EXPLORING INFLUENCES ON COUPLE THERAPIST VIOLENCE SCREENING PRACTICES: A QUALITATIVE STUDY

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A DISSERTATION

Submitted to
Michigan State University
in partial fulfillment of the requirements
for the degree of

Human Development and Family Studies – Doctor of Philosophy

2018

ABSTRACT

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Intimate Partner Violence (IPV) is a tremendous social problem with devastating consequences for survivors and loved ones, with effects that often last for generations. IPV not only affects the victim but it hurts society as a whole, and costs billions of dollars to the US economy each. Yet it is a preventable problem. Many couples who experience abuse seek solutions through couple therapy, yet most therapists working with couples do not directly address nor assess for the presence of violence, one estimate finding that only 4% of therapists follow guidelines to routinely screen for partner violence. Engaging couples in treatment when violence has not been assessed is dangerous for victimized clients and ethically perilous for the therapist. There is a healthy discourse in the IPV literature about how best to respond to violence in couples seeking treatment, but what is missing from this discussion is a thorough understanding of factors which influence therapists' couple violence screening practices. Guided by two theories, Ecological Theory and Role Theory, this qualitative study explores the many factors that influence clinicians in their screening practices around the topic of violence, and highlights the individual and contextual elements that govern clinical choices by the therapist. Data was gathered from clinicians working in a variety of contexts, and was analyzed using a thematic analysis approach. Findings contribute to a growing knowledge of literature that focuses on violence detection efforts within the field of mental health, and may inform educational and training policy.

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To my family and to my husband

ACKNOWLEDGEMENTS

So many professors, friends and family have helped me to reach this milestone, and I could not have made it this far without each of your contributions. Nobody does this without the support of a community, and I feel blessed to have such wonderful people around me. I would like to thank my parents, Pilar and Don, for your unwavering love, support and encouragement. Your shared values of education, integrity, service to community and strong work ethic have been my inspiration. I cannot express enough my gratitude for how you have both helped me throughout this endeavor. To my incredible husband, Drew, you have seen me across the finish line of this program and I would not have made it without you by my side. All you have done to support me and cheer me on exceeds all expectation, and I am blessed to have you as my partner. To my brother Dax and Libby, and to my parents-in-law, thank you for your consistent encouragement and support. It has meant the world to me.

I am tremendously thankful to have had a wonderful doctoral committee of such accomplished scholars and amazing people. I would especially like to thank my advisor and chair, Dr. Adrian Blow. I am eternally grateful for your guidance, encouragement, and kindness throughout this project. You have patiently allowed me to find my own way in this program, yet have always encouraged me and advocated for me. Thank you for being a wonderful advisor. Dr. Marsha Carolan, it has been my deepest pleasure to know you through my time in this program. I admire and respect you greatly, and for all that you have done for myself and the many other students in this department. Dr. Ruben Parra, thank you for your loyalty and encouragement from the beginning of this program. Your passion and drive are an inspiration and it has been an honor to learn from you. Dr. Diane Doberneck, my committee would not have been complete

without you. Thank you for being such a wonderful and guiding presence in this process, your expertise and your encouragement have been invaluable.

I have met so many amazing friends and colleagues through this program. It has been a joy to work among you. Mil gracias a todos.

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CHAPTER 1: INTRODUCTION TO THE STUDY

Statement of the Problem

Intimate Partner Violence (IPV) is a pervasive public health issue which occurs in all contexts among all religious, socioeconomic, and cultural groups (Garcia-Moreno et al., 2006). The Centers for Disease Control and Prevention estimates that the aggregate number of American adults affected by IPV annually, including IPV, sexual violence and stalking, is 12 million (Breiding et al., 2014). Findings from the 2010 National Intimate Partner and Sexual Violence Survey (NISVS), which conducted telephone interviews with 8000 women and 8000 men, suggest that women are disproportionately affected by IPV and stalking (Breiding et al., 2014). Results from the NISVS indicate that 1 in 5 women (19.3%) compared to 1 in 59 men (1.7%) have been raped in their lifetime; 1 in 4 women (22.3%) have been the victim of severe physical violence by an intimate partner, compared with 1 in 7 men (14.0%); and 1 in 6 women (15.2%) have been stalked during their lifetime, compared to 1 in 19 men (5.7%) (Breiding et al., 2014). Some estimates are even greater, suggesting between 25-54% of U.S. women will be exposed to partner violence in their lifetimes (Thompson et al., 2006.)

IPV includes a myriad of behaviors including physical, sexual, and emotional abuse, stalking, and other controlling behaviors (e.g., isolation, restriction of access to finances, education, healthcare) by an intimate partner (Garcia-Moreno et al., 2006). Physical violence frequently includes sexual violence and is also usually associated with emotionally abusive tactics. For example, in a multi-country study done by the World Health Organization 23–56% of women who reported ever experiencing physical or sexual IPV, had experienced both (Garcia-Moreno et al., 2006). Similarly, the National Intimate Partner and Sexual Violence Survey found that among survivors of IPV, 1 in 3 women experienced multiple forms of rape, stalking, or

physical violence (Breiding et al., 2014). Many victims of IPV are assaulted repeatedly. Researchers Tjaden and Thoannes (2000) have estimated that the annual incidence of sexual assault of U.S. women by an intimate partner is 322,230, and physical assaults of U.S. women by an intimate partner is 4.5 million, and an estimated annual incidence of physical assaults against U.S. men by intimate partners is 2.9 million (Tjaden & Thoannes, 2000).

The emotional and physical consequences of abuse are tremendous. The most severe presentations of IPV, patriarchal terrorism, escalates over time (Johnson, 1995), and in the most extreme cases becomes lethal. According to the Centers for Disease Control and Prevention, three women in the United States are murdered every day by an intimate partner (Breiding et al., 2014). According to a 2001 estimate, approximately one-third of female homicides reported in police records were perpetrated by an intimate partner (Federal Bureau of Investigation [FBI], 2001). Of the 926 women who were murdered by an intimate partner in 2011, 264 were shot during the course of an argument (Violence Policy Center [VPC], 2013). Unlike rape which is more prevalent for younger women, according to the Bureau of Justice Statistics [BOJS] (2006), individuals in their 30's and mid 40's (40%) are more likely to be victims of homicide at the hands of an intimate partner than those younger than 30 (29%).

One of the most abhorrent forms of IPV is sexual assault. 1 in 5 American women has been raped in their lifetime and half of those women (51.1%) report that the rape was perpetrated by an intimate partner (Breiding et al., 2014). Roughly 14% of women (13.4%) have been physically injured as a result of sexual violence, physical violence, or stalking by an intimate partner (Breiding et al., 2014). In the U.S. annually, 1.5 million women and 834,732 men are raped or physically assaulted by an intimate partner (Tjaden & Thoannes, 2000).

While the greatest burden related to IPV is directly borne by women, men are also

impacted by IPV at alarming rates. In the U.S. 7.6% of men will be exposed to partner violence in their lifetimes (National Center for Injury Prevention and Control [NCIPC], 2003), and 1 in 7 men have experienced severe physical violence perpetrated by an intimate partner (Breiding et al, 2014). Annually there are an estimated 600,000 injuries among men resulting from IPV related assaults (NCIPC, 2003); one estimate shows that over the course of their lifetime, 3.5% of men will sustain a physical injury as a direct result of sexual violence, physical violence, or stalking by an intimate partner (Breiding et al., 2014). Just as violence against women may escalate to lethal levels, violence among and against male partners can also be fatal. Men are more likely to kill their partners following an increase in violence and usually after their partners have attempted to exit the relationship (Garcia, Soria and Hurwitz, 2007; Kellerman & Heron, 1999; Lee, Thompson & Mechanic, 2002; McFarlane et al., 1999; Tjaden & Thoannes, 2000), whereas women are more likely to kill their partners in self-defense or in response to prior abuse (Kellerman & Heron, 1999; Tjaden & Thoannes, 2000).

Women who have been abused are at greater risk for developing substance dependencies and recent research has expanded our understanding of the links between substance use and its impact on IPV (Catalá-Miñana, Lila, Oliver, Vivo, Galiana & Gracia, 2017; Shipway, 2004). Women who have been abused are 15 times more likely to abuse alcohol and 9 times more likely to abuse other drugs than women who have not experienced abuse (Shipway, 2004). One study found that 90% of women in a drug treatment program had experienced severe domestic and/or sexual violence from an intimate partner (Miller, 1994). Furthermore, substance dependency has been used as a wider means of controlling a partner in abusive relationships, as perpetrators have been found to sabotage the mental health and sobriety efforts of their partners in an effort to limit independence (Warshaw, Lyon, Bland, Phillips & Hooper, 2014). The presence of substance use

within the context of an aggressive relationship may increase both the frequency (Caetano, Cunradi, Clark, & Schafer, 2000; Cunradi, Caetano & Schafer, 2002) and severity (Testa, Quigley & Leonard, 2003) of violent encounters. In a study by Lipinsky, Caetano, Field and Larkin (2005) heavy drinking by a partner increased the risk of IPV by 5 times, and prevalence of IPV increased proportionately with the amount of alcohol consumed by that partner. Substance use and abuse affects both men and women negatively and has been found to increase instances of aggression in both men and women (Bushman, 1997).

A growing knowledge base of the LGBTQ community has demonstrated a substantial presence of IPV in non-heterosexual populations though prevalence estimates within these groups have shown large discrepancies (Krahé, Bieneck, & Möller, 2005). A report based on a national data set found that sexual minority rates of IPV are equal to or higher than sexual majorities: 35% of straight women reported either experiencing rape, physical assault, and/or stalking by an intimate partner in her lifetime, while 44% of gay women and 61% of bisexual women reported experience of abuse in their lifetime (Walters, Chen and Breiding, 2013). In another nationally representative sample in the US (N= 14,182), Messinger (2011) identified IPV in non-heterosexual individuals, and found that respondents who reported a history of same-sex relationships were roughly twice as likely to report verbal aggression (69%), controlling behaviors (77%), physical aggression (36%), and sexual aggression (11%) in their relationships than those who reported exclusively heterosexual relationship histories. There is no conclusive body of research comparing prevalence rates of IPV among lesbian women and gay men (Hellemans, Loeys, Buysse et al., 2015) though it has been hypothesized that IPV is more prevalent among lesbian couples than gay male couples (Turell, 2000). For example, one 1997 study found that lesbians were more likely to be victims of physical IPV than gay men, though

no differences were found when examining the severity of the aggression (Waldner-Haugrud et al., 1997). Numerous studies have substantiated the prevalence of physical and sexual IPV among non-heterosexual couples, yet knowledge of psychological violence within this specific population is underdeveloped (Hellemans, Loeys, Buysse, et al., 2015). While there is still much to be learned about the unique presentations of partner violence within non-heterosexual couples, we do know that partner victimization among non-heterosexual couples has negative implications for survivors. Descamps et al. (2000) reported that lesbian victims of IPV had an increased rate of depression and alcohol abuse compared to lesbian women without a history of IPV victimization (Garcia, Soria, & Hurwitz, 2007; Paulozzi et al., 2001).

Mental and Physical Health Impacts of IPV

Abusive relationships have adverse and often long-term impacts on an individual's health, and can lead to both physical and somatic health conditions (Coker et al., 2002; Plichta, 2004; Sutherland, Sullivan, & Bybee, 2001). Physical and non-physical abuse are detrimental to health and the longer a survivor is exposed to IPV, the worse the health impacts become (Bonomi, Thompson, Anderson, Reid, Carrell, Dimer, & Rivara 2006). In a review of the literature documenting the health impacts of IPV, Plichat (2004) found the following health implications: traumatic brain injury, femicide, gastro intestinal disorders, neurological disorders such as dizziness, paralysis, memory loss, left- or right- side weakness, chronic pain such as joint disorder, facial pains, and worse health behaviors like smoking, drinking, higher use of pain medications, and unhealthy weight control behaviors. In a large, multistate study, Breiding, Black, and Ryan (2008) examined the similarities and differences in health impacts for both men and women as a result of IPV; not only did they find that both men and women are more likely to experience health problems but they also found that those who had experienced IPV exhibited

more detrimental health behaviors than those who had not (heavy smoking and drinking, HIV risk factors, not visiting a doctor for a health checkup in the past year).

