches that will take into account the needs of the individuals, without compromise to safety for the women, in an environment which promotes hearing the woman's story of trauma and abuse; confronting the partner with it, in a safe and a supportive environment. Clinical assessment is again important to the starting of the process, in this case, a brief joint meeting and then individual meetings. Marital therapy is not officially started until enough consultations have occurred to ensure violence has been addressed and the couple is ready to move on to address maintaining the relationship. As much as men are required to take responsibility for their violent actions, women are held accountable for their safety in that they are empowered to become un-paralyzed and act on their own behalf to put their safety first.

Heyman and Schlee (2003) developed a feminist-social learning approach to ending wife abuse, taking into account the context in which the violence occurs and the society we live in that perpetuates violence as the most extreme power imbalance of all. Males continue to use aggression because it works, and there are rewards. The violence is

aggression taking place within the context of a relationship and society. This treatment format relies on treating the behavior that is occurring and the context for it. Abuse results from how the abuser interprets the behavior of their spouse. The ultimate goal is to stop all aggression, physical, psychological, and sexual. Therapists must extend their efforts to foster nonviolence to contexts outside of the therapy room through research, dissemination of findings, abuse prevention programs in the community and military.

Heyman and Schlee (2003) found most couples coming to therapy do not identify the abuse in the relationship and have not come from the population typically seen in shelters or in jails. It was found 71 percent of couples seeking therapy reported some physical aggression in the prior year. Most was mild, however 34 percent of the husbands were classified as severely aggressive and 13 percent of the abused wives sustained substantial injuries like broken bones and teeth. Almost none identified abuse as the reason for wanting couples therapy.

Conjoint marital therapy will not be appropriate for every couple, making the assessment process critical. Gauthier and Levendosky (1996) advocate for a three pronged approach for couples requesting therapy; to always include assessment for domestic violence, conducting separate interviews with each spouse and calling upon therapists to take responsibility for their own attitudes and personal beliefs about domestic violence. Todahl, Linville, Chou and Maher-Cosenza (2008) also studied the impact of universal screening and found therapist training about domestic violence is needed to decrease anxiety and increase effectiveness particularly among less experienced therapists.

Heyman and Schlee (2003) would recommend proceed with therapy with spouses who are married and living together and the therapeutic process would include homework activities. Conditions for not pursuing conjoint therapy as appropriate would include: not living together due to abuse and safety and having an order for protection in place. Screening is also suggested for post-traumatic stress disorder and other mental health issues including current substance abuse, psychotic symptoms, severe psychopathology limit participation, and a pattern of violence with those outside the marriage. A high dropout rate was reported for this therapy of 47 percent.

Greene and Bogo (2002) pursued whether there is a difference in the violence seen in the community and the violence seen in shelters, feeling the current approach treats both with the same intervention process. Research suggests two qualitatively distinct types of intimate violence: the male power and control model and the other involving mutual conflict between partners. Even newer models of treatment do not distinguish between types of violence against women and may not reflect an understanding of the lived experiences of many couples, which denies them the type of help they seek. Fifty to sixty five percent of couples report some form of aggression. Ninety percent do not see it as the major problem in the relationship. Self-referred couples and individuals seeking therapy versus court ordered clients tend to be less violent and more motivated to change the behavior. When appropriate screening is done, very few women reported being afraid of their partner.

Recent trends in intimate violence theory and intervention include focusing on the direct impact upon children who live in a violent home as detrimental to physical and mental health, and an increased sense of loss and estrangement within the family. Often

when the discussion occurs around domestic violence the attention is focused mainly upon the adults, but it is important to note domestic violence affects children in the household as well. McDonald et al. (2006) estimated the number of American children living in homes with domestic violence at 15.5 million. These children exposed to violence are more likely to attempt suicide, abuse drugs and alcohol, run away from home, engage in prostitution and commit sexual assault crimes. Children witnessing violence creates perpetration of violence into the next generations. Treating domestic violence gives hope for breaking the cycle of intergenerational transmission

Ehrensaft and Vivian (1996) identify a broad web of personal, interpersonal, social, situational and cultural factors in play, broadening the traditional patriarchal, male dominant aggressor model. Bograd (1999) suggests it is up to those working with victims of domestic violence to be open to expanding models of therapy and mental health systems may have a role in unintentionally maintaining abusive situations and therapists should be compelled to examine their own personal and professional roles.

When couples stay together, reports of the success of batterer intervention programs vary. Completion rates vary, estimated to be about one third. The results of follow-up to assess the outcome of these programs are mixed. A certain percentage of men, by some reports as high as ten to fifteen percent worsen after treatment. Holtzworth Monroe and Stuart (1992) described three categories or subtypes of offenders and tailoring treatment to variations may be helpful based upon the severity of violence, the incidence of partner only violence and violent behavior that is present in other contexts. A subgroup of violent men identified as family only, low level violent partners who were not subject to escalation of violence may be responsive to a treatment tailored to their

needs. This begs the question if we do a disservice to men and women by not being flexible in meeting the request of the couple for therapy. It is also known female partners use violence against their male partner, while it does not typically rise to the level of male violence or cause their partners to be fearful, it is still helpful for both partners to cease violent behavior within the relationship. Women who react violently or use violence in a relationship are also more likely to encounter severe violence from their partner.

Providing couples therapy when there is domestic violence present is not without controversy. Couples therapy in situations without violence would most often adopt a framework where the individuals accept equal responsibility for repairing the relationship. There is a danger in this when domestic violence is present because the relationship is already so unbalanced in power, asking the women to be responsible for what has been happening is asking her to accept blame for the violence. Also it is recommended a distinction be made when the violence includes control, subjugation and intimidation. There is a chance this would place the partner at even greater risk for further harm through increased violence of greater severity and frequency. This speaks towards the need for careful screening and excludes couples in which the male fits the pattern of behavior aligned with the label of batterer.

Another therapy model is Domestic Violence Focused Couples Treatment. A feminist informed approach integrating several theoretically compatible family therapy models. Solution focused therapy as developed by de Shazer in 1991, provides the overall framework; it is an integrated treatment model which includes narrative approaches. Each individual session begins and ends with individual meetings to assess safety and any

indication of risk for violence results in a suspension of conjoint therapy until safety is assured.

### **Domestic Violence Assessment Procedures**

Assessment for domestic violence is recommended by a significant number of medical associations: The American Medical Association (AMA), the American Academy of Pediatrics Committee on Child Abuse and Neglect (1998), the American College of Obstetrics and Gynecologists, the American Academy of Family Physicians, the American College of Nurse Practitioners, but among mental health professional associations, only the National Association of Social Workers (2002) and the American Psychological Association (2002) recommend universal screening. Carr (2009) recommends initial assessment of domestic violence is essential to determine if the couple is suitable for treatment. The overall recommendations for medical settings include routine screening for all female patients. The benefit is seen as having a preventative effect because they aren't waiting to see signs and symptoms of injury (Todahl & Walters, 2011). Todahl and Walters also note not all studies are conclusive about the effectiveness of this type of screening, particularly in the case of screening in therapy situations when domestic violence is not the presenting issue. Heyman, Felbau-Kohn, Ehrensaft, Langhinrichsen - Rohling and O'Leary (1990) found the type of tool or questionnaire used matters greatly when attempting to categorize or type violence between men and women. Todahl & Walters (2011) remind us while there are risks in treating couples affected by domestic violence, there are risks that come from not recognizing it and not treating those affected. Bograd and Mederos (1999) contend the assessment of couples for domestic violence should be a part of every intake interview, as



a means of ensuring safety for the therapy work to begin with definitive data on the issues involved in the relationship. Greene and Bogo (2002) believe there are three main questions a therapist needs to answer about the couple; the type of violence most likely to be encountered, how the therapist may tell the difference and how will treatment proceed.

Besides the benefit of having domestic violence disclosed at assessment, it is also important to know what to do with this information, in other words, what the therapist needs to do with it. The information may be used to reduce harm and increase safety for the affected partner, provide a safe environment where it is known it is safe to talk, the therapist decreases isolation by the connection to the client, is able to disrupt internalized messages of blame and guilt, and provide information in various formats and referrals to appropriate community agencies (Todahl & Walters, 2011).