IPV victimization has been well documented to have an association with severe mental health impacts including posttraumatic stress disorder (PTSD) (Mechanic, Weaver & Resick, 2008), depression (Golding, 1999; White & Satyen, 2015), anxiety (Shorey, Sherman, Kivisto, Elkins, Rhatigan & Moore, 2011), and low self-esteem (Zlotnick, Johnson & Kohn, 2006). A review of literature by Dillon, Hussain, Loxton, and Rahman published in 2013 found the following mental health implications for survivors of IPV: depression, PTSD, anxiety, insomnia and disturbed sleep, migraines, chronic fatigue, concentration difficulties, as well as a predilection for other illnesses such as the flu and raised blood pressure. In a 5-year follow up study of a nationally representative sample of American married or cohabiting women, the authors found that women who had experienced IPV were significantly more likely to experience depression, functional impairment, and lowered self-esteem (Zlotnick, Johnson & Kohn, 2006). Both PTSD and depression have been found to persist long after the abuse has ceased (Campbell & Soeken, 1999; Zlotnick, Johnson & Kohn, 2006). Some research suggests that the emotional abuse can lead to worse mental health outcomes than the physical abuse itself (Dutton & Goodman, 2005).

A lethal consequence of IPV victimization is an increased risk of suicidal behaviors (Devries et al. 2011; Ellsberg, Jansen, Heiss, Watts, Garcia-Moreno, 2008). Those who are assaulted by an intimate partner are more likely to contemplate suicide than those who are assaulted by a stranger (Simon, Anderson, Thompson, Crosby & Sacks, 2002) suggesting a unique risk given the nature of the relationship. Racial and ethnic minorities have been found to be at the greatest risk of suicide in the context of an abusive relationship when compared to non-

ethnic minority counterparts (Cavanaugh, Messing, Del-Colle, O'Sullivan & Campbell, 2011; Meadows, Kaslow, Thompson, & Jurkovic, 2005), for example, rates of suicidality more than doubles for low-income African American women living with an abusive relationship (Kaslow et al, 2000). Some literature has suggested that suicidal behavior is influenced by the suicidal behaviors of others (Mościcki, 2001; as cited by Cavanaugh, Messing, Del-Colle, O'Sullivan & Campbell, 2011), and a study of 662 adult victims of IPV, authors reported that abused women whose partners made threats of suicide were more likely to make threats of suicide themselves (Cavanaugh, Messing, Del-Colle, O'Sullivan & Campbell, 2011).

Decades worth of literature has documented the myriad negative impacts to women's reproductive health as a result of IPV (Coker, 2007). Pregnancy is a time of increased risk within abusive relationships (Gelles, 1988) most especially for unintended pregnancies (Gazmararian, Adams, Saltzman, Johnson, Bruce, Marks, & Zahniser, 1995). Women who are abused during pregnancy present with more risk factors for homicide compared with women who are abused and not pregnant (McFarlane, Parker & Soeken, 1995). Results of a review of the literature related to pregnancy-associated violent deaths suggests that one- to two- thirds of pregnancy-associated homicides in the U.S. are perpetrated by an intimate partner, and that pregnant women make up 5% of urban intimate partner female homicides (Martin, Macy, Sullivan & Magee, 2007). Abusive partners have been documented to use reproductive health as a means of coercive control through pregnancy-promoting behaviors (forced unprotected sex, contraceptive sabotage, and verbal threats about pregnancy), and to exert control and physical abuse during pregnancy to influence pregnancy outcomes (Moore, Frohwirth, & Miller, 2010). A review of literature on the impact of IPV on women's reproductive health and pregnancy across various countries found an increased risk for pre-term delivery and neonatal death, and increased risk for low birth weight in

infants (Sankar, 2008).

Abuse negatively diminishes a victim's social functioning (Bonomi, Thompson, Anderson, Reid, Carrell, Dimer, & Rivara 2006) and hinders his or her ability to maintain steady employment (Tolman & Raphael, 2000; Tolmand & Rosen, 2001; VandeWeerd, Coulter, & Mercado-Crespo, 2011). In a sample of women from Washington State (n=3429) it was found that those who had experienced some form of IPV had lower social functioning than non-abused women, and lower than or comparable functioning to women experiencing chronic illnesses such as cancer and heart disease (Bonomi, Thompson, Anderson, Reid, Carrell, Dimer, & Rivara 2006). A study by McCaw, Golding, Farley, and Minkoff (2007) surveyed women attending a routine HMO annual check-up, and found that among those who either previously or currently experienced IPV (n=391), having a history of abuse was reliably and consistently associated with impaired social functioning, even when that abuse was not active within the previous year, indicating the lasting impact of experiencing abuse.

Increased Health Care Utilization

The impact of IPV on society is demonstrated by the heightened use of medical and mental health care, and the substantial costs that result. Survivors of IPV use more medical services than those who have not. According to the National Center for Injury Prevention and Control, IPV survivors have a 1.6- to 2.3-fold increase in health care use compared with non-abused peers (Ulrich, Cain, Sugg, Rivara, Rubanowice & Thompson, 2003). Rates of healthcare use are highest during times of ongoing abuse, and rates decrease after abuse has subsided (Bonomi, Anderson, Rivara, & Thompson, 2009). In a study by Bonomi, Anderson, Rivara and Thompson, (2009); 3,333 women between the ages of 18-64 were randomly sampled from membership of a health plan, and surveyed by telephone to assess history of IPV, and healthcare

utilization and costs were assembled for both abused women and never abused women. Healthcare utilization was higher in all categories of health service during active IPV compared to women without IPV, and that utilization of services decreased over time after cessation of IPV (Bonomi, Anderson, Rivara & Thompson, 2009). Longitudinal analysis of this same sample by Rivara, Anderson, Fishman, Bonomi, Reid, Carrell and Thompson (2007) found that 5 years after women's abuse ceased, healthcare utilization was still 20% higher than compared to women without IPV.

Similar to medical health care utilization, individuals who have experienced partner violence use more mental health services than those who have not experienced partner abuse (Coker et al., 2002). It is estimated that the U.S. spends between $2 and $7 billion annually on medical and mental health care as a result of IPV (Brown, Finkelstein & Mercy, 2008). Survivors of IPV are more likely to access social services, caseworker services, and housing assistance compared to those who have not experienced IPV (Lipsky, Caetano, Field & Larkin, 2005). Friedman and Loue (2007) estimate the total number of mental health care visits by female IPV victims each year to be more than 18.5 million. As a result of documented health impacts, healthcare costs for women exposed to IPV are roughly twice the amount when compared to women with no exposure (Ulrich, Cain, Sugg, Rivara, Rubanowice & Thompson, 2003). The highest rates of mental health service use are for those for whom the abuse is ongoing (Bonomi, Anderson, Rivara, & Thompson, 2009).

Mental Health Service Provider Identification of IPV

Couples experiencing violence in their relationships interface with many mental health service providers. The vast majority of available literature on universal screening comes from medical practitioners such as physicians, nurses, emergency room staff, obstetricians,

gynecologists, pediatricians and others; as such, the term providers will be used to describe health care workers across these contexts, while the terms clinicians and therapists will be used to refer to mental health therapists. Though prevalence rates vary widely across many studies, it is estimated that over half of women seen in a range of mental health settings have been abused by an intimate partner at some point in their relationship (Mowbray, Oyserman, Saunders, Rueda-Riedle, 2011; Warshaw, Brashler & Gill, 2009). O'Leary, Vivian and Malone (1992), estimate that as many as half of female family therapy clients have been physically assaulted by their partner within the last year. Despite the prevalence of partner violence within mental health services, violence often remains undetected (Jose & O'Leary, 2009; Kamimura et al., 2014; Madsen et al., 2012). In a clinical study by Stith, Rosen, Barasch, and Wilson (1991), 12% of 262 families initially reported IPV as the presenting problem, though upon further investigation IPV was occurring in at least 40% of the families.

Despite the abundance of literature documenting the high prevalence of violence, the momentous and long-lasting health costs to victims, and the high incidence of abuse in therapy-seeking populations, the occurrence of a comprehensive universal screen by therapists working with couples is shockingly low. Schacht, Dimidjian, George and Berns (2009) presented findings from a national survey conducted in 2000 with participants randomly selected from 620 members of the American Association for Marriage and Family Therapy. The 4.5% of participants who reported that they did not screen any couples for violence were excluded from analyses, and authors concluded that fewer than 4% of respondents consistently conducted universal screening using separate interviews and questionnaires as recommended. A survey by Danis (2003), assessed screening procedures of licensed BSWs and MSWs (n=145). In response to the survey item: "I ask all my female clients if their intimate partner is currently threatening or

actually inflicting physical harm on them by hitting, shoving, or slapping them or by using a weapon against them," 22.6% (n=33) answered 'None of the time', and only 11.6% (n=17) responded 'All of the time.'

Gap in current knowledge. Violence screenings continue to be underutilized in clinical practices, yet there is little knowledge of what maintains these low rates of use. There is a significant gap in the literature on the topic of therapist practices when it comes to violence screening (Todahl & Walters, 2011) and while numerous studies have addressed the patient or client experiences of receiving a screen, they do not provide information as to the experience of the *clinician* who is conducting that screen. As well, many studies explore screening practices according to other medical providers, but they do not address the unique challenges and complexities inherent in the role of a couple therapist. Many studies of universal screening have been carried out in specific contexts i.e., a large hospital organizations (Minsky-Kelly, Hamberger, Pape & Wolff, 2005) or a university training clinic (Todahl, Linville, Chou, & Maher-Cosenza, 2008). In such settings, the practice of violence assessment is required of clinicians in a top-down fashion and therapists are practicing within the parameters of larger organizational factors. This is not representative of the experiences of clinicians practicing privately or in other community settings.

A qualitative approach to exploring violence assessment in community settings can gather important and relevant information to understand practice models, IPV screening assumptions, and assessment practices, which are not yet established in the literature (Todahl, Linville, Chou, & Maher-Cosenza, 2008). Not widely discussed in the literature are issues of insurance reimbursement and payment structure concerns, the use of time in initial therapy sessions, legal ramifications of disclosures of abuse, managing confidentiality, therapist

responsibilities with regard to minor children in the home, concerns about the therapist-client alliance- all of which are elements of clinical practice that warrant further exploration. Despite the breadth of scholarly and organizational support in favor of universal screening for intimate partner violence, the gap in current knowledge of therapist perspectives is considerable.

Although IPV is one of the leading causes of death among women in the United States (Breiding et al., 2014), it is something that is preventable (Ellsberg et al., 2008). High rates of aggression among couples seeking treatment paired with low rates of detection suggest that therapists frequently treat violent couples, even when they don't recognize that it is occurring (Jose & O'Leary, 2009; Kamimura et. al., 2014; Madsen et al., 2012). As clinicians working with couples, when we do not take steps to assess the presence of violence we miss the underlying clinical issues and as a result both clients and clinicians are put at risk.

Purpose of the Study and Research Questions

The purpose of this study is to identify influences on violence screening and assessment behaviors by mental health therapists who work with couple clients in both private practice and community agency settings. The data gathered in this qualitative study will be organized according to the five ecosystemic levels that constitute Bronfenbrenner's Ecological Systems Theory (EST).

Macro-system influences. The first goal of the study is to explore the macro-level elements, which influence therapist screening. The research questions that will guide this goal are:

1. How do therapist attitudes and beliefs about IPV influence violence assessment practices in clinical work with couples?
    a. How does exposure to cultural messages about couple violence impact therapist awareness related to the need to screen for violence?

b. How does the individual's understanding of a therapist's role in treating and preventing partner violence, influence how he/she assesses violence with clients?
c. How do IPV training experiences influence therapist views toward IPV screening and assessment?
    i. When therapists feel prepared or underprepared to address violence with clients, how does that influence screening practices?
    ii. What has helped them to feel prepared?

2. What contextual elements of the clinical practice setting create barriers or motivations for IPV screening practices?
    a. What aspects of the practice environment support or inhibit addressing violence with clients?
    b. In what ways does the reimbursement structure of the therapy business affect clinical practices addressing violence?

Micro-system influences. The second goal of the study is to explore the micro-level influences, or personal experiences, relationships, contexts, which influences therapist screening practices. The research questions that will guide this goal are:

1. What motivates therapists who work with couples to ask about violence as a key component of treatment?
    a. How do individual experiences with Intimate Partner Violence (family of origin and own personal relationships) influence their clinical practices?
    b. In what ways do individual violence screens create a barrier to assessing violence in-session with couples who have come to therapy seeking conjoint sessions for relational dynamics?

i. How do therapists maintain the therapeutic alliance with couple clients when carrying out violence assessments?

c. How do prior clinical experiences with Intimate Partner Violence influence clinical practices?

d. How do relationships with other mental health professionals influence a therapist's understanding of IPV in therapy clients?

i. How do connections with other professions indirectly impact therapist awareness of the need to assess violence?

e. How do the practices of addressing violence change over the course of a therapist's career?

Theoretical Framework

Ecological systems theory. Social research can be informed by examining variables connected to systems within which the individual develops. The controversial nature of the topic of gender-based violence in some settings leads to great potential for bias, so it is important in this study to explore the individual within a context. Human ecological theory seeks to describe and explain (Bubolz & Sontag, 2009) and is thus well suited to qualitative exploration. Brosi and Carolan (2005) highlighted the influence that ecological factors play in the countertransference reactions of therapists when working clinically with instances of partner abuse. In Ecological Systems theory (EST), Bronfenbrenner described the environment as a complex web of systems that exist and are "nested" within each other at different levels, and that the individual develops and grows through interactions with both the immediate environment and with more distal environments (Bronfenbrenner, 1976). This theory proposes that the individual develops within a social network, which is directly shaped by the interdependent interactions of these systems

(Bronfenbrenner, 1976; Garbarino & Bronfenbrenner, 1976). This network of interdependent systems is composed of the micro-, meso-, exo-, chrono-, and macrosystems, which shape an individual.

The *Microsystem* includes all of the immediate systems with which an individual personally interacts. With regard to therapists, this includes personal characteristics (personal histories, current family norms and behaviors, individual mental health) as well as the immediate social system (current practice setting norms and requirements), which will affect a therapist's level of comfort with the topic of IPV. For example, if a therapist works in an agency or group which requires the use of an intake procedure that includes problems about violence; this will directly affect the assessment behaviors of that therapist. Similarly, a therapist who is a survivor of an abusive relationship may be either desensitized to abusive dynamics or have a heightened awareness of abuse and manipulation when interacting with clients.

The *Mesosystem* refers to interactions between two or more microsystems, which are directly involved with the individual. These interactions include things like family of origin legacies of violence or aggression, and past clinical experiences with IPV. These interactive effects can influence how therapists connect to and manage client relationships, how they balance the therapeutic alliance between couple clients, and how they feel about approaching a potentially uncomfortable topic such as partner violence with couples who have come to therapy for help.

The *exosystem* is made up of settings or events that have an indirect effect on an individual's microsystem or mesosystem. These include professional affiliations, laws, policies, and educational requirements connected to the treatment of partner violence that evolve within the field of mental health and which will impact the practice habits of therapists across numerous

clinical settings. For example, if a therapist is socially or professionally connected to someone who works in domestic violence advocacy, passage of state mental health codes that include a duty to report imminent danger to a client, a focus of partner violence by a professional organization in which a therapist participates, all may have bearing on how an individual in practice approaches and addresses active violence with clients.

The *macrosystem* is the larger social environment within which the individual develops. Nested within the individual's macrosystem are the micro-, meso- and exosystems, which create the cultural context in which that an individual grows, learns, and develops. Examples of elements of interest in this study are the cultural values and social stereotypes around IPV that an individual is exposed to, which will influence one's understanding of the prevalence and philosophies about partner violence. As connected to therapist assessment of active violence, a therapist who believes that violence is most prevalent in low-income families, may not actively address violence with affluent clients because of an assumption that it is not as likely to occur in these families.

Lastly, the *chronosystem* refers to the effect of time on individuals and other variables of interest across the ecosystem. For example, the wider societal dialogue about the topic of IPV has varied greatly over the last several decades, and so the opinions and beliefs of individual clinicians may also develop as clinicians continue to practice. A clinician, who received his education twenty years ago, may not have been exposed to coursework and discourse about the prevalence of violence in therapy seeking couples. As well, a clinician who has worked with several couples that experienced violence over the course of several years of practice may be more aware the need to assess current violence than she was when she first began practicing.

Role theory. While ecological theory is used to understand the wider context in which

clinicians practice, in contrast Role Theory will be used to expand the understanding of the relationship between the macro- and exosystemic influences of culture and profession on clinical choices and behaviors. Our social environment influences our beliefs and understanding of the world (Cosgrove, 2000), and role theory will provide a bridge to explore how that environment connects to individual level therapist behaviors.

The term role theory describes a diverse body of literature that examines the connections between social systems, cultural elements, and behaviors when individuals are engaged in interactions with others (Ritzer, 2005). A theoretical understanding of roles originated in the theater (Thomas & Biddle, 1966) and the foundation of role theory within social science was developed more than 60 years ago (Babinski, 2016; Lemay, 1999). Writings by Linton (1936) brought social role theory to prominence, while George Herbert Mead (1934) authored symbolic interactionism, and Talcott Parsons' writings (1951) explored social positions within role behavior; these authors' contributions constitute the major concepts which make up Role Theory.

Role theory is centered on the concept of roles, or scripts for predictable patterns of behavior, and posits that we as individuals carry expectations for our own patterns of behavior and those of others based on our roles (Biddle, 1986). One's role is crafted by the larger social system by established expectations of a spectrum of "obligatory, acceptable, and prohibited conduct" (Kessler, 2013, pg. 671). For example, when a client states that her partner has been physically abusive very recently following an argument, a therapist will likely carry out a safety plan with that client because it is what he or she believes is the appropriate action at that point.

An understanding of others' expectations for acceptable behaviors is what one uses to build a schema for how to respond in any given situation (Kessler, 2013), and a core concept of role theory is that our behaviors are governed by our understanding of the rules of our roles

(Kessler, 2013) and assumes that people behave in predictable ways according to their identity and position within the given situation (Biddle, 1986). As well, the understanding of role norms can vary from person to person within the same position (Biddle, 1986) meaning two people will carry out the same job in slightly different ways because differences in their understanding of their roles. For example, a therapist who works at a domestic violence shelter and is meeting with a client who alludes to high conflict in her relationship will likely ask in-depth questions to understand the severity of the violence because she believes that this is part of her job. However, a therapist practicing in a private office and not in a violence shelter may not probe as directly about the presentation of conflict because she may not understand that to be part of her role as a therapist.

These behavioral expectations inform our interactions with others within the social system as we attempt to carry out our understood roles. As the theory posits, we carry out our roles to earn rewards for acceptable behavior and avoid negative consequences for unacceptable behavior (Kessler, 2013). In the example of carrying out a safety plan with a client that may be at risk for violence, a therapist will likely document the safety plan in clinical progress notes because of the fear of negative consequences for not documenting a safety plan with a high-risk client.

Role Theory has been widely applied to medical settings (Guirguis & Chewning, 2005; Hardy & Conway, 1988; Riahi, 2011; Blakely & Dziadosz, 2015) and mental health service professions (Acker & Lawrence, 2009) to understand workplace behaviors. Following the theory, all actors exhibit some innovation and creativity as they carry out role behaviors, most especially outside of highly formalized environments such as military, hospital, or monastery (Ritzer, 2005). Role theory is a useful approach when examining provider-client interactions (Bissell,

Traulsen, Haugbolle, 2001) because it is focused on the interplay between social structure and individual behavior over time. As Fellows and Kahn write individual actors "translate expectations into scripts for performance, while modifying those expectations and the definition of their roles through subsequent performances" (2013, pg. 674). So, as therapists gain clinical experience and work with clients experiencing a myriad of clinical issues, this experience influences how therapists understand their roles and clinical responsibilities to their clients. Similarly, as therapists gain life experience through continued training and education and through interactions with others in informal settings, their understandings of their roles as therapists will develop over the lifespan.

Across the many inceptions of role theory are the underlying assumptions that expectations help us to formulate roles, that these expectations are learned over time, and that individuals are cognizant of the expectations to which they are subject (Biddle, 1986). Role theory proposes that individuals come to understand what is appropriate behavior in a given context through their interactions over time.

Integrated framework. This research study will pull from the two theories identified to provide structure and guidance for investigating influences on therapist violence screening practices. Ecological Systems Theory (Bronfenbrenner, 1986) will provide a structure for understanding clinical interactions as couched within various contexts, and Role Theory will guide the understanding of work-place behaviors and motivators (Heiss, 1981).

Table 1.1 demonstrates the integrated conceptual framework with corresponding research question. Sample questions used in the interview protocol are included with corresponding research questions.

Table 1.1 Conceptual framework with research questions

Guiding Theory	Research Questions	Sample Questions
Ecological Theory/ Role Theory	What motivates therapists who work with couples to ask about violence as a key component of treatment?	I'd like to know all about what has influenced your thinking, your feelings along the way, and any specific experiences that have been formative for you.
Ecological Theory	How do therapist attitudes and beliefs about IPV influence violence assessment practices in clinical work with couples?	How do think your religious background or cultural background have shaped your attitudes about talking with clients about violence?
Ecological Theory	How does exposure to cultural messages about couple violence impact therapist awareness related to the need to screen for violence?	Have you had any personal exposure to violence in childhood or in your community?
Role Theory	How does the individual's understanding of a therapist' role in treating and preventing partner violence, influence how he/she assesses violence with clients?	Can you tell me how you think about the role of a social worker/MFT in the bigger picture of domestic violence work?
Ecological Theory	How do IPV training experiences influence therapist views toward IPV screening and assessment?	How has education or any other training impacted your beliefs on this topic of the therapist' role?
Ecological Theory	What contextual elements of the clinical practice setting create barriers or motivations for IPV screening practices?	There are a lot of different recommendations for how to assess for violence with couples, and many of these recommendations include 3 elements: 1) A written assessment by both partners, 2) Verbal interviews with each partner separately to do a private assessment as well, 3) This should be done with all couple clients regardless of what is their presenting issue. What are your reactions to those suggestions? How does payment structures and getting reimbursements from insurance companies influence your intake and assessment process with couples?

Table 1.1 (cont'd)

Ecological Theory	How do individual experiences with Intimate Partner Violence influence their clinical practices?	How do you see your life experiences that you have shared with me today, influence your views on the need to ask couples about abuse before engaging them in treatment?
Ecological Theory	How do therapists maintain the therapeutic alliance with couple clients when carrying out violence assessments?	What problems might you foresee in asking every couple about violence?
Ecological Theory	How do prior clinical experiences with Intimate Partner Violence influence clinical practices?	Tell me about the worst experience that you have had working with a couple that had a high level of aggression or violence? How did that experience influence your current practice in working with couples?
Ecological Theory/Role Theory	How do relationships with other mental health professionals influence a therapist's understanding of IPV in therapy clients?	Can you tell me about any other people that have influenced your thinking about asking couples about the possibility of violence?
Ecological Theory/Role Theory	How do the practices of addressing violence change over the course of a therapist's career?	How do you think that your understanding of the need to identify violence has evolved over the years that you have been in practice?

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CHAPTER 2: LITERATURE REVIEW

Intimate partner violence (IPV) is often referred to as domestic violence and partner abuse, and relationship violence. Because this review pulls from therapy as well as medical literature, these terms will be used interchangeably to refer to the same phenomena. The definition of IPV as offered by the Centers for Disease Control is "physical, sexual, or psychological harm by a current or former partner or spouse…[which] can occur among heterosexual or same-sex couples and does not require sexual intimacy" (NCIPC, 2003).