### **Ethical Implications in the Treatment of Domestic Violence**

Professionals providing mental health services have ethical obligations to provide: Adequate screening, increase their own knowledge of domestic violence, knowledge of best practices and an obligation to educate clients and community in order to prevent domestic violence (Todahl & Walters, 2011; APA, 1999). Schacht, Bimidjian, George and Berns (2009) completed a study of 620 members of the American Association of Marriage and Family Therapists. The results found a majority of couple therapists do not routinely engage in the recommended domestic violence screening practices or assess for severity of abuse, which is an important determinate for safety risks. Since it has been determined moderate to severe domestic violence may be present in couples seeking therapy, a significant number of therapists may be unaware of the violence as they enter into the treatment process, which in addition to raising safety concerns for the victim,

also raises ethical concerns for the therapist (Holtzworth-Munroe et al., 1992; O'Leary, 1999; Hansen et al., 1993). It is not clear how undetected domestic violence, which is not addressed in the treatment plan, may contribute to poor outcomes for therapy because of the missed opportunity to openly discuss the violence and perform safety planning.

### **Conceptual Framework**

Overall domestic violence remedies have developed from the feminist perspective. From this paradigm, domestic violence exists because of male oppression, seeking power and control over women and children (Jenkins, 1990). Feminist theory sees the polarized impact of domestic violence, with certainly, the lethal aspects of it at the far end of the continuum from equality for the genders (Green and Bogo, 2002). This perspective has influenced how therapy has been accessed and developed within counseling services. For example, gender separate groups, male groups that focus on reduction of violence by education about patriarchy and power and control, female only groups that focus on empowerment for the victim, and a general taboo for providing conjoint therapy to a couple when there has been or still is domestic violence in the relationship.

Therapists performing marital therapy may include a feminist informed perspective as they set a treatment plan and goals. This usually means in order to avoid victim blaming or victimization, a stance is maintained that the violent spouse needs to be accountable by taking responsibility for their actions, violence must cease and more education is provided to the couple about the causes (inequality, power and control) of violence in the relationship.

Most of the literature states the traditional stance on family and couples therapies starts from a systems perspective, whatever the nature of the dysfunction, the cause is interconnected among the members of the unit through implied or expressed rules, roles and expectations; therefore it may be treated by improving the understanding and communication of the members. There is little in literature supporting one model of

therapy over another for treating couples involved with domestic violence. Therapy approaches may use Cognitive Behavioral models, Emotionally Focused Couples Therapy or Brief Solution Focused Therapy. In some of the more recent literature, a greater effort has been made to include cultural context as a lens when working with families that have been impacted by domestic violence in order to be sensitive to how this family may need a different approach or the therapist being sensitive to issues and role of culture.

The strengths of the feminist approach are movement towards social change that includes equality for oppressed people, not just women. This perspective as it relates to ameliorating domestic violence has set up a framework for responding to family violence by criminalizing domestic violence (gives it a consequence), works towards holding the offender accountable for the violence and empowering women to leave violent situations. The presence of domestic violence is a risk to safety for the female partner and their children. The feminist approach fits well with the ethical values of social work and social justice principles of working for equality and justice for oppressed groups.

Difficulties arise with the feminist perspective and couple therapy. When used as a framework for therapy, it may interfere with the therapist's ability to remain neutral, which is the usual stance taken when developing the therapeutic relationship. Clients typically come to therapy and set their own goals, in the case of working with a couple where there is domestic violence, and the therapist is setting the treatment goal as addressing domestic violence, even if it is something the couple does not see as a problem.

Another concern with the feminist approach is it has been shown domestic violence, while occurring in significant numbers among couples, happens on a continuum from mild to extreme. The feminist approach is considered as a one size fits all approach which may not be appropriate. Treating all couple relationships with the same approach is also problematic when the standard of not offering therapy for couples in violent relationships is in conflict with what the couple is seeking, and could be viewed as not ethical practice unless the therapist is able to provide suitable alternatives in the community through referrals and safety planning with the victim to decrease risk.

The feminist approach does not account for research findings that spouses may be equally violent towards each other. While in most of these cases, we are not talking about extreme violence, but women who are verbally aggressive and may also slap or push their partner. Feminist theory has recently needed to acknowledge violence is not strictly divided on lines of gender when considering the broad context of violence in our society and the equally broad make up of couples which include gay and lesbian violence. Evidence also supports women's violence is different from men, with men's aggression occurring more frequently and creating more substantial injuries and fear in their partner (Heyman, R., Feldbau-Kohn, S., Ehrensaft, J., Langhinrichsen-Rohling, and O'Leary, D., 1990).

Including a cultural framework is important since we are typically dealing with the primary cultural influence of gender and violence and its infusion within mainstream culture, however culture encompasses so much more. Cultural frameworks are inclusive of more than gender by their understanding of ethnic and other minority groups such as lesbian, gay, transgender and queer populations or differences among Latinos and

African American families. The focus is on listening to the story of the victim, for their personal meaning. When the focus is on the person who has been violent, the work is helping them understand how power and control promote violence, and the value of not passing on this part of their culture.

The most closely related models for assessing domestic violence come from the medical community, where recommendations exist for universal screening to assess for domestic violence. Other areas where there are standards and recommended practices for screening for domestic abuse occur in child protection settings and other community based services.

For the most part assessment, by its nature, is structured in its approach. Assessment, when universal, is relatively insensitive to race or ethnicity, and focuses much more on obtaining information in a proscribed manner. There are certain elements that should be asked, specific tests which may be given. From the various conceptual frameworks used during the treatment phase of marital therapy, the common denominator in determining the presence of domestic violence is the assessment process before therapy moves forward. The generally adhered to protocol for assessment is meeting with each client separately and together to determine suitability for therapy and identify risk. This process is also dependent upon the skill and knowledge of the therapist.

The nature of the assessment process lends itself to a structured approach. The intent is to find out how therapists, in particular soliciting responses inclusive of Licensed Clinical Social Workers since little is known about how this category of therapists, most studies have addressed the assessment practices of Licensed Marriage and Family therapists, Psychologists and medical professionals such as nurses and

doctors. It was then be possible to determine if recommended assessment procedures endorsed by professional associations are used routinely. This process intended to uncover what the norms are for assessment in practice settings. One recommendation for therapists is all couples need to be screened for domestic violence; this is a structural response for the treatment of violence (Bograd & Mederos, 1999). Another recommendation is therapists not rely on a single assessment format and assessments be multimodal, including interviews, individual and joint and screening tools (Gauthier & Levendosky, 1996). There may be some discovery about Licensed Clinical Social Worker values and ethics around the assessment process and how therapy proceeds in the presence of domestic violence.

The strength of the proposed research is the ability to format questions, surveys, testing materials in a concrete manner, to be less subjective. A weakness is also the rigidity of the format, removing the ability to capture individual responses that may be unique to the process. In addition to the conceptual framework related to the process of assessing for domestic violence in relationships, insight may be found into whether the feminist perspective is rigidly followed by therapists or if there is accommodation to what couples need to remain in relationships and have the violence end. Literature shows the assessment of domestic violence in relationships, besides its structured approach, questions the relationship from a feminist perspective, so before starting marital therapy, couples need to pass through this process, to determine suitability for treatment or for a recommended treatment program to begin. Therapists need the information from a good assessment in order to accurately conceptualize the case and plan the best methods for working with the client.

### **Methods**

Given the prevalence of domestic violence in couple relationships, universal screening for domestic violence is a recommended guideline for healthcare professionals. Before beginning couples therapy, it is critical to assess whether domestic violence exists in the relationship in order for the therapist to decide the most appropriate path for treatment. The purpose of this study was to determine the prevalence of universal pre-counseling assessments for domestic violence among couples seeking conjoint therapy in clinical settings and the methods used for assessment. Additional information was collected about factors that therapists may consider in making a decision if conjoint therapy is appropriate, ethical implications for working with couples involved in violent relationships and therapist training in assessment practices and domestic violence.

Expectations are that not all participants will perform assessments for domestic violence with all couples presenting for conjoint therapy. While it is a recommendation, therapists may not follow the guideline for any number of reasons. It was expected participants from a broad range of ages, practice settings and experience would be included in the study and not all would practice in the same manner due to influences such as educational background, training, experience and internal factors and beliefs about domestic violence and providing conjoint therapy.

The knowledge gained by assessing for domestic violence at the start of couples counseling gives the therapist information pertinent to appropriate situations for counseling couples or if other resources may be more helpful given the current situation. Based upon accepted feminist theories of treating domestic violence, not all couples will be appropriate and if counseling is to be offered, the safety of the victim needs to be a



priority. A significant understanding of the dynamics of violence in relationships is needed in order to proceed in a treatment approach that holds the perpetrator of the violence accountable for their use of violence and care needs to be taken to not blame or re-victimize the partner who has been abused.

### **Participants/Sample**

In order to identify the population of social workers and other therapy providers falling into this category, it was necessary to locate potential respondents through contacts with counseling agencies, both private and nonprofit sectors, over a broad geographical area. Mailing lists were available from the Minnesota Board of Social Work, the Minnesota Association of Marriage and Family Therapists, and the Minnesota Psychological Association and were used to solicit email addresses for survey candidates. The Minnesota Board of Social Work was the only certifying agency that provided emails with the mailing list. Using the names and addresses provided, email contact was made with agencies where LMFT and Psychologists were employed and personal email addresses were available for individual therapists on their web sites. The focus was on agencies in Minnesota, it did not appear to be necessary to expand outside of the state in order to achieve a statistically significant number of 30 respondents in the time available. This sample, which was selected by non-probability, and based upon convenience sampling of potential respondents, had the limitation of nongeneralizability to the general population.

The respondents to the survey included 30 Licensed Independent Clinical Social Workers, 19 Licensed Marriage and Family Therapists and five respondents indicating belonging to other categories. These included: Licensed Independent Clinical Social

Worker, both Licensed Marriage and Family Therapist and LICSW, both Licensed Psychologist and LICSW, and two respondents holding both Licensed Marriage and Family Therapist and Psychologist credentials. The total number of respondents was 54.

Respondents were asked to provide a description of their practice setting. Twenty two participants were in private practice, followed by ten from private mental health clinics. Additional practice settings included eight respondents practicing in public mental health clinics and six respondents practicing in another type of setting.

The racial makeup of the sample included: 48 Caucasian, one respondent each Multi Racial and Native American, and four responses indicating another racial identity. The gender of the group included 38 female and 16 male subjects.

No study participants were less than 30 years old. The majority of the sample, 29 respondents, were older than 50. The remaining age groups included 18 age 40 – 49 and seven between the ages of 30 – 39.

### **Protection of Human Subjects**

This research project received approval from the University of St. Thomas Institutional Review Board (IRB). The approval letter may be viewed in Appendix A. Approval was based on an appropriate risk/benefit ratio and project design. The project received expedited review based on applicable federal regulations. Risks were minimized and all research was conducted in accordance with this approved submission. Appendix B consists of the IRB approved Consent Form which was administered at the beginning of the survey.

The target population selected to receive this survey was not considered a vulnerable population. The intent was to sample professional therapists in this situation.

The survey results were anonymous, since each participant was asked to respond individually and were not required to provide identifying information in order to participate.

The survey itself did not contain questions which were overly invasive in nature. Few risks were associated with responding to the items included. Participation in the survey was voluntary, and based upon whether the participant decided to click the link and send in their responses. The first page of the survey included a statement of informed consent for the participants to review (Appendix B). If they chose to continue, they entered a response indicating their agreement. Participants in the survey were able to exit the survey at any time. The questions which were asked in the survey are available for review in Appendix C.

### **Research Design**

The purpose of this study was to determine the prevalence of universal pre-counseling assessments for domestic violence among couples seeking conjoint therapy in clinical settings and the methods used for assessment. Additional information was collected about factors that therapists may consider in making a decision if conjoint therapy is appropriate, ethical implications for working with couples involved in violent relationships and therapist training in assessment practices and domestic violence.

This research project explored how therapists conduct assessments at the start of couple's therapy to determine if domestic violence is present in the relationship. It was then possible to determine if therapists are screening all couples according to recommended guidelines and best practices models for assessment. Cross-sectional sampling was used to focus on this population at a single point in time. For this study, a

research design was used that included a written survey by mixed methods, using both quantitative and qualitative questions. The survey was completed online utilizing Qualtrics program access provided through the University of St. Thomas. An email was sent to the identified population of respondents who provided an email address in order to take part in the survey. Once clicked, the link took the participants directly to the survey questions.

### **Measurement/Variables**

The items used in this survey were adapted from the work of Schacht, Dimidjian, George and Berns (2009). The written survey was prepared and included for the most part, multiple choice questions with the option in some cases for a short answer related to other responses not covered by the given choices. One qualitative question was asked to obtain feedback from the respondents about any other information they would like to provide about working with couples and assessing for domestic violence. For the purpose of this research project, the questions used focused on the assessment practices of the respondents, their experience in working with couples, any specific training, ethical concerns and demographic information to describe the population responding to the survey (Appendix C). There were six quantitative questions, one that was qualitative, requiring the respondent to provide a written answer, and in addition, six questions related to the demographic population of the sample. In order to ensure clarity about the definition of domestic violence, and avoid individual interpretations of the term, the same description was provided to test subjects as was used by Schacht et al. (2009): “When referring to domestic violence, we are referring to a pattern of behavior that includes physical and/or sexual abuse, and may also include psychological abuse. In addition we

are focusing in particular on male violence toward adult female partners. Thus, we are not asking about other forms of violence in families (e.g. child abuse).” This statement was provided at the start of the questionnaire.

Since the intention was to find responses from therapists engaged in working with couples in therapy, respondents were asked to indicate if they have worked with couples in the past year and provide an estimate of how many. Therapists who have not done any work with couples within the past year were asked to exit the survey.

### **Data Analysis**

Analysis of the data used descriptive statistics for quantitative information received. Descriptive statistics were used to describe similarities and differences among the respondents in the sample to the quantitative survey items and also the demographic information. Measures of frequency distribution utilizing percentages were used for the most part. Measures of dispersion were used to indicate how spread out the values were in the distribution of responses.

In the case of qualitative responses received to the one open ended question, these were coded into general themes relating to pre counseling assessment of domestic violence prior to beginning couples therapy. Content analysis was used to reduce the data by looking for patterns that describe core consistencies and meanings or themes that emerged. An inductive grounded theory method was used to generate codes and themes, moving from the specific information gathered in the responses to the more general themes indicated in the data. In order to identify the codes in the data, open coding was used, which involves examining the data line by line, coding first for similarities and then for differences (Berg, 2008). When looking at responses to qualitative questioning, in

addition to assessment of the manifest content of the data, attention was given to the presence of latent content.

## Results

Given the prevalence of domestic violence in couple relationships, universal screening for domestic violence is a recommended guideline for healthcare professionals. Before beginning couples therapy, it is critical to assess whether domestic violence exists in the relationship in order for the therapist to decide the most appropriate path for treatment. The purpose of this study was to determine the prevalence of universal pre-counseling assessments for domestic violence among couples seeking conjoint therapy in clinical settings and the methods used for assessment. Additional information was collected about factors that therapists may consider in making a decision if conjoint therapy is appropriate, ethical implications for working with couples involved in violent relationships and therapist training in assessment practices and domestic violence. The knowledge gained by assessing for domestic violence at the start of couples counseling gives the therapist information pertinent to appropriate situations for counseling couples or if other resources may be more helpful given the current situation.

Marital therapy with couples is routinely provided by various professionals in several licensing categories, including psychologists, marriage and family therapists, and licensed clinical social workers. The importance of studying the assessment practices of this group provided information about how individuals, differing licensing categories, and the overall group assess for domestic violence in couples presenting for conjoint therapy and what they do in their practice when domestic violence is identified. The method for the present study utilized a survey consisting of both quantitative and qualitative items requesting responses to find out if assessments for domestic violence are

occurring within settings that provide conjoint marital therapy and if the therapists provide therapy or refer for other services depending upon the severity of the violence.

### **Quantitative Analysis**

In response to completion of the consent form, 105 respondents consented to continue with the survey. No respondents chose to exit the survey at this point. Results found therapists with current experience seeing couples requesting conjoint therapy. At this point, 59 respondents, 60 percent, indicated having seen couples in the past year requesting conjoint therapy. The remaining 40 respondents, 40 percent, indicating no practice experience with couples in the past year were asked to exit the survey. Again, the 59 respondents (N=59) were asked to estimate the number of couples seen within the past year. As shown in Table 1, the average number of couples seen in therapy overall was 14.15. An outlying response was omitted due to the improbability of this number of couples actually receiving therapy in a year's time or the possibility of a typographical error in answering the survey question. Table 1 also describes how the responses were collapsed into a range of responses, number of responses in each category and the mode of each.