Violence Typologies

In reviewing literature on family violence Johnson found that two camps of violence research existed- feminist scholars with data sampled from shelters and social services, and family violence scholars who gather data from national data sets- and that these two camps were studying two different phenomena and populations (1995). He argued that control is a critical factor in classifying the presentation of violence. As a result, Johnson proposed three typologies of domestic violence: intimate terrorism, violent resistance, and common couple violence (2008), and with co-author Ferraro proposed a forth type, mutual violent control (2000).

Intimate Terror (IT) is characterized by an asymmetrical pattern of violent and non-violent behavior aimed at gaining control over a partner. IT is more likely to be encountered in court-ordered and shelter populations (Rosen et al., 2005) and involve frequent mild to severe levels of violence, more than other presentations (Johnson, 2000). Perpetrators are more likely to be male and violence is not likely to be mutual because of the level of fear on the part of the partner.

Violent resistance is characterized by a pattern in which a partner retaliates against IT control by an abusive partner (Johnson, 1995). The resistor is most likely to be female (Johnson,

2000) and most likely to be found in samples from court-ordered and shelter populations (Rosen et al., 2005).

Mutual Violent Control is a symmetrical pattern of abuse in which both of the partners attempt to control each other through both violent and non-violent behaviors. This presentation is described as two Intimate Terrorists battling for control (Johnson & Ferraro, 2000), though the level of severity of violence generally perpetrated by males and females differs, as does the level of fear experienced across gender lines (Jacobson et al., 1994), which is notable in that fear is a primary mechanism of control in abusive relationships (Hamberger & Guse, 2002).

Common couple violence (CCV) is a pattern of intermittent violence perpetrated by both or one partner erupting from conflict with the purpose of gaining control around a specific topic (Johnson & Ferraro, 2000), rather than general control of a partner as typified by the other presentations; it is often referred to in the literature as Situational Couple Violence (SCV) for this reason. The frequency and severity of violence in common couple violence presentations are less than what is observed in other typologies (Johnson, 1998) though therapists working with voluntary couples are most likely to encounter common couple violence (Greene & Bogo, 2002).

Types of Perpetrators

Just as research on presentations of abuse has revealed various typologies, some research on batterers themselves suggests homogeneity among perpetrators themselves (Holtzworth-Munroe, Meehan, Herron, & Stuart, 1999). Gottman et al. (1995) found that batterers could be divided into two groups, those whose heart rate lowered during violent encounters with a partner (Type 1) and those whose heart rate became elevated during violent encounters (Type 2). Gottman et al. (1995) speculated that there may be a physiological marker for this typology. Type 1 batterers appear angrier, and they begin the violent encounters with higher levels of

aggression that decrease during the interaction. Type 2 batterers are violent outside of the marriage in other areas of life, have a history of exposure to violence between their own parents, and become more aggressive as the encounter unfolds. Despite these differences, the level of violence between types was equal in these studies. Gottman et al. (1995) proposed that these two groups of batterers would not benefit from the same treatments because impulse control and emotional regulation is not a fitting treatment for Type 1 males. Jacobson and Gottman (1998) described these two presentations of perpetrators as cobras and pit bulls, in which cobras are cold and calculating, more akin to Type 1 in the Gottman et al. study (1995), while pit bulls are more emotionally dependent and impulsively reactive to feelings of abandonment, more akin to Type 2 batterers in the Gottman et al. study (1995). Research on the differences between presentations of violence and of perpetrators, suggests a need for differing approaches to effectively treat the various presentations of violence (Jacob, 2013), and indeed Holtzworth-Munroe and Stuart (1994) suggest that some types of violent men can be treated, while others cannot.

Violence and Therapy

The mental health profession has been slow to recognize partner abuse as a pervasive clinical problem (Avis, 1992; Bograd, 1984) and understandings of couple violence and treatment options have developed over time. Beliefs about how best to respond to these couples has divided the field of mental health as few other topics have (Nichols & Schwartz, 1998). For decades, the predominating response to suspicions of partner violence has been to separate couples, and send batterers to batterer treatment and survivors to advocacy services (Avis, 1992; Nichols & Schwartz, 1998; Tolman & Edleson, 1995), while conjoint work with couples experiencing partner violence has been viewed as unsafe and potentially iatrogenic (Avis, 1992; Bograd, 1984; Green and Bogo, 2002; Saunders, 1986).

Systemic therapies have been criticized for failing to acknowledge gender-based imbalances of power that exist within couples, and engaging in victim-blaming conceptualizations of abuse (Berns, Jacobson & Gottman, 1999; Bograd, 1984; Bograd 1992; Bograd & Mederos, 1999; Harway & Hansen, 1993). Bograd highlighted the complications to the therapeutic alliance in work with couples experiencing abuse, citing that a therapeutic alliance cannot be established with perpetrators who wish to control the course of treatment nor with survivors who risk retaliation for their partners for what is disclosed during treatment (1984). The longstanding belief has been that conducting conjoint therapy with couples engaged in abuse is contraindicated (Bograd, 1984) and that treating violent couples conjointly can be both unsafe and ineffective, and requires an individual treatment approach (O'Leary, 1999).

Feminist scholars have criticized Marriage and Family Therapists (MFTs) for adherence to a circular understanding of problems in relationships, which does not take into account the contextual and societal influences of power, sexism, and other forms of oppression (Avis, 1992; Serra, 1993). Avis and others have argued that understanding partner violence from a systemic perspective gives the therapist no grounding for personal accountability and so minimizes the abusive nature of the dynamic (Avis, 1992; Bograd, 1992; Goldner, 1993; Jory, Anderson & Greer, 1997;) and ostensibly "blames" the victim for the abuse (Greene & Bogo, 2002). Within the field of MFT, work with couples experiencing partner violence has been viewed as unsafe and potentially iatrogenic (Avis, 1992; Green & Bogo, 2002).

The IPV field has stressed the urgency of identification of potential for violence and safety planning as integral parts of both assessment and treatment when working with couples experiencing violence (Aldarondo & Straus, 1994; Greene & Bogo, 2002), though many therapists in the field do not formally assess and typically do not have a plan to manage

disclosures of violence when they occur (Daire, Carlson, Barden and Jacobson, 2014). Regardless of the fact that therapists working in community settings are most likely to see common couple violence in couples presenting with some form of physical aggression (Greene and Bogo, 2002), individual intuition alone is not a reliable tool for assessment of risk and for violence. Hansen, Harway, and Cervantes (1991) presented to family therapists an actual case scenario in which a family member was killed as a result of domestic violence, and then ask respondents how they would intervene in the case. Within this group of family therapists, only 2% of therapists recognized the possibility of lethal violence, 41 % of the respondents failed to identify any presence of violence, and 55% saw no need for immediate therapeutic intervention for violence.

Treatments for Violent Couples

While conventional couple therapy has been found to be iatrogenic to couple dynamics when there is an ongoing presence of violence (Avis, 1992; Bograd, 1984; Green & Bogo, 2002; Saunders, 1986) findings from several studies suggest that conjoint treatment can be a safe and effective approach to changing abuse patterns (Cleary Bradley & Gottman, 2012; Karakurt, Whiting, Esch, Bolen & Calabrese, 2016; Simpson, Atkins, Gattis & Christensen, 2008; Stith, Rosen, McCollum, & Thomsen, 2004). A study by Stith Rosen, McCollum and Thomsen (2004) used The Domestic Violence Focused Couples Treatment program, a feminist-informed approach that pulls from several family therapy models, to observe benefits of conjoint group therapy over gender specific group therapy for male violence recidivism and aggression. Forty-two couples were randomly assigned to either individual couple or multi-couple group treatment with nine couples as a comparison group who did not participate in any treatment. Conjoint group therapy participants completed 10-12 couple sessions, while individual couples completed

12 weeks of treatment. Couples were considered to recidivate if the female partner reported any physical aggression by the male partner since completing treatment. At 6-month follow-up, couples in the comparison group reported a 67% recidivism, while the individual couple rate was 43% and multi-couple treatment group had a 25% recidivism. At a 2-year follow-up of all couples who had received treatment (both individual couple and multi-couple treatment groups) only one female reported physical aggression since the 6-month follow-up (a 5.4% recidivism rate), while half of the comparison group reported subsequent violence or 50% recidivism. Reports of instances of abuse dropped greatly for the treatment groups but not the control groups, suggesting some potential for sustained impact on instances of aggression following treatment.

In a review of treatments for IPV, Stover, Meadows and Kaufman (2009) suggested the most promising support for conjoint work has come out of behavioral couple therapy (BCT) and multi-group couples interventions for couple perpetrators of violence with co-occurring substance abuse disorders. Fals-Stewart, Kashdan, O'Farrell, and Birchler (2002) found recidivism rates of 18% for behavioral couple therapy versus 43% recidivism for individual substance abuse treatment, for men with comorbid substance abuse and domestic violence. Cleary Bradley and Gottman (2012) evaluated a psycho-educationally based intervention to reduce common couple violence. One-hundred-fifteen couples were randomly divided into treatment or no-treatment groups, and the study used a multiple time point, and multi-informant design to evaluate a group-based intervention to improve relationship skills. Results suggested that low-income, situationally violent couples, could be safely taught relationship skills and produced a reduction in IPV in long term outcomes. A study by Schlee et al. (1998) evaluated conjoint group therapy using the Physical Aggressive Couples Treatment (PACT) versus couples in gender specific-group therapy. Both interventions produced a reduction in violence, but

greater improvement on marital adjustment was found in husbands within the conjoint group therapy treatment (O'Leary, Heyman & Neidig, 1999; Woodin & O'Leary, 2006).

Couples Seeking Therapy

There are high rates of abuse among therapy seeking clients (Greene & Bogo, 2002). Clients who present with symptoms of depression and anxiety may also be living in a situation of intimate partner violence, the prevalence of which mental health clinicians and couple therapists should be aware (Ferrari *et al.,* 2014). Clients seeking services who are experiencing some forms of violence in their relationship may be unlikely to state that as a concern when first seeking services unless directly assessed. In a clinical study by Stith, Rosen, Barasch and Wilson (1991) 12% of 262 families initially reported IPV as the presenting problem, though upon further investigation IPV was occurring in at least 40% of the families. There are numerous reasons for the underreporting of violence by therapy seeking clients. Many couples will not recognize the severity of the situation in which they find themselves, often instead reporting that "communication issues" have lead them to seek services (Dutton, 1995; Silva, McFarlane, Soeken, Parker and Reel, 1997). Indeed, one study of therapy seeking couples found that only 20% of couples met the characterization of "no violence" (Simpson, Doss, Wheeler & Christensen, 2007). The majority of couples (50%-65%) who seek couple therapy report some level of physical aggression, yet 90% of these couples do not perceive physical aggression as a major relationship problem (Ehrensaft & Vivian, 1996).

In instances of abuse, perpetrators will make direct efforts at deception and minimization of their abuses (O'Leary & Murphy, 1992). Couples will often seek therapy in a last effort to fix the relationship and abusers will frequently only attend therapy if it is conjoint; victims will remain in a relationship with the hope that therapy will resolve the abuse (Almeida & Bograd,

1991; Bograd & Mederos, 1999; Jenkins, 1990). In instances of abuse, perpetrators will make direct efforts at deception and minimization of their abuses (O'Leary & Murphy, 1992), and in couple therapy, male reports of wife assault will be reported as less severe than a wife's report of assault and victimization (Lehr, 1988). Some studies have found that psychological defenses of denial and minimization are most prevalent in severely abused women as well as men who inflict the most severe abuse (Browning & Dutton, 1986; Campbell, 1995).