Table 1. *Number of couples seen by therapists within the past year for conjoint therapy*

Number of couples seen	N	Percent
2 – 15	175.5	21
20 – 45	375	45
50 – 65	278	34
Total	828.5	100.0

Respondents were asked to indicate the amount of training received specific to assessment for domestic violence in couples presenting for therapy. Results indicate that 24 respondents, 43 percent, had received less than two hours of training, ten respondents,



18 percent, had received between two to four hours of training, and the remaining 22 respondents, 39 percent, had more than four hours of training. Participants were asked about their training specific to increasing their knowledge and understanding of the dynamics of violent relationships. The responses showed that 32 participants, 58 percent, had received more than four hours, nine, 16 percent, had received two to four hours, and 14, which accounted for 25 percent of the sample, had less than two hours of training.

The survey asked about the frequency of therapist screening for domestic violence when couples present for conjoint therapy. Respondents were asked about their screening for domestic violence and the majority, 45, or 79 percent reported that they conducted universal screening, that is, they screened all couples presenting for therapy for the presence of domestic violence. Of the respondents who did not report universal screening, ten, 18 percent, reported screening some couples. A minority of two participants, four percent of the sample, reported screening no couples. When asked about the use of a structured interview to screen for domestic violence, 31, 55 percent of participants use a structured interview some of the time. The universal use of a structured interview every time was reported by 16 respondents, 29 percent of this sample. Nine respondents, 16 percent, indicated they did not use any form of structured interview. Therapists were asked about their practice of speaking to couples separately. While the majority, 34 respondents, or 61 percent, reported screening some couples separately, one respondent reported they never saw couples separately and conducted conjoint interviews when screening for domestic violence. The remainder of the sample, 21 respondents, 38 percent, conducted separate interviews some of the time. See Table 2 for a summary of the frequency of screening practices in couples presenting for conjoint therapy.

Table 2. *Frequency of Therapist Screening Practices*

Variable	Value	Response	Percent
Universal screening	Screens all couples	45	79.0
	Screens some couples	10	18.0
	Screens no couples	2	4.0
	Total	57	101
Use of Structured interview	Some of the time	31	55.0
	All of the time	16	29.0
	Not at all	9	16.0
	Total	56	100
Interviews couples separately	Some of the time	34	61.0
	All of the time	21	38.0
	Not at all	1	2.0
	Total	56	101

Screening methods used by therapists were asked about in two of the survey items. The use of three main screening methods was included. No participants reported using questionnaires (or written screening tools) alone to screen for domestic violence. The participants were split in their remaining responses with 29 respondents, 52 percent relying on interviews alone and 27 respondents, 48 percent relying on both interviews and questionnaires (or written screening tools) as methods of screening for the presence of domestic violence. These results are summarized below in Table 3.

Table 3. *Methods of Screening for Domestic Violence*

Variable	Response	Percent
Questionnaire alone	0	0
Structured interview alone	29	52
Questionnaire Plus Structured Interview	27	48
Total	56	100

The survey examined the use of multimodal questioning as a method for working with couples seeking conjoint therapy. Twenty four participants responded they use screening for domestic violence by structured interview and/or questionnaire all of the

time in 43 percent of cases. Twenty-five respondents, or 45 percent, use both methods some of the time and seven respondents, 13 percent, do not use structured interview or questionnaire at all. These results are summarized below in Table 4.

Table 4. *Use of structured interview and Questionnaire*

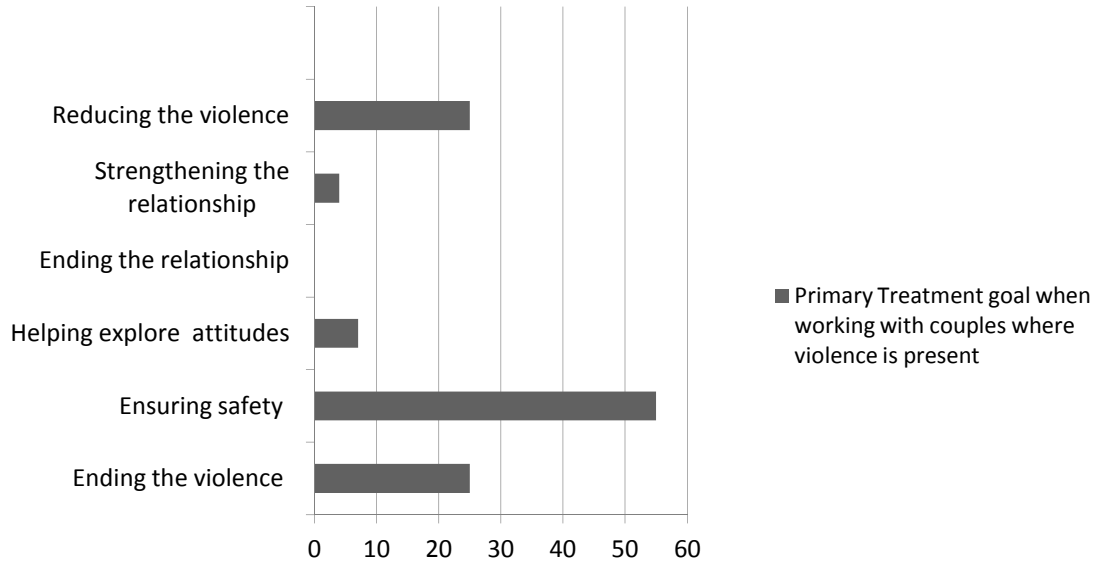
Variable	Value	Response	Percent
Use of structured interview and Questionnaire	All of the time	24	43
	Some of the time	25	45
	Not at all	7	13
	Total	56	101

Participants were surveyed about what they consider to be the five most important questions to ask about domestic violence. The top five responses were: the presence of risk factors (weapons, past threats to kill, severe abuse, fear level of victim, victim is planning to leave or has left in the past), ongoing violence in the relationship, pattern of conflicts, controlling behavior (financial, limiting activities, isolating from friends and family) and severity of the conflicts. Responses that were selected less frequently included: frequency, presence of physical abuse, fear of one partner towards the other, expression of and role of anger in the relationship and how the violence has impacted the children and parenting of the children. Considered least often were: the presence of sexual abuse, presence of emotional abuse, motivation to control, history of violence outside of the couple relationship and quality of other aspects of the relationship (finances, sexual relationship for example).

A list of factors was provided that a therapist may consider as significant in determining whether a couple is appropriate for therapy when domestic violence has been determined to be present. Among the choices, up to five could be selected. The most

selected determining factors were: Victim's level of fear and safety (is there a safety plan), perpetrator's acknowledgement of responsibility for the violence, if the partner is in imminent danger from abuse, potential impact of therapy to make the violence worse or cause retaliation towards the victim and if the abuse is ongoing or in the past. The responses falling in the mid-range of factors to be considered included: the presence of other psychopathology in either partner (including substance abuse), concurrent participation in other therapy (e.g. gender specific group), where the abuse falls on a continuum from mild to severe, professional expertise and clinical intuition in determining if therapy is appropriate and perceived motivation and likelihood of the partners to change. The least selected for consideration included the impact of violence on children in the family, other available support systems, use or presence of weapons, the abuse partner prefers to save the relationship, involvement of the legal system (police or courts) and the history of perpetrator's violence in past relationships.

Participants in the survey were asked to select their primary treatment goal when working with couples where domestic violence is present. The most often selected response 55 percent, was ensuring safety for the abused partner in the relationship followed by 25 percent responding that ending violence in the relationship was the primary treatment goal. The remaining responses received significantly few responses. These may be viewed in Table 5 below.

Table 5. *Primary Treatment Goal*

Therapists were asked about ethical considerations they may find most challenging when working with couples where domestic violence is present. Each participant was allowed to mark as many as they felt applied. Difficulty in maintaining neutrality in the therapeutic relationship was the most frequently cited as selected by 58 percent of participants, followed by the client's right to self-determination at 51 percent. The third most selected response was equally divided between a therapist questioning their own competence to provide therapy and being unable to engage both perpetrator and victim in a trust based relationship. Ranking in the mid-range of responses were; the tolerance of violence in our society, need to address social problems and injustice, value and importance of human relationships and being bound to help people in need. The least often endorsed ethical considerations were the therapist having their own agenda for therapy and not the client's, victim blaming, challenges to beliefs about causes of violence, challenges your own values and beliefs about male and female roles, and indifference to prevention of violence in the community.

### **Qualitative Analysis**

In the case of qualitative responses received to the one open ended question, these were coded into general themes relating to pre-counseling assessment of domestic violence prior to beginning couples therapy. Content analysis was used to reduce the data by looking for patterns that describe core consistencies and meanings or themes that emerged. An inductive grounded theory method was used to generate codes and themes, moving from the specific information gathered in the responses to the more general themes indicated in the data. In order to identify the codes in the data, open coding will be used, which involves examining the data line by line, coding first for similarities and then for differences (Berg, 2008). When looking at responses to qualitative questioning, in addition to assessment of the manifest content of the data, attention was given to the presence of latent content.

In addition to the quantitative questions, the survey also includes an open-end question to allow participants to provide any additional comments about working with domestic violence in couple relationships. These responses were analyzed to locate common features or themes present within. In general it seemed that the participants commented most often on the need for safety, the importance and use of community resources, the influences of society and culture and the frustrations of dealing with a complex social problem.

Participants commented on the use of community resources specific to working with the abused partner as significant: "If the violence is current, I recommend other resources to each partner, and also provide the person being abused with local resources and how to access them. Therapist comments included the need to be aware of where to

refer a client for appropriate assistance: “I refer women who have identified abusive behavior to visit with our county’s domestic violence alliance. The reasons for making such referrals was identified as a means for the client to discuss the issues around the violence, leaving the therapist to maintain an unbiased stance: “I find it a neutral place for clients versus me as their therapist having my own agenda in their eyes or trying to persuade them about the future of the relationship they’re in.” One respondent also offered that, it may be helpful to explore if there are reasons that resources have not been utilized: “... it’s important to help her/him understand the reasons why they might not access the help, i.e., what their barriers are to seeking help.” It may not be enough to just provide the referral, the therapist may feel the need to follow up to ensure the client received the help they need, and be knowledgeable about the resources offered and how effective they are.

It was expressed that conjoint therapy is not done or appropriate for situations where domestic violence is present. Several participants noted: “I do not work with couples if there is violence involved.” In addition to not feeling that conjoint therapy is an acceptable route, at times it is still felt therapy would be appropriate for the individuals. “I don’t think it’s good practice to work on couples therapy with both present when there is current domestic violence occurring due to safety.” This last comment includes another theme that is present, safety concerns when working with couples. “I focus on safety first, skill building and setting healthy boundaries.”

Several comments gathered focused on systems related difficulties in working with couples and domestic violence in therapy. It was noted that Minnesota Statutes require a “certified domestic violence counselor”, to complete domestic violence

evaluations (these are for the most part, perpetrators of violence court ordered for individual evaluation), not to see or refer for couples therapy. Another system related comment was: “One of the most difficult things I have encountered is when the system so strongly advocates for the woman’s safety, to the exclusion of the larger couple relational context...that it prevents any possible repair of unhealthy dynamics and therefore contributes to an ongoing unhealthy relationship between the couple.” Systems include those outside of the therapist’s office: “Society typically blames the victim... our judicial system fails the victims where judges are giving battered children to perpetrators.”

Therapists expressed thoughts around the need for more research and training about working with and understanding the role of domestic violence in couples relationships and counseling: “I would like to see more research about effective strategies for working with couples who have domestic violence issues in their relationship” and “This is a topic that could use more training and understanding.”

Therapists commented upon the complexity of the issues involved in attempting to work with couples where domestic violence is involved: “It can be a very grey area, couples say they want to and will stop the violence, but can’t always, it is sometimes like treating an addict, the want to forgive and forget is strong, but time is an important factor.” Some of these complex issues exist within the person: “It is often difficult to get an accurate assessment of the degree and impact of the violence (due to) minimizing.” In some cases, this complexity requires approaches that offer more options: “I have required each to have their own therapist ... individual therapists then decide together whether or not couple is appropriate.” Sometimes social factors play into the complex issue of domestic violence: “Many times the female victim will make the choice to return



...despite numerous therapy sessions.” Culture is also a part of what makes domestic violence a complex and frustrating issue: “There is a significant need for professionals to become knowledgeable about the complex dynamics of domestic abuse; how common it is in our culture, how society typically blames the victim,” and “The challenges are clearly many, this is particularly true when there has been no prior criminal intervention and the couple comes in for more than issues of violence.” An additional comment was collected about the lack of therapists willing to offer couples therapy. The forms of domestic violence in a relationship are complex and variable. Often thought of in terms of physical abuse, we are reminded that there is more to it than that: “Emotional (control) abuse is the most common... withholding money, anger over the struggle now between traditional marriage and the reality of both having to work and the husband not changing the views on workload etc.” A rather surprising comment, when considering the prevalence of violence in relationships, was made about the lack of having encountered domestic violence in relationship counseling. Which appears to contrast sharply with the comment of this participant: “It’s truly heartbreaking work.”

## **Discussion**

This research was conducted to find out how frequently and by what methods assessments for domestic violence are occurring when couples present initially to therapists for conjoint therapy. As a result of surveying Licensed Clinical Social Workers and other licensed therapists, such as psychologists and Licensed Marriage and Family Therapists, information was gathered about the frequency and methods used for assessment. Participants responding to the survey were questioned about what factors they consider most important to consider when completing an assessment for domestic violence and what they think the most important factors are to consider when deciding if a couple is appropriate for conjoint therapy. Participant views on what they would consider as the primary treatment goal in provide conjoint marital therapy were collected. Domestic violence and the provision of therapeutic services may be ethically challenging. Participants were also asked to comment on what they feel are ethical challenges tied to encountering domestic violence between couples seen in their practice.

### **Comparison of Schacht, R., Dimidjian, S., George, W. and Berns, S. (2009) with current study**

The initial idea for this study was based upon research conducted by Schacht, Dimidjian, George and Berns, originally published in 2009. The survey questionnaire used in this project was based upon the questions asked in the original study, making it possible to look for similarities and differences in the responses received. Schacht et al. (2009) reported domestic violence screening for all couples at 53 percent, some couples, 42 percent, and four and one half percent receiving no screening. Respondents in the current survey when asked about screening for domestic violence, 79 percent reported

that they conducted universal screening with all couples presenting for therapy for the presence of domestic violence, eight percent reported screening some couples and a small minority, four percent, reported screening no couples. From this comparison, it appears that the number of therapists performing screening for domestic violence has increased, leaving less couples unscreened and entering into therapy with undetected domestic violence.

When looking at how therapists structure initial interviews with couples, Schacht, et al. (2009) found therapists conducted separate interviews with all couples 37 percent of the time, some couples were separately interviewed 54.9 percent of the time and eight percent of the participants did not conduct separate interviews. The results for the current survey found that 61 percent of respondents reported screening some couples separately; one respondent reported they never saw couples separately. The remainder of the sample, 38 percent, conducted separate interviews all of the time. From these results it appears that the incidence of separate interviews to screen for domestic violence is slightly lower.

The use of multimodal screening was included as part of the assessment process for couples as a method to find out if domestic violence is present in the relationship. Participants were asked whether they rely solely on interviews, questionnaires or combined the use of both. Schacht et al. (2009) found among their respondents 12 percent, used both questionnaire plus interview, 40.6 percent used interviews only and no reported use of questionnaires alone to screen for domestic violence. Participants responded in the current study that the use of screening for domestic violence by structured interview and/or questionnaire occurs all of the time in 43 percent of cases, 45

percent in some, and not at all in 13 percent. See Table 6. For a comparison of screening frequency and methods.