Despite this knowledge, many therapists do not identify the presence of violence in their clients even when it is indicated (Froerer, Lucas & Brown, 2012). High rates of aggression among couples seeking treatment paired with low rates of detection suggest that therapists frequently treat violent couples unknowingly (Jose & O'Leary, 2009; Madsen et al., 2012; Kamimura et. al., 2014). And while here have been developments of conjoint treatments for couples experiencing IPV (Antunes-Alves & Stefano, 2014; Connors, Mills, & Gray, 2013; Simpson, Atkins, Gattis & Christensen, 2008; Vall, Seikkula, Laitila, & Holma, 2016; 2018), developers insist that such treatments are not appropriate for couples who meet specific criteria indicating high risk to victims (Almeida & Durkin, 1999). Couples experiencing high degrees of violence or who might be categorized as engaged in patriarchal terrorism are not appropriate for conjoint work, and the characteristics of the violence and perpetrators should be treated differently from each other (Friend, Cleary Bradley, Thatcher & Gottman, 2011) and differently than couples who experience no violence. This necessitates a thorough screening and assessment of presentation and type of abuse.

Education and Ethics

Education and training plays a significant role in clinicians' sensitivity and awareness of domestic violence. For example, Dersch, Harris and Rappleyea (2006) conducted a study to

assess whether clinicians will recognize and respond to indicators of IPV. They asked 112 mental health clinicians to read a case vignette, and respond to open ended questions about the case and what their clinical responses to it would be, while remaining blind to the purpose of the study. Authors found that the significant predictors of ability to recognize IPV indicators included clinician's education, mental health discipline, and theoretical orientation. The marriage and family therapy (MFT) core competencies as offered by the American Association for Marriage and Family Therapy (AAMFT) identifies the domain of Clinical Assessment and Diagnosis, and requires member competence to "screen and develop adequate safety plans for substance abuse, child and elder maltreatment, domestic violence, physical violence, suicide potential, and dangerousness to self and others." (American Association for Marriage and Family Therapy [AAMFT], 2004). Yet the AAMFT has not issued a recommendation for the use of universal screenings for IPV, only the National Association of Social Workers (NASW) and American Psychological Association (APA) have issued recommendations for universal screenings (Todahl & Walters, 2011). Competencies identified for working with clients impacted by IPV comprise active listening, empowerment-based responses, and providing appropriate referrals for additional services, and specifies competencies for assessment of DV; this includes the ability to discern level of safety and lethality, the ability to recognize abuse patterns, competent evaluation of health issues, and assessment of clients' access to services (Stover & Lent, 2014).

Despite this knowledge, there are no national standards of education in IPV or DV for providers at any level of service, including social work, marriage and family therapy, or psychology, and in most states the required hours of training in this area is minimal (Cervantes, 1993; Haddock, 2002; Stover & Lent, 2014). Further curriculum and graduate training for work

with families experiencing violence is needed according to surveys of mental health professionals (Campbell, Raja & Grining, 1999). One study (Danis, 2003) surveyed 146 licensed social workers on this issue, and 55% of respondents reported that they had received little or no training in the area of domestic or intimate partner violence. Many authors have examined the ethical complications inherent in clinical work with families experiencing violence and highlighted the ethical obligations of therapists to support survivors of abuse (Cervantes, 1993; Cervantes & Hansen, 1997; Jory & Anderson, 2000; O'Leary & Murphy, 1992). Of identifying violence patterns with clients, authors O'Leary and Murphy write:

> Before embarking on a program of couple therapy, the clinician needs to make a judgment, in light of evidence that abuse is commonly minimized by spouses, that further violence escalation is possible, and that there is potential danger in discussing difficult issues conjointly. The clinician should never collude with minimization or denial by failing to address acts such as slapping or pushing, directly as abuse. Where violence has become more severe, more potentially injurious, and often more unilaterally male perpetrated, couple therapy may perpetuate or implicitly sanction a severe imbalance of power (O'Leary & Murphy, 1992, p. 31).

Without first assessing the presence of violence before engaging therapeutically with couples clients, therapists put themselves in an ethically and legally precarious position (Willbach, 1989). Screening to identify the presence of violence is important to maintaining client safety during treatment. As stated by Wathen and MacMillan "failure to ask patients about partner violence exposure may lead to misdiagnosis or inappropriate investigations or treatments" (2012, pg. 713). A positive identification of abusive dynamics and imbalances of power can be used to inform treatment goals and direction, and directly impact the course of treatment.

Universal Screening for Intimate Partner Violence

Early identification is critical to ensure safety, prevent further victimization, and reduce negative health consequences (Stark & Flitcraft, 1988) and health-care providers are responsible

for identifying threats to client safety including IPV, and offer viable options to intervene with impending violence (Coker, 2006). Health care settings provide a unique opportunity to identify systematic abuse and prevent future harm (Family Violence Prevention Fund, 2004) and routine screenings for IPV can facilitate interventions that reduce violence and conflict, increase safety, and improve health outcomes (Nelson, Nygren, McInerney & Klein, 2004). Universal violence screening is defined by the Assistant Secretary for Planning and Evaluation (ASPE) of the U.S. Department of Health and Human Services as "clinician screening [of] every female patient through age 64 for domestic violence, as opposed to only screening certain patients because of risk factors or warning signs" (Boinville, 2013). In a review of literature on family violence and IPV, Nelson, Nygren, McInerney and Klein offered this definition of screening: "as assessment of current harm or risk for harm from family and intimate partner violence in asymptomatic persons in a health care setting" (2004), pg. 388).

Screening is important because it dictates treatment. When violence goes undiagnosed by clinicians working with families, it can have detrimental consequences. Traditional couple treatment with undetected IPV runs a risk of increasing abuse patterns by magnifying partner insecurities, challenging dominance and triggering attachment anxieties in partners (Bograd & Mederos, 1999; Stith, Rosen & McCollum, 2003; Jory, 2004). When therapists are aware of the risk factors and thoroughly address them during treatment, the chance that physical abuse will recur is decreased (Stith, Rosen, & McCollum, 2003).

Criticism and benefits. Critics of universal screening cite study findings which have failed to produce consistent evidence of benefits to individual health and well-being following screening (Nelson, Bougatsos & Blazina, 2012; Wathen & MacMillan, 2003; 2012). Qualitative evidence as to the positive benefit of universal screening for women has included prompting

survivors to reevaluate an abuse situation, reduce isolation (Spangaro, Zwi & Poulos, 2011), and increase their knowledge of IPV (Koziol-McLain, Giddings, Rameka, & Fyfe, 2008). Universal screening provides an avenue for appropriate intervention and connection to other community resources when and as appropriate. In fact, women who talk with a healthcare provider about the abuse they are experiencing are 4 times more likely to use an intervention service in their area, and 2.6 times more likely to terminate an abusive partnership (McCloskey at al., 2006). Violence screening has consistently been found to increase detection rates across several medical contexts (Duncan, McIntosh, Stayton & Hall, 2006; Freund, Bak & Blackhall, 1996; Hathway, Willis and Zimmer; 2002; Holtrop, Fischer, Gray, Barry, Bryant and Du, 2004). For example, in a study of urban emergency departments by Krasnoff and Moscati (2002), 89% of women who screened positive for IPV agreed to speak to an advocate, and 54% of those seen by an advocate accepted case management and expanded treatment past the scope of an initial violence screen. Female clients are unlikely to report relationship violence unless directly asked by their providers (McNutt, Carlson, Gagen, & Winterbauer, 1999;), and most women and survivors of IPV prefer that their medical providers inquire about violence with them directly (Rodriguez, Sheldon, Bauer, & Perez-Stable, 2001; Tower, 2006; Zeitler, Paine, Breitbart, Rickert, Olson, Stevens et al., 2006). Providers are more likely to screen routinely when the work environment provides opportunities, support and accountability to do it (Tower, 2003; Allen, Lehrner, Mattison, Miles & Russell, 2007).

IPV screening can be conducted safely within a couple therapy context (Stith, Smith, Penn, Ward, & Tritt, 2004) and a positive violence screening predicts instance of future violence (Houry, Feldhaus & Peery, 2004). Universal screening increases rates of disclosure among client populations and can lead to more appropriate handling of presenting and

underlying concerns, and identification of intimate partner violence can facilitate victims' access to services and resources (Phelan, 2007; O'Campo, Kirst, Tsamis, Chambers & Ahmad, 2011). Therapy screening and identifying abuse provides clients an opportunity to consider their options, to make more empowered and informed decisions, assess safety concerns and make arrangements as they see necessary, and provide a safe space to consider future viability of the partner relationship (Jennings & Jennings, 1991). Qualitative evidence as to the positive benefit of universal screening for women has included an increase in client knowledge of IPV (Koziol-McLain, Giddings, Rameka, & Fyfe, 2008) and prompting survivors to reevaluate an abuse situation and reduce isolation (Spangaro, Zwi & Poulos, 2011).

Universal screening increases rates of disclosure among client populations and can lead to more appropriate handling of presenting and underlying concerns, and identification of intimate partner violence can facilitate victims' access to services and resources (Phelan, 2007; O'Campo, Kirst, Tsamis, Chambers & Ahmad, 2011). Therapy screening and identifying abuse provides clients an opportunity to consider their options, to make more empowered and informed decisions, assess safety concerns and make arrangements as they see necessary, and provide a safe space to consider future viability of the partner relationship (Jennings & Jennings, 1991). Qualitative evidence as to the positive benefit of universal screening for women has included prompting survivors to reevaluate an abuse situation, reducing isolation (Spangaro, Zwi & Poulos, 2011), and increase knowledge of IPV (Koziol-McLain, Giddings, Rameka, & Fyfe, 2008).

Outcomes. There has been great debate as to the impact on health outcomes of conducting universal violence screenings (Nelson, Nygren, McInerney & Klein, 2004; Ramsay, Richardson, Carter, Davidson & Feder, 2002; Wathen & MacMillan, 2003). Recent randomized

trials have failed to produce evidence of significant outcomes (Koziol-McLain et al., 2010; MacMillan et al., 2009), however, several methodological flaws in screening outcome studies have been sufficient to raise debate among researchers as to appropriate measures when evaluating outcomes related to IPV screenings (Lachs, 2004; Zink & Putnam, 2005; Wathen, MacMillan, & Jamieson, 2006; Spangaro, Zwi & Poulos, 2011). Of these methodological challenges, such as loss to follow-up and insufficient sample size (Spangaro, Zwi & Poulos, 2011), authors Spangaro, Zwi & Poulos state "the diversity of women's situations may explain difficulties in achieving significant findings by RCTs on screening impacts" (2011, p. 150), and support the need to further identify outcomes that survivors living in violent situations identify as important (Koziol-McLain *et al.*, 2010).

Implementation. Many efforts to implement a screening protocol in a clinical context have introduced the practice after a single-step training involving education about IPV, however, educating clinicians about IPV as a motivator for conducting universal screening in itself does not sustain screening over time (Wiist & McFarlane, 1999). In a review of studies of universal screening programs for IPV within health care settings, the authors evaluated "*how* screening programs work as well as *whether* they work" (O'Campo, Kirst, Tsamis, Chambers & Ahmad, 2011, p. 855) and found that more successful screening programs incorporated multiple program components and had support at the institutional level. In this review, the authors identified four program components which increase provider self-efficacy for screening: 1) institutional support; 2) effective screening protocols; 3) thorough initial and ongoing training; and 4) immediate access/referrals to onsite and/or offsite support services. Results of this review support a multi-component comprehensive IPV screening program approach that seeks to increase provider efficacy around the practice (O'Campo, Kirst, Tsamis, Chambers & Ahmad, 2011). Thorough

and consistent procedures for conducting universal screens are not common in many social service settings (Allen, Lehrner, Mattison, Miles & Russell, 2007) and screening practices vary widely (Phelan, 2007; Stayton & Duncan, 2005), so penetration of screening procedures may play a role in mixed results from outcome studies for benefits of universal screening.

Universal Screening in Therapy. Existing evidence suggests couple therapists do not screen routinely for history or presence of partner violence (Allen, Lehrner, Mattison, Miles & Russell, 2007; Daire, Carlson, Barden, & Jacobson, 2014; Schacht, Dimidjian, George & Berns, 2009). Authors Froerer, Lucas and Brown (2012) explored violence screening and assessment practices of marriage and family therapy trainees in a training clinic to determine whether an IPV assessment by therapists could be predicted by risk factors for IPV as indicated by logistic regression analysis of client's self-report intake forms. Results showed that only when violence was reported as currently active did the trainees carry out a violence assessment, suggesting that the responsibility of disclosure resided on the clients.