Table 6. Comparison of Screening Frequency and Methods

Variable	Value	Schacht/Percent	Current Study/Percent
Universal screening	Screens all couples	53.0	79.0
	Screens some couples	42.0	18.0
	Screens no couples	4.5	4.0
Total		99.5	101
Use of Structured interview	Some of the time	37.2	55.0
	All of the time	54.9	29.0
	Not at all	7.9	16.0
Total		100	100
Interviews couples separately	Some of the time	54.9	61.0
	All of the time	37.2	38.0
	Not at all	7.9	2.0
Total		100.7	101

Both surveys asked about what participants considered to be the five most important questions to ask about domestic violence. The top five responses found by Schacht et al. (2009) were:

- current abuse
- the presence of risk factors (weapons, past threats to kill, severe abuse, fear level of the victim, victim is planning to leave or has left in the past)
- severity of conflicts
- history of violence
- quality of other aspects of the relationship (e.g., finances, sexual relationship for example)

Respondents in the current survey selected the following responses as the five most important questions to ask about during assessment for domestic violence:

- the presence of risk factors (weapons, past threats to kill, severe abuse, fear level of victim, victim is planning to leave or has left in the past),
- ongoing violence in the relationship,
- pattern of conflicts,
- controlling behavior (financial, limiting activities, isolating from friends and family) and
- severity of the conflicts.

A list of factors was provided that a therapist may consider as significant in determining whether a couple is appropriate for therapy when domestic violence has been determined to be present. Among the choices, up to five could be selected. The most selected determining factors in the survey conducted by Schacht et al. (2009) were:

- prognosis for improvement
- victim's level of fear and safety (is there a safety plan)
- nature of abuse(severity, frequency)
- mental health, participation in other therapy
- perpetrator's acknowledgment of responsibility for the violence

In the current survey, participants were presented with the same list of factors found in the Schacht et al.(2009) study and responded with the following answers to the question of which factors were considered most significant in determining if couple therapy is appropriate for relationships where domestic violence is present:

- victim's level of fear and safety (is there a safety plan)

- perpetrator's acknowledgement of responsibility for the violence,
- if the partner is in imminent danger from abuse,
- potential impact of therapy to make the violence worse or cause retaliation towards the victim
- if the abuse is ongoing or in the past.

Next, therapists were asked to select what they considered to be the primary treatment goal in cases where domestic violence was found in couple relationships. The respondents in the Schacht et al (2009) survey selected ending the violence in the relationship and ensuring safety for the abused partner in the relationship. The same two responses were also selected in the current survey as the primary treatment goal.

### **How therapists are doing when it comes to assessing for violence**

Conjoint marital therapy will not be appropriate for every couple, making the assessment process critical. The results here found that while a majority, 79 percent of couples presenting for therapy are screened all of the time, this is still short of the recommendation that therapists screen all couples for domestic violence, even when such screening is recommended by medical associations and the National Association of Social Workers and the American Psychological Association. Table 1 refers to the frequency of screening and Table 6 shows the comparison of the rates found in the current study with those found by Schacht et al. (2009) where the assessment rates for screening couples all of the time were even lower.

The methods used in assessing for domestic violence in couples are central to being able to consistently gather the information necessary to uncover problems with domestic violence. Gauthier and Levendosky (1996), along with recommending

screening for all couples included recommendations for using more than one type of screening method such as structured interviews with the couple together and separately and screening questionnaires. Findings indicate that rates between the studies are similar and it appears that more couples are being interviewed all or at least some of the time versus not at all. Most therapists it appears rely on interviews with clients to determine if domestic violence is present. The use of multimodal testing as recommended is relatively low at only about half, however this is higher than the 18 percent found by the Schacht et al. in 2009.

Given the cited incidence of domestic violence in couples estimated at from one half to as high as two thirds of clients having experienced some form of aggression in the year before coming to therapy (Holtzworth-Munroe, 1992; O'Leary, 1999), this leaves a question about the impact of undetected domestic violence on the ability to effectively treat couples in therapy and perhaps most significantly, fails to recognize serious safety issues for the abused partner. Even mistaking the presence of domestic violence in one couple has the potential for lethal consequences.

Overall the responses to what therapists consider important questions to ask in assessment indicate that they do pay attention to safety for the abused partner. The top five answers for what is most important to ask about when assessing for violence relate to the presence of the factors related to severe abuse in the relationship: Current abuse, high risk to safety by the presence of lethality indicators such as weapons and threats to kill, assessing the severity and pattern of conflicts and the history of violence in the relationship.

It may be considered whether therapist training and knowledge of assessment practices and the dynamics of domestic violence are part of why a universal screening standard are not being met. The results here indicate that less than 40 percent of therapists receive any training specific to assessment of domestic violence in relationships. It is more encouraging that at least half of respondents have received more than four hours of training, however at least one quarter of respondents had received less than two hours specific to the dynamics of domestic violence. Individual responses from therapists include an acknowledgement of a need for more training, in particular towards strategies that work for treatment of couples. Additional study would be necessary to find out if training is available and best methods for delivering training to therapists on the topic of assessment for and dynamics of domestic violence. What training should include has received some attention and according to Todahl et al. (2008) recommendations include training on the incidence and prevalence of domestic violence, information about the continuum of violence and what distinguishes the various forms, appropriate informed consent policies, training to address ethical considerations arising within the treatment sessions, understanding of danger indicators and lethality assessments for domestic violence, individual interview procedures, procedures to guide what is to be done with disclosed information, the ability to safety plan, understanding of the therapists own personal attitudes and the ability to adapt therapy models for a diverse population.

Once the assessment is completed and in cases where domestic violence is indicated, this presents the therapist with a decision to make about what to do next. Individual responses received from therapists indicate that proceeding with therapy in cases of active domestic violence would not be considered. This response appears to fit



with recommendations in literature not recommending couples counseling because it is felt the abused partner will be re-victimized by being held responsible for making changes in the relationship and joint counseling provides a platform for the batterer to blame his victim for causing him to be violent (Jenkins, 1990; Hattendorf & Tollerud, 1997). Individual responses from therapists appear to indicate conjoint therapy would not continue and referring for a more appropriate method of treatment is often a course of action, including referring the partners to individual resources such as a batterer's intervention program, community programs where the focus is to aid and support victims of domestic violence, or individual therapy until it is established that the violence has stopped.

### **Study limitations**

This sample, which was selected by non-probability, and based upon convenience sampling of potential respondents, had the limitation of nongeneralizability to the general population. While the results of the comparison of Schacht et al. (2009) and the current survey yielded some interesting data, there is not enough information about other factors that may be responsible for the differences in outcome. Such as, most of the literature reviewed involved psychologists and not Licensed Clinical Social Workers. This makes drawing conclusions about what factors may account for differences in response, whether it is due to differences in being an LICSW or holding a license in a different category

While it was good to specifically include this previously overlooked group of therapists, the overall response of LICSW participants was higher than other categories of therapists because Psychologist and LMFT email addresses were more difficult to solicit. This may be one factor that could be considered when deciding where differing responses

exist to the et al. survey. It remains unclear if responses were different between the LICSW practitioners and other categories, were due to differences in training, education and experience.

In order to keep the scope of the survey on a narrow focus, items to address issues that may be specific to culture and diversity were not included. This may impact the application of findings to work with Lesbian, Gay, Transgender or Questioning couples. While we are sure that domestic violence occurs across all types of relationships, this study does not account for how these differences may need to be addressed in assessing for domestic violence.

When asked about performing multimodal testing, it is not well defined what other written questionnaire may be used. Literature generally mentions the Conflicts Tactics scale or other measures that may assess for aggression in the relationship. The lack of use for written measures may suggest possibilities that these may not be available, not known to the therapists who responded to this survey, or if their use is found to not be helpful in assessing for domestic violence.

### **Ethical considerations**

There are ethical considerations to take into account as licensed clinical social workers are expected to help people in need and address social problems. From the feminist perspective, victims of violence are an oppressed and vulnerable population and social workers are bound to provide access to needed services and resources. From the qualitative answers received, it appears that therapists address this by providing appropriate referrals to ensure that they are aware of options and resources that are

available, and realize that proceeding with the usual marital therapy may not be the best option.

When empowerment means allowing a victim to make their own choices, and that choice is to remain with a partner who has been abusive, for whatever reason, it is not within the power of a domestic violence advocate or therapist to change her mind for her (Hattendorf & Tollerud, 1997). The struggle that therapists face with allowing client self-determination was the second most selected ethical issue by respondents in this survey. Over half of respondents selected this as one of their top five issues when working with couples and domestic violence. The victim of domestic violence faces a myriad of cultural, economic, religious, individual values and mores that make remaining in a relationship that is potentially dangerous, and is believed to be best at the time (Stith & McCollum, 2011; Goldner (1998). Contact with a professional outside the relationship presents the opportunity to provide education and information about options available and the risks associated with maintaining the relationship. This allows the therapist to provide information about what healthy relationships look like to the person who is weighing all of the reasons for remaining against the uncertainty of leaving, and may help the abused partner decide if there is a way that the relationship may be maintained without violence or if the risks are too great.