Recommended Practices. Conducting a thorough screening for partner violence at the outset of treatment or within the duration of treatment is gaining support as an important aspect of responsible practice for mental health therapists (Aldarondo & Straus, 1994). Many researchers have called for MFTs to adopt universal screening procedures (Bograd & Mederos, 1999; Jory, 2004; McCloskey & Grigsby, 2005) and espoused a need for further research to generate knowledge of screening and assessment for IPV amongst mental health clinicians (Froerer, Lucas, & Brown, 2007; Johnson & Ferraro, 2000). Universal violence screening of all clients seeking therapy has been recommended by scholars because of the high prevalence of IPV (Bograd & Mederos, 1999; Green & Bogo, 2002; Jory, 2004; Bradford, 2010) and this recommendation has been echoed by the American Medical Association (AMA, 1992), the

American Psychological Association (APA, 2002), the National Association of Social Workers (NASW, 2002) and the U.S. Preventive Services Task Force (Nelson *et al.*, 2012). The American Association of Marriage and Family Therapists has yet to issue a recommendation or endorsement for universal violence screening.

There are various sources for procedures and guidelines for conducting universal screenings, such as the American Psychological Association (2002), and the Family Violence Prevention Fund (2004). However, these recommendations are not tailored to the role of a couple therapist and do not account for ethical and clinical issues that are germane to clinical work with couples (Bograd & Mederos, 1999; Todahl, & Walters, 2009). Universal screening procedures specific to couple therapists have been offered by Bograd and Mederos (1999). These involve: 1) a conjoint intake session for general information-gathering which does not include an in-depth inquiry about violence; 2) meeting separately with each partner, which is explained to clients as a standard procedure to gather information within the privacy of an individual meeting; and 3) conduct a more in-depth assessment of presence and presentation of possible abuse in order to make an informed decision about moving forward with conjoint couple work. Therapists are cautioned that when carrying out clinical interviews that perpetrators may deny, minimize, and/or rationalize their aggression and make efforts to conceal abuse (Sugarman & Hotaling, 1997). Discrepancies in reports of violence between male and female partners are common, especially within couples engaged in partner abuse (Heyman & Schlee, 1997), and clinical assessment researchers have argued that greater weight should be given to female reports of abuse than their male partners because of the likelihood of perpetrator denial and desire to hide the abuse (Bograd & Mederos, 1999).

The universal screening procedures as outlined by Bograd and Mederos have been

criticized for failing to provide a detailed informed consent as pertinent to IPV in the context of couple therapy (Todahl & Walters, 2009), nor do the authors specify the use of a written measure in addition to a verbal interview. The use of a standardized written assessments has been endorsed by many in the domestic violence field, because a written component added to an in-person interview greatly increases the validity of a violence screen (Aldarondo & Straus, 1994; Jory, 2004; Todahl & Walters, 2011).

Barriers to Screening

The vast majority of available literature on universal screening comes from medical practitioners such as physicians, nurses, emergency room staff, obstetricians/gynecologists, and pediatricians; as such, the term providers will be used to describe health care workers across these contexts, while the terms clinicians and therapists will be used to refer to mental health therapists. Within this literature, several barriers to full implementation of universal screening procedures have been documented, and screening practices have been found to vary widely both across practice sites as well as across individuals (Phelan, 2007; Stayton & Duncan, 2005).

There are many ways to think about these barriers, and authors have organized them in different ways. Gremillion and Kanof (1996) proposed four categories of barriers experienced by physicians. These included, (a) societal and cultural barriers, or the implicit and explicit societal dictates that normalize and minimize gender inequities and gendered violence; (b) personal barriers, or the internalized understandings of racism, sexism, classism, and ageism; (c) institutional and legal barriers, such as constraints of time and reimbursement structures; and (d) professional barriers, including issues germane to the patient-provider relationship, one's education and training, and confusion about the role of medicine in violence prevention efforts. Loosely borrowed from this organization, barriers will be described around the following

categories: 1) attitudes and beliefs 2) closeness and distance to violence 3) organizational factors 4) lack of practitioner knowledge and training 5) provider priorities 6) disclosure and confidentiality, and 7) provider fears and anxieties.

Attitudes and beliefs. The attitudes and beliefs affect provider motivation and willingness to carry out screening practices Dowd, Kennedy, Knapp & Stallbaumer -Rouyer, 2002; Jaffe, 2005; Minsky-Kelly, Hamberger, Pape & Wolff, 2005. Provider's reservations about the practical benefits to screening impacts motivation because many doubt the benefits of doing a screen and have cited the lack of evidence supporting positive outcomes of screens (Jaffe, 2005) as well as concerns about the outcome and efficacy of screening (Dowd, Kennedy, Knapp & Stallbaumer -Rouyer, 2002; Minsky-Kelly, Hamberger, Pape & Wolff, 2005). Subsequently, many providers believe that screening will do more harm than good for survivors, which hinders internal motivation to screen (Dowd, Kennedy, Knapp & Stallbaumer-Rouyer, 2002; Minsky-Kelly, Hamberger, Pape & Wolff, 2005). Dowd, Kennedy, Knapp and Stallbaumer-Rouyer (2002) completed focus groups in a children's hospital to assess the attitudes and beliefs toward routine screening for IPV both of mothers and of the nurses and physicians who treat them. Staff described concerns about negative implications of screening. A female physician stated "It's irresponsible for us to initiate screening if we don't have the staff and resources. Can we appropriately direct them and meet their needs?" (Dowd, Kennedy, Knapp and Stallbaumer – Rouyer, 2002, p. 797). These sentiments were echoed by a male nurse who stated "If you ask me to do this, you've got to have something to give me. When a woman is trying to leave her relationship, that's when she is most vulnerable. We have to make sure that whatever we give her is open to her needs" (Dowd, Kennedy, Knapp and Stallbaumer –Rouyer, 2002, p. 797).

Prejudicial attitudes of providers against victims of violence (Cohen, DeVos, and Newberger,

1997; Moore et al., 1998; Parsons et al., 1995) and frustrations that patients do not leave an abuser following an intervention (Brown, Lent, & Sas, 1993; MacGrath et al., 1997; Minsky-Kelly, Hamberger, Pape & Wolff, 2005; Sugg & Inui, 1992) have been identified as additional barriers for screening. Similarly, lack of follow up with referrals on the part of survivors following a screen produces frustrations in providers (Ferris, 1994; Rodriguez et al., 1999). A national survey by Parsons et al. (1995) revealed that some providers were reluctant to screen women for violence because they believed there was no way to verify the patient report of abuse.

The lack of a belief in their responsibility to address partner abuse with clients presents a significant barrier to violence screening (Chamberlain & Perham-Hester, 2002). A Swedish study by Alfredsson, Ask, and von Borgstede, (2014) surveyed community members (n= 650), to identify motivational and cognitive predictors of citizens' proclivity to intercede against IPV. Results of the study showed that motivational and cognitive factors were significantly related to respondents' self-reported readiness to take intervening action against IPV. The strongest predictor of propensity to intervene was an internalized belief that it is one's responsibility to intervene in domestic abuse, and the extent to which respondents experienced emotional discomfort with IPV was the second strongest predictor. The authors proposed that a high personal relevance, often as a result of personal experience with the IPV, is reliably associated with an increased propensity to act among the social service representatives included in the study (Zurwernik & Devine, 1996).

Closeness and distance to violence. Relevancy of violence to one's own life has emerged as a barrier to prevention efforts. A study by Jakobsson et al. (2013) explored the perceptions and beliefs, and what they refer to as "possibilities and hindrances" for the prevention of IPV in their community, through focus groups with 42 social and health-care professionals, as well as

local-level politicians, business people, and police force representatives. The theme of "closeness and distance" to IPV emerged from group discussions. Researchers found that the lived experiences of the professionals they spoke with demonstrated that the degree of closeness to IPV impacted their understanding of their own involvement in prevention of IPV.

> "The professionals who frequently encountered IPV in their daily work regarded prevention work as more suitable for organizations other than their own. On the other hand, those who had knowledge about the problem, but no everyday contact with it, acknowledged that they could contribute to prevention, either by themselves or through their organization…Although the [social and health-care] professionals realized that they could have a role to play in preventing IPV, they thought that another profession or organization might be more suited for the work." (Jakobsson et al., 2013, pg. 341-342).

Organizational factors. Many factors at the level of the organization have been found to create barriers to screening in healthcare settings (Allen et al., 2007; MacGrath et al., 1997) such as a lack of administrative support for prioritizing a universal screen (Cohen, DeVos, & Newberger, 1997; Larkin, Rolniak, Hyman, MacLeod & Savage, 2000) and the lack of mechanisms of accountability when screening protocols are not followed (Allen et al., 2007; Campbell, Coben, McLoughlin, Dearwater, Nah, Glass, et al., 2001; Larkin, Rolniak, Hyman, MacLeod, & Savage, 2000). Research on violence screening in an urban emergency department by Larkin, Rolniak, Hyman, MacLeod, and Savage (2000) revealed that screenings were not carried out on a consistent basis without administrative accountability, but rates of screening drastically increased following a formalization of their screening process by including it in the job description and the quarterly performance review. Cohen, DeVos, and Newberger (1997) conducted a qualitative study of five community hospitals, and conducted 480 interviews with physicians and other health care providers. The study participants reported that they experienced judgment from their peers when they took an active role in violence prevention, and actually had to pay out of pocket for tests, and spend extra time with suspected victims of violence. This

study concluded that these practices served to create a hostile environment related to the practice of screening.

Lack of practitioner knowledge and training. One of the most widely cited barriers to IPV screening across health and social service settings is the lack of practitioner knowledge (Hamberger, 2004; Sugg & Inui, 1992). In a focus group study of IPV screening in a children's emergency department, a male physician stated: "I don't think witnessing IPV falls under the classic definition of child abuse that we are required to report" which belies a lack of understanding of current definitions of abuse relevant to IPV (Dowd, Kennedy, Knapp & Stallbaumer-Rouyer, 2002, pg. 797.) Providers either feel ill equipped to broach the topic of abuse and violence (Cohen, DeVos, and Newberger, 1997; Dowd, Kennedy, Knapp & Stallbaumer-Rouyer, 2002; Iverson, Wells, Wiltsey-Stirman, Vaughn, & Gerber, 2013; Jaffee et al., 2005; Parsons, Zaccaro, Wells, and Stovall, 1995; Williams, Chinnis, & Gutman, 2000), are uninformed about prevalence of IPV in the populations they serve and therefore do not see the immediate relevance (Dowd, Kennedy, Knapp & Stallbaumer-Rouyer, 2002; Jaffee et al., 2005; Parsons, Zaccaro, Wells, & Stovall, 1995), or they feel ill equipped to manage client needs following a positive disclosure of abuse (Dowd, Kennedy, Knapp & Stallbaumer-Rouyer, 2002; Iverson, Wells, Wiltsey-Stirman, Vaughn & Gerber, 2013; Jaffee et al., 2005; Nyame et al., 2013; Rose, Trevillion, Woodall, Morgan, Feder, & Howard, 2011). These factors make some clinicians hesitant to open what is often referred to in the literature as the figurative Pandora's box (Spangaro, Poulos & Zwi, 2011).

Practitioner's unmet needs in training and supervision for carrying out violence screens appropriately has been documented as a common barrier (Iverson, Wells, Wiltsey-Stirman, Vaughn & Gerber, 2013; Jaffee et al., 2005; Larkin, Rolniak, Hyman, MacLeod & Savage, 2000;

Sugg & Inui, 1992). A survey of one hundred and thirty-one mental health professionals revealed that most respondents (60%) felt that they lacked adequate knowledge of support services for violence, and 27% of respondents felt that their workplace did not have adequate referral sources for domestic violence (Nyame et al., 2013). Similar sentiments have been echoed in studies of social work students (Warrener, Postmus, & McMahon, 2013). As such, providers often feel frustrated at the prospect of carrying out universal screens (MacGrath et al., 1997; Minsky-Kelly, Hamberger, Pape & Wolff, 2005), though these frustrations may abate over time. In an Australian study held across 10 antenatal, mental health, and substance abuse services, focus groups were held with healthcare workers following an initial introduction of violence screening also facilitated by brief, scripted questions embedded into assessment schedules, additional training, and access to referral services. Focus group feedback reported that over time, providers gained familiarity with practice, and received positive feedback from female clients, which supported a consistent screening practice and encouraged practitioner buy-in (Spangaro, Poulos, & Zwi, 2011).

Provider priorities. Within the screening literature, time to conduct comprehensive violence screenings emerges as a consistent barrier. When providers are under pressure to conduct all aspects of their work, a screening for violence may become less of a priority. Several studies have highlighted the perceived pressure of limited amounts of time that a provider may spend with clients as a challenge to completing a thorough screen (Beynon, Gutmanis, Tutty, Wathen & MacMillan, 2012; Dowd, Kennedy, Knapp & Stallbaumer-Rouyer, 2002; Iverson, Wells, Wiltsey-Stirman, Vaughn & Gerber, 2013; MacGrath et al., 1997; Minsky-Kelly, Hamberger, Pape & Wolff, 2005; Sprague, Swinton, Madden, Swaleh, Goslings, Petrisor & Bhandari, 2013; Sugg & Inui, 1992). These concerns highlight other literature documenting provider reservations

about the relevance and value of screening given patient presentation and the associated clinical setting (Minsky-Kelly, Hamberger, Pape & Wolff, 2005), which inhibits provider motivation to put time and attention to screening as well as a lack of motivation to seek out the resources needed to carry out a thorough violence screening (Garimella, Plichta, Houseman, & Garzon, 2000). Other research documents the "complexity" that providers feel that a universal screen adds to work with clients (Spangaro, Poulos, & Zwi, 2011, pg. 130). This body of literature belies a provider perception that carrying out a violence screen will add to their workloads.

Disclosure and confidentiality. Provider concerns about client privacy and confidentiality has been documented as a barrier to carrying out universal screens (Jaffee et al., 2005; Spangaro, Poulos, & Zwi, 2011; Sprague, Swinton, Madden, Swaleh, Goslings, Petrisor, & Bhandari, 2013) and limits to that confidentiality present unique challenges (Beynon, Gutmanis, Tutty, Wathen, & MacMillan, 2012; Spangaro, Poulos, & Zwi, 2011). In a qualitative study of nurses and physicians experience of carrying out violence screens, Beyon et al. (2012), reported that an informed consent of fear of obligation to report abuse and possible removal of children presents a barrier to initiating conversations with women about abuse. "I feel obliged to tell women that if they now disclose violence we must call CAS [Children's Aid Society]. I think that this is a huge barrier to what we are trying to achieve" (2012, p. 5).

Provider fears and anxieties. Barriers relevant to the provider-patient relationship have been documented in screening literature (Dowd, Kennedy, Knapp & Stallbaumer-Rouyer, 2002; Jaffee et al., 2005; Rose et al., 2011; Spangaro, Poulos, & Zwi, 2011; Sugg & Inui, 1992). Practitioners interviewed by Rose et al. (2011) spoke about a fear of re-traumatizing survivors. Providers have described fears of offending the patient by bringing up the topic of violence (Dowd, Kennedy, Knapp & Stallbaumer-Rouyer, 2002; Jaffee et al., 2005; Sugg & Inui, 1992), and subsequent

fears of professional retaliation from offended parties **(**Beynon, Gutmanis, Tutty, Wathen, & MacMillan, 2012). In a study of medical settings, which included feedback from nursing staff, one nurse stated,

> Many abusers complain about the nurses and care and we have little support from management. We end up having to write up the situations. The fear of being reported as more complaints are being sent to the CNO (College of Nurses of Ontario) is now a factor. (Beynon, Gutmanis, Tutty, Wathen, & MacMillan, 2012, p. 7).

Other therapist-specific barriers. Despite empirical knowledge that therapists' violence screening occurs at low rates (Samuelson & Campbell, 2005; Schacht, Dimidjian, George & Berns, 2009), there is limited literature which documents barriers experienced by couple therapists to universal screening (Todahl & Walters, 2011). Within the limited research on therapist-specific barriers to screening, many of the same elements emerge such as concern about clients' reactions to screening, and clinicians' lack of time, training, and discomfort with the issue of violence (Samuelson & Campbell, 2005), similar to wider health services barriers identified.

A qualitative study by Todahl, Linville, Chou and Maher-Cosenza (2008) examined the dilemmas of twenty-two master's students in a COAMFTE-accredited program. Participants were working as interns in an outpatient clinic setting either at a university's family therapy clinic or at a community-based agency of their choosing. Participants had seen an average of 400 hours of direct client contact at the time of the interviews. All participants had completed a required 10-week course fully devoted to interpersonal violence, which was taught by the first author of the article. Despite the specialized training, the authors found that among participants, there was high anxiety and low confidence in their ability to intervene in IPV. Qualitative findings of the various responses to universal violence screening included the following: a) struggles with a confidentiality/no secrets policy; b) concerns that screening would escalate

violence; c) frustration with a lack of sophisticated assessment and clinical techniques; d) lack of confidence; e) feelings of sadness and feeling overwhelmed; f) engagement of therapist's own family values and past experiences; g) belief that benefits outweigh risks of screening; and four participants stated that they believed it was "their role and responsibility" to universally screen for IPV (Todahl, Linville, Chou, & Maher-Cosenza, 2008, p. 38).

A British study by Rose et al. (2011) used a cross sectional qualitative design to identify facilitators and barriers to violence screening in mental health violence screening by interviewing both services users and mental health providers. Ten females and ten male mental health providers were interviewed, and interviews were coded using thematic analysis. Dominant themes that emerged within these interviews were barriers around provider competence and role ambiguity. Similar to other literature, reservations about providers' lack of training and knowledge to deal with issues of domestic violence emerged. There was also differing views on the topic of provider roles. One female psychologist stated, "on the whole, it is not seen as the remit of a community mental health team to be dealing with domestic violence unless there's diagnostic mental health problems as well," while a male psychiatrist offered "Another aspect is they [survivors] might not see it as their role but, you know, we take a broader view that our role is to help people live healthier lifestyles" (p. 191). Other findings from this study as reported by Trevillion, et al. (2012) include struggles with unclear referral pathways, difficulty in maintaining a supportive therapeutic alliance while complying with legal and ethical reporting mandates, and the tendency for mental health services to focus primarily on current symptomology and excluding other contextual factors.

Brosi and Carolan (2006) explored ecosystemic influences to therapist responses to violence when working with clients, by interviewing Marriage and Family Therapy trainees at a

university training clinic. Seven participants were interviewed following the viewing of a clinical vignette video. Study results revealed a pervasive belief that personal history and family of origin influenced the trainee's responses to client violence. As one participant stated:

> I have a fear of violence. I mean, I do. I grew up in high violence and so I have to check that. Sometimes I let that (certain) thought come in, I check it, and that is one way that...that is my anxiety is when I hear the word ''violence''—I get anxious. I am like, oh my God, remain calm, remain calm and cool, you are a therapist, you are not 13. (Brosi & Carolan, 2006, pg. 120).

Other themes emerged such as the impact of level of clinical experience, developmental stage of the therapist, feelings of insecurity in level of competence, and other significant clinical experiences working with families with ongoing violence. While study findings report significant therapist reactions to violence, the study did not directly address practices of universal screening or assessment.

The limited literature on the topic of therapist practices related to universal screening points to a significant gap in knowledge as to the experience of the clinician who is conducting that screen. Studies which explore screening other medical providers do not address the unique complexities inherent in the role of a couple therapist. A consistent finding across both physicians (Coker, Bethea, Smith, Fadden & Brandt, 2002) and family therapists (Todahl *et al.*, 2008) is the degree to which practitioners believe it is within their professional role to conduct universal screenings influences their decision-making practices. Providers are more likely to screen for violence when their work environment provides opportunity and accountability to do so, and in the absence of these supports, detection rates are lower (Allen, Lehrner, Mattison, Miles, & Russell, 2007; Larkin, Rolniak, Hyman, MacLeod, & Savage, 2000).

A qualitative approach can gather important and relevant information when it comes to understanding clinical practice models, and is a good fit for the study of IPV screening

assumptions and practices which are not yet established in the literature (Todahl, Linville, Chou, & Maher-Cosenza, 2008). Not introduced in the literature are issues of insurance reimbursement concerns and payment structures, the use of time in initial therapy sessions, legal ramifications of disclosures of abuse and managing confidentiality, therapist responsibilities with regard to minor children in the home, concerns about therapist alliance, all of which are elements of clinical practice that warrant further exploration. More information is needed to generate a framework for studying screening practices of couple therapists. Despite the breadth of scholarly and organizational support in favor of universal screening for intimate partner violence, the gap in current knowledge of therapist perspectives is considerable.

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CHAPTER 3: METHODS

Overview of the Research Design

Processes of clinical decision-making about violence screening have been explored in the current study through individual interviews with couple therapy clinicians. Clinicians were asked about contextual elements and personal experiences that inform their thinking and choices about violence screening, as well as the individual meanings ascribed to those choices (see Interview Protocol in Appendix C). Qualitative data gathered from interviews were analyzed through both semantic and latent analytic approaches, using the steps of thematic analysis. Research findings have been analyzed and summarized in two manuscripts. These manuscripts are intended to contribute to the body of knowledge on universal violence screenings.

Qualitative approach. Intimate Partner Violence is a highly controversial topic and topics of a highly sensitive nature lend themselves well to a qualitative approach (Creswell, 2013). We know that the vast majority of MFTs do not screening as is recommended (Todahl & Walters, 2011) and many individual clinicians feel reluctant to discuss this topic. Such a reluctance lends itself to an interview approach in which trust and rapport between researcher and participant can lead to a more open discussion. This provides an avenue for a nuanced and detail-rich understanding of a selected phenomena (Ritchie & Lewis, 2003). In addition, qualitative methods present a preferred approach for this type of inquiry due to the lack of documented knowledge of the specified topic, the exploratory nature of the study, and the depth and complexity of understanding desired (Hartman & Hedblom, 1979; Marshall & Rossman, 2011; Snape & Spencer, 2003). What is missing from the established knowledge base is an understanding of *how* therapists integrate various personal and contextual influences into decisions about violence screening practices, and what this thought process entails, suggesting a

qualitative approach (Denzin & Lincoln, 2005). In this case, the identified phenomena are individual processes of clinical decision-making about violence screening.

Sampling and participants. A purposive sample of 15 couple therapists was recruited via community and social media outreach (i.e. fliers, snowball sampling, & referrals). Study and recruitment announcements were circulated to clinicians licensed and currently practicing in the state of Michigan. Numerous group practice and social service agencies were contacted and recruitment fliers were circulated to clinical staff. To support recruitment efforts, a webpage was created for advertisement of the study and from there prospective participants were directed to contact the researcher. Interested participants were contacted via phone or email (as per their preference) to verify that inclusion criteria were met, and to schedule an interview. Participants were asked to set aside 1.5 hours for the interview and were given the option of completing the interview in person or via web conference depending on distance from the location of the researcher. All consent and confidentiality information was emailed to participants prior to the interview (Appendix B). Consent and confidentiality information was discussed with participants at the time of the interview to verify they understood and agreed to the conditions of confidentiality and how their data would be used, and to obtain their consent for participation. Participants were given a $40 gift card for their time.

Participants were included in the study if they met the following inclusion criteria: 1) an actively practicing clinician licensed as a Marriage and Family Therapist 2) identified as working with couples with regularity 3) had at least two years of post-graduate clinical experience; 4) obtained a master's degree or higher in a clinical program. Excluded from the study were clinicians who were trained but not currently practicing, or not working with couples. Those with less than two years of clinical work were excluded from interviews. Clinicians who reported

practicing within a setting that specifically targeted Intimate Partner or Domestic Violence, i.e. shelters or advocacy centers, were excluded from this study because of the potential to produce a skewed sample. Clinical practice in this study was defined as contact with couple clients for the purpose of talk therapy. Clinical work with couples was defined by a treatment focus located on the relational dynamics of the couple. Other forms of involvement with clinical work such as case management and supervision of therapy did not meet the inclusion criteria and these individuals were not selected for interview participation.