The most often selected ethical issue by respondents in this project was the difficulty of remaining neutral in cases where domestic violence has been disclosed. This may be likely given the understanding that domestic violence is a big safety issue for the abused partner, and some action needs to be taken for the protection of this person. Within the top five responses to ethical issues faced by the participants was a therapist

questioning their own competence to provide therapy and being unable to engage both perpetrator and victim in a trust based relationship. Given the previously discussed results around the amount of training received on assessing for domestic violence and training received specific to the dynamics of domestic violence, this feeling of a lack of competence in providing therapy in an effective manner perhaps needs to be addressed by finding out what the training needs are and making more options available in order to increase competence and effectiveness (Todahl et al. 2008).

### **Issues impacting assessment**

Respondents, when asked about any additional comments they wanted to make about working with couples and domestic violence, responded within several reoccurring themes, among these were safety issues, the utilization of outside resources, the need for training and comments about the complexity of working with domestic violence.

Assessment for domestic violence in couples relationships may be difficult since victims prefer to keep violence a secret within the family, often out of fear of retaliation from their partner if the abuse comes to light (Bachman, 1998; Carlson, 2008). Reporting abuse also poses risks to the safety of the victim. The importance of assessment is critical given the incidence of domestic violence reported in relationships (Ehrensaft & Vivian, 1996). Values and ethics around the assessment process for domestic violence and how therapy proceeds in the presence of domestic violence.

### **Additional considerations when working with couples and domestic violence**

Additional factors that perhaps should receive more attention and make thorough, well informed assessment procedures necessary include the impact of domestic violence on the family as a whole. Adult partners are not the only people impacted by violence in

the family, each year, approximately 15.5 million children are exposed to violence in the home (McDonald, Jouriles, Ernest, Ramisetty-Mikler, Caetano, & Green, 2006). Therapists are in a position to offer a means to end child exposure to violence in their home, and perhaps stopping the intergenerational transmission, or at the very least, to improve the outcomes for children, who may otherwise be at greater risk for suicide, drug and alcohol abuse and other risky behavior (McDonald et al., 2006).

A continuing controversy within the domestic violence advocacy community is the provision of mental health services for victims due to a belief that professional counselors do not adequately understand domestic violence and stigmatize the victim with a diagnosis of mental illness (Carlson, 2008). This belief carries through to the provision of conjoint therapy for intimate partners seeking counseling services when adequate assessment for domestic violence is not done or the signs of emotional abuse are not fully recognized by a professional providing service (Goldner, 1998). Therapists may need to move more into roles that voice their opinion on when therapy is effective and warranted. Through more careful study of outcomes for assessment, the effectiveness of interventions, the field may build a body of knowledge that supports the use of effective strategies for working with couples where domestic violence is an issue. When therapists can demonstrate a solid base of knowledge and effective best practices for proceeding, this will lend validity to the services provided. Bograd (1999) suggests it is up to those working with victims of domestic violence to be open to expanding models of therapy and mental health systems to avoid unintentionally maintaining abusive situations and therapists should be compelled to examine their own personal and professional roles.

Another dilemma in the treatment of violent relationships is the failure of traditional feminist models to address that violence in relationships occurs on a continuum from minimally abusive to an extreme of severe violence (Todahl & Walters, 2011). Whether violence occurs in the relationship as a reaction to violence of another, or it is used as a tool for control and intimidation, it is not helpful to the promotion peaceful family environments and should not go unaddressed when encountered. Therapists need more understanding and knowledge of how to distinguish which risk factors indicate the severity of violence in order to determine the appropriate intervention. When should therapy not go forward and other resources are indicated, or the safety of the partners may be assured and the risks are low. This again becomes an area where initial assessment and collecting the right information about the relationship is critical. Past research indicates that screening for domestic violence in couples may take a back seat to other issues that are presented by couples coming to therapy (Geiss and O'Leary; 1981). Therapists need to know what the indicators are for domestic violence that are demonstrated in other areas of the relationship such as how the couple handles finances, child rearing and be flexible enough to reevaluate for the presence of domestic violence when indicated. Most couples will not identify abuse as the reason for wanting couples therapy, when as high as two thirds will have experienced some mild form of aggression and approximately one third will have experienced more severe violence. Therapists need to be informed and aware of the potential for a dangerous situation.

### **Implications for social work practice, policy and research**

Implications for social work practice include making sure therapists have the knowledge needed to make appropriate decisions about providing therapy to couples that

have been violent in their relationship. Domestic violence has the potential to affect how services are provided and methods of conceptualizing what treatment strategies are useful and what the goal of therapy will be. The scope of this study was focused on assessment by therapists for domestic violence in couples presenting for therapy. Responses indicated that therapists are looking for guidance in what to do when domestic violence is disclosed. It appears that training focused on the topic would be helpful to therapists around assessing for domestic violence, the dynamics of violent relationships and options for how to proceed upon disclosure of domestic violence.

Ethical issues also arise pertaining to domestic violence. Including discussions of how these may be dealt with may be needed as part of training. Domestic violence presents a challenge to skills in the areas of feeling competent to work with identified couples. In such cases the therapist may need the availability of supervision that would include the ability to consult with another therapist over issues that arise from working with couples that present with domestic violence as part of the relationship issues. Therefore, therapists, licensed clinical social workers or others providing supervision would need to be knowledgeable about what issues arise around domestic violence.

### **Conclusion**

The purpose of this study was to determine the prevalence of universal pre-counseling assessments for domestic violence among couples seeking conjoint therapy in clinical settings and the methods used for assessment. Additional information was collected about factors that therapists may consider in making a decision if conjoint therapy is appropriate, ethical implications for working with couples involved in violent relationships and therapist training in assessment practices and domestic violence.

When asked if therapists assess all couples presenting for conjoint therapy for domestic violence, results indicate that not all therapists assess for domestic violence in a universal manner, leaving some couples unscreened for violence in the relationship. When asked what methods are used to screen for violence in the relationship, the methods used were not consistent with recommendations from professional organizations and research based literature that more than one method be used to perform screening for domestic violence. Overall impressions received about therapist responses to working with domestic violence in relationships and ethical concerns indicate safety for the abused partner is considered a foremost concern. The largest barrier to effectively assessing for domestic violence appears to be a lack of knowledge and training about assessment and dynamics of violent relationships which would increase therapist feelings of competence in their work. It is also indicated that there is a lack of evidence based research or agreement on what the best methods are to assess and treat violent relationships.



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## Appendix A. IRB Project Approval Letter

## Institutional Review Board



UNIVERSITY of ST. THOMAS

Institutional Review Board - University of St. Thomas  
 2115 Summit Ave. - Mail #AQU319  
 St. Paul, MN 55105-1078  
 Phone: 651-962-5341 - Email: irb@stthomas.edu

DATE: February 17, 2012

TO: Ilene Grosam, BS., LSW  
 FROM: University of St. Thomas Institutional Review Board

PROJECT TITLE: [284405-1] Assessment for Domestic Violence in Couples Requesting Co-joint Therapy: Current Practice of Assessment among Licensed Therapists

REFERENCE #:  
 SUBMISSION TYPE: New Project

ACTION: APPROVED  
 APPROVAL DATE: January 5, 2012  
 EXPIRATION DATE:  
 REVIEW TYPE: Expedited Review

REVIEW CATEGORY: Expedited review category # [enter category, or delete line]

Thank you for your submission of New Project materials for this project. The University of St. Thomas Institutional Review Board has APPROVED your submission. This approval is based on an appropriate risk/benefit ratio and a project design wherein the risks have been minimized. All research must be conducted in accordance with this approved submission.

This submission has received Expedited Review based on applicable federal regulations.

Please remember that informed consent is a process beginning with a description of the project and insurance of participant understanding followed by a signed consent form. Informed consent must continue throughout the project via a dialogue between the researcher and research participant. Federal regulations require that each participant receives a copy of the consent document.