Data collection. The purpose of the study was to obtain what is known as a rich description of the elements involving a clinician's decision-making processes and related behaviors regarding violence screening (Josselson, 2013; Merriam, 2009; Marshall & Rossman, 2006). The focus of the study was the individual participants' lived experiences of conducting clinical work with couples, and as such, in-depth interviews with individual participants is an appropriate data collection strategy (Josselson, 2013; Marshall & Rossman, 2011). Asking participants about their internalized beliefs, the impact of their past training and clinical experience, personal histories of violence exposure, as well as their concept of the therapist's role in violence prevention efforts, are integral to answering the research questions of how these factors influence their work. As such, exploring these deeper perspectives through individual interviews was considered an excellent approach. Interviews were completed either face-to-face or via video conferencing. In-person interviews were completed in the offices of participants for familiar surroundings to encourage openness in sharing their experiences (Creswell, 2013). Video conferencing was completed from a secured network connection.

Interview protocol. A semi-structured interview protocol was used in this study (see Appendix C) and was used to ensure consistency across interviews, while also allowing for

flexibility in responses and follow up prompts (Josselson, 2013). All participants were asked a standard set of questions, and follow-up questions that emerged from responses. Both the theoretical framework and a review of the literature guided the development of the interview protocol. Interviews consist of two types of questions, open-ended (descriptive) and close-ended (structural). Neutral non-leading questions were used so as to avoid presenting a bias (Hartman & Hedblom, 1979). The interview began with participant descriptions of their current practices for identifying violence with couples. The second section of the interview explored in greater depth what led to those practices. Interviews concluded by obtaining basic demographic information about the participants, including age, race, ethnicity, gender, current practice setting, and years of clinical experience. This information is summarized in Table 4.1. All interviews were digitally recorded (audio or video) with the permission of the participant and lasted between 45 and 90 minutes.

Institutional Review Board

Because this study involves human subjects, approval by the Institutional Review Board (IRB) was obtained prior to beginning research activities. Approval for the study was obtained through the Michigan State University Institutional Review Board/Human Research Protection Program (https:hrpp.msu.edu/applications). The lead researcher has completed Responsible Conduct of Research (RCR) training as required by the educational institution and a required consent form was developed in adherence with IRB and RCR protocols and used with all study participants. Informed consent outlined the conditions of confidentiality and participants were informed that their responses would be kept confidential. A Conflict of Interest form was also filed with the university.

Researcher-as-Instrument Statement

It is also important for the researcher to locate herself within the subject matter (Creswell, 2013; Morrow, 2005.) It is a personally held belief of the researcher that assessing for safety at the outset and throughout treatment is extremely important in effective and ethical practice. The lead researcher has worked in a clinical setting with a culture of prioritizing violence screening, and has co-created a screening and assessment protocol for use in that clinic. Despite personal opinions about best practices as a clinician, the role as the researcher in this study is required to present as a non-threatening entity and failing to do so would put at risk the integrity of data. It is understood by the researcher that the topic of partner violence in society as a whole is a difficult one to discuss, and within the field of therapy as well. Many clinicians believe that safety in practice is important, yet who may be uncomfortable discussing their practices for fear of being judged or exposed in some way. Strategies for managing bias and assumptions will be detailed in the trustworthiness section of this chapter.

Thematic Data Analysis: Semantic and Latent Approaches

The exploratory nature of this study lends itself to the use of thematic analysis, which is an approach to recognizing, then analyzing and representing recurrent patterns of certain themes in a defined set of data. This is different from a phenomenological approach, which aims to understand *experiences* and different from a grounded theory approach, which aims to generate new theory (Creswell, 2013). Thematic analysis organizes information from a data set around the structure of themes that are established in the existing literature on the topic, while also allowing for the addition and generation of new and different themes (Boyatzis, 1998). The aim of data collection was to collect participant's original thoughts and stated experiences, what Willig refers to as "participant-generated meanings" (2001, pg. 15) as this study may set the

groundwork for further quantitative study of the problem by establishing the relevant variables of the subject at hand.

Data were coded in an iterative fashion and a code diary was created. The following steps were followed, in accordance with guidance provided by Braun and Clarke (2006). These steps included (1) Familiarization with the data; (2) generation of initial codes; (3) searching for themes; (4) reviewing themes; (5) defining and naming themes; (6) producing a final report. A more detailed overview of the steps of Thematic Analysis can be found in Appendix E. At each step of analysis, data were reviewed to ensure sufficient data was gathered and provided adequate saturation of themes, or themes that "reflect the depth and complexity of human life" (Williams & Morrow, 2009, pg. 578).

The intent of this study was to explore both the internal processes and the external influences that exist in the context of clinical work and decision-making of therapists, so both a semantic and a latent approach as described by Braun and Clarke was used in data analysis (2006). A semantic approach involves identifying explicit language used by study participants, not interpreted by the researcher, but guided by existing knowledge of the topic (Patton, 1990). Initial semantic analysis was augmented by the latent analysis, which explores the assumptions and beliefs underlying the data (Braun & Clarke, 2006). In the first phase of analysis, transcripts of participant interviews were read multiple times. In the second phase of analysis, what participants said about their experiences and contexts- the semantic analysis- were coded and labeled according to Bronfenbrenner's ecological systems outlined in the theoretical framework? Also in the second phase of analysis, the initial latent analysis was generated and inferences to underlying beliefs about screening practices and understandings of their role in identifying violence were recorded and labeled according to Bronfenbrenner's ecological systems. The

process of analysis is a recursive one, which moves from a descriptive analysis at first to further interpretation (Joffe, 2011), and these initial semantic and latent level analyses were used to inform the formation of themes in the third phase of data analyses.

Trustworthiness. Morrow and Smith (2000) describe trustworthiness as the "goodness" of a study. Trustworthiness in qualitative study includes four components (1) credibility, or how close the research findings are to the reality of the situation; 2) transferability, meaning that the findings can be applied to other contexts; 3) dependability**,** which is the degree to which the findings can be consistently reproduced; and 4) confirmability, or the extent to which the findings are unbiased by the researcher (Lincoln & Guba, 1985). To aid in managing the reactivity and bias of qualitative researchers and legitimizing qualitative findings Padgett (1998) suggests a set of strategies be established to achieve trustworthiness.

The credibility of this study was sought first by becoming well versed in the literature of universal screenings for intimate partner violence. Prolonged engagement in the field of couple therapy by the lead researcher and members of the study committee, all support the credibility of the study as they are intimately familiar with the topic and logistics of clinical practice. As a doctoral student in a couple and family therapy program and a practicing clinician for several years, the lead researcher has been integrated to the culture of clinical work and those who perform it. The opinions and impressions of the researcher related to each interview, have been recorded in a standardized format following each interview, to enhance the development of consistent themes; this template can be found in Appendix D, which have supported the evaluation and manage the assumptions, expectations, and biases the researcher has brought to the investigation (Morrow, 2005). Key informants were used at the time of research design to provide feedback on the interview guide. Analysis and findings have been presented using direct

quotes by participants, which provide transparency allowing the reader to identify with the interpretation and to establish integrity of the data (Williams & Morrow, 2009).

Of the concept of transferability, Morrow states "given the usually small sample sizes and absence of statistical analyses, qualitative data cannot be said to be generalizable in the conventional sense" (2005, pg. 252), but it can be accomplished to an extent by presenting to the reader a detailed description of the researcher herself, the instrument of exploration, the participants, and the context and process of the research, so that the reader may reasonably assess the generalizability of the presented findings (Morrow, 2005). Details about the researcher, the participants, and steps of data collection and analyses have been provided and a thorough "audit trail" has been be kept so that the same study could be replicated (Creswell, 2013; Lincoln & Guba, 1985; Shenton, 2004).

Format of the Manuscripts

Paper one. The first paper explores therapist's thinking and perceptions about universally screening for violence., as well as their current practices and norms. A total of 15 interviews were conducted with clinically active couple therapists, ranging in years of clinical experience from 2 to 51. Participants were asked to describe their current practices for identifying violence and how they came to adopt those practices. They were then asked to respond and offer reactions to the core components of universal screening (i.e. written report, separate verbal interview, universally screening), and were prompted to reflect on other contextual influences that may inform their thinking and practices. Participants were asked about early formative experiences, education and training, societal exposure, clinical and field work that has impacted them, and connections with colleagues. Paper one is a descriptive presentation of significant themes identified across participant interviews. Results are organized in three major themes: Lack of

Uniform Knowledge Results in Inconsistent Screening Practices, Inconsistent Routines of Screening and Assessment, Clinical Practices and Perspectives Continue to Evolve Over Time. Implications for practice, training, supervision, and policy are discussed.

Paper two. In the second paper, the exploration of meaningful contextual influences is extended by investigating the connections that therapists' experiences with violence have to their daily practices and these micro-level influences are analyzed in greater depth. Therapists reflected on how direct and indirect exposure to violence throughout their personal and work lives inform their approach to identifying violence in their work with couples. Results are organized into four major themes: Therapists Draw on Personal Experiences of Violence Which Shape How They Approach Screening Couples, Professional Experiences Working with Abuse and Violence Impact Therapists and Their Screening Practices, Therapists Adopt Strategies to Manage their Own Reactions in Light of These Personal and Professional Experiences. Implications for clinicians, for training, and supervision are discussed.

APPENDICES

Appendix A: Recruitment Flyer

Calling all LMFTs!
Participants needed for dissertation study!

- Are you a Licensed Marriage and Family Therapist?
- Do you work with couples to resolve relationship problems?
- If so, I would like your feedback. Are you interested?

Participants in this study will be asked to partake in a **60-90-minute individual interview**. All participants will receive a **$40 gift card** to your choice of Starbucks, Tim Hortons, or Panera Bread.

The interview will either be in-person or via videoconference, whichever is more convenient for you, and at a time that is convenient for you. Your insights and experience can help improve therapist training, and impact legislative policy for working with couples. Researchers from Michigan State University are conducting this study, and this study has been designated exempt by the MSU IRB.

I want to talk to you!

If you are interested in participating, please contact Nicole Monta for more details by

Phone: (517) 614-2925

or

Email: montanic@msu.edu

Appendix B: Qualitative Study Consent Form

Research Participant Information and Consent Form

You are being asked to participate in a research study. Researchers are required to provide a consent form to inform you about the research study, to convey that participation is voluntary, to explain risks and benefits of participation, and to empower you to make an informed decision. You should feel free to ask the researchers any questions you may have.

Study Title: Violence Screening by Therapists When Working with Couples: A Qualitative Study

Researcher and Title: Dr. Adrian Blow, Principle Investigator

Researcher and Title: Nicole Monta, Secondary Investigator

Department and Institution: Human Development and Family Studies, Michigan State University

Address and Contact Information:

Dr. Blow can be reached by telephone: (517) 432-7092, e-mail: blowa@msu.edu, or regular mail: 552 W. Circle Drive, 3B Human Ecology, Michigan State University, East Lansing, MI 48824.

Nicole Monta can be reached by telephone: (517) 614-2925, e-mail: montanic@msu.edu or regular mail: 1560 Catalpa Dr, Berkley MI 48072

1. PURPOSE OF THE RESEARCH

I am doing a study titled Violence Screening by Therapists When Working with Couples: A Qualitative Study, to better understand the experiences and factors that influence therapist's practices when they first start therapy with couples. Findings will contribute to a growing knowledge of literature that focuses on violence detection efforts within the field of mental health, and may inform educational and training policy.

2. WHAT WE WILL DO

This study consists of interviews with therapists who meet with couples on a regular basis. You must be at least 18 years old to participate in this research. To participate in this research study you will meet with me for one interview. The interview will take place either in-person or via videoconference, and it is expected to take approximately 60-90 minutes to complete. The interview will be audio recorded so that it can be transcribed into written text.

3. POTENTIAL BENEFITS

You will not benefit personally from being in this study. However