Please note that any revision to previously approved materials must be approved by this committee prior to initiation. Please use the appropriate revision forms for this procedure.

All UNANTICIPATED PROBLEMS involving risks to subjects or others (UPIRSOs) and SERIOUS and UNEXPECTED adverse events must be reported promptly to this office. Please use the appropriate reporting forms for this procedure. All FDA and sponsor reporting requirements should also be followed.

All NON-COMPLIANCE issues or COMPLAINTS regarding this project must be reported promptly to this office.

This project has been determined to be a Minimal Risk project. Based on the risks, this project requires continuing review by this committee on an annual basis. Please use the appropriate forms for this procedure. Your documentation for continuing review must be received with sufficient time for review and continued approval before the expiration date of .

Please note that all research records must be retained for a minimum of three years after the completion of the project.

If you have any questions, please contact Eleni Roulis at 651-962-5341 or e9roulis@stthomas.edu. Please include your project title and reference number in all correspondence with this committee.

## Appendix B. Informed Consent Form

## Consent Form

St. Catherine University/University of St. Thomas

GRSW682 Research Project

Assessment for Domestic Violence in Couples Requesting Co-joint Therapy: Current Practice of Assessment Among Licensed Therapists

I am conducting a study that is intended to find out how therapists assess couples for the presence of domestic violence in the relationship. This study is being conducted by Ilene Grosam, LSW, a graduate student at the School of Social Work, St. Catherine University/University of St. Thomas and supervised by Dr. Evan Choi, PhD, LISW.

## Background Information:

The purpose of this study is to gain knowledge of how a varied group of therapists, including Licensed Clinical Social Workers, Licensed Marriage and Family Therapists, Psychologists and other professionals perform assessments for domestic violence when couples present for therapy.

## Procedures:

If you agree to participate, I will ask you to do the following things: I have a prepared a Qualtrics survey to be completed on line. The survey includes items related to how you might assess a couple when initiating therapy to find out if there is domestic violence present in the relationship. Most of the items in the survey are multiple choice questions. Some responses may need a short answer. I am asking about your professional level of licensure, experience in working with couples in therapy, and knowledge of domestic violence. It is estimated that the survey will take about 10 minutes to complete. The collected data will be used to construct a research paper which is required for the completion of the Master of Social Work program. In addition to the written work, a presentation will be prepared to be delivered on the campus of St. Catherine University May 18, 2012.

## Risks and Benefits of Being in the Study:

The study has no risks. The study has no direct benefits.

## Confidentiality:

The records of this study will be kept confidential. As a classroom protocol, the results of this study will be published by the university and a copy will be kept on campus and available via the library. The responses to the survey will be confidential in that there will be no identifying information that will be collected, unless the respondent chooses to provide information for follow-up contact.

## Voluntary Nature of the Study:

Your participation in this study is entirely voluntary. You may skip any questions you do not wish to answer and may stop the survey at any time. Your decision whether or not to participate will not affect your current or future relations with the College of St. Catherine, the University of St. Thomas, or the School of Social Work. If you decide to participate, you are free to withdraw at any time without penalty. Should you decide to withdraw, data collected about you may still be used if it is of value to the assignment.

#### Contacts and Questions

My name is Ilene Grosam. You may ask any questions you have prior to taking the survey by contacting me at (507)440-7009, or Jeong –Kyun (Evan) Choi, MSW, PhD, at (507) 205-2077.

You may also contact the University of St. Thomas Institutional Review Board at 651-962-5341 with any questions or concerns.

#### Statement of Consent:

I have read the above information. I affirm that I am at least 18 years of age. I consent to participate in the study.

Yes

No

## Appendix C. Survey Questionnaire

Within the past year, I have practiced therapy with couples. If yes, please indicate an approximate number of assessments for conjoint therapy.

- Yes Approximate number of couples seen in the past year:
- No

In the following survey questions, DOMESTIC VIOLENCE refers to "a pattern of behavior" that includes physical abuse, sexual abuse and psychological abuse." This survey focuses in particular on male violence toward adult female partners. Thus, the questions are not asking about other forms of violence in families such as child abuse.

Since the intent of the following survey is to find out about how therapists work with couples, if you have not engaged in any couples assessments within the past year, and have responded "no" to question "1", you may exit the survey at this point. Thank you for your cooperation.

- Exit Survey

When a couple is seeking therapy, I perform screening for domestic violence:

- All of the time
- Some of the time
- Not at all

Using a structured interview, I speak to couples separately:

- All of the time
- Some of the time
- Not at all

When domestic violence is identified, I speak to couples separately:

- All of the time



Some of the time

Not at all

Methods of screening for domestic violence include:

Questionnaires (or written screening tools)

Interviews

Both interviews and questionnaires (or written screening tools)

I use screening for domestic violence by structured interview and/or questionnaires:

All of the time

Some of the time

Not at all

I have received training specific to assessment of domestic violence in couples presenting for therapy:

Less than 2 hours

2 - 4 hours

More than 4 hours

I have received training specific to increasing my knowledge and understanding of the dynamics of violent relationships:

Less than 2 hours

2 - 4 hours

More than 4 hours

What do you consider to be the FIVE most important question(s) to ask about domestic violence?

Severity of conflicts

- Pattern of conflicts
- Frequency
- Presence of physical abuse
- Presence of sexual abuse
- Presence of emotional abuse
- Ongoing violence in the relationship
- Motivation to control
- Fear of one partner towards the other
- Presence of risk factors (e.g., weapons, past threats to kill, severe abuse, fear level of victim; victim is planning to leave or has left in the past).
- History of violence outside of the couple relationship
- Quality of other aspects of the relationship (e.g., finances, sexual relationship for example).
- Expression of and role of anger in the relationship
- Controlling behavior (e.g., financial, limiting activities, isolating from friends and family).
- How the violence has impacted the children and parenting of the children
- Other

What FIVE factors do you consider most significant in determining whether couple therapy is appropriate for relationships where domestic violence is present?

- Where the abuse falls on a continuum from mild to severe (e.g., frequency, severity, duration).
- If the abuse is ongoing or in the past
- If the partner is in imminent danger from abuse

- If the abused partner prefers to save the relationship
- Professional expertise and clinical intuition in determining if therapy is appropriate
- Perceived motivation and likelihood of the partners to change
- Victim's level of fear and safety (is there a safety plan)
- Presence of other psychopathology in either partner (including substance abuse)
- Concurrent participation in other therapy ( e.g., gender specific group)
- Perpetrator's acknowledgment of responsibility for the violence
- Involvement of legal system (police and/or courts)
- Other available support systems
- Impact of violence on children in the family
- Use or presence of weapons
- History of perpetrator's violence in other relationships
- Potential impact of therapy to make the violence worse or cause retaliation towards the victim
- Other

What is your PRIMARY treatment goal when working with couples where domestic violence is present?

- Ending the violence in the relationship
- Ensuring safety for the abused partner in the relationship
- Helping the couple explore their own attitudes about roles in the relationship
- Ending the relationship
- Strengthening the relationship

Reducing the violence

Other

What ethical considerations do you find most challenging when working with couples where domestic violence is present? You may select ALL that apply.

Challenges your own values and beliefs about male and female roles

Challenges to beliefs about marriage

Challenges to beliefs about causes of violence

Difficult to maintain neutrality in the therapeutic relationship

Have my own agenda for therapy, not the client's

Victim blaming

Tolerance of violence in our society

Questioning own competence (knowledge and skills in domestic violence ) to provide therapy

Indifference to prevention of violence in the community

Need to address social problems and injustice

Value and importance of human relationships

Bound to help people in need

Unable to engage both perpetrator and victim in a trust based relationship

Right of the client to self determination

Other

Is there anything else that you would like to comment on about working with domestic violence in couple relationships?

I have a license to provide therapy as a \_\_\_\_\_

- Psychologist
- Licensed Clinical Social Worker
- Licensed Marriage and Family Therapist
- Other

Practice setting

- Public Mental Health Clinic
- Private Mental Health Clinic
- Private Practice
- Medical Hospital or clinic
- Other

Race

- Caucasian (Non- Hispanic)
- African American (Non -Hispanic)
- Asian
- Hispanic

Multi-Racial

Native American

Other

Gender

Male

Female

Age

Less than 30

30 - 39

40 - 49

50 or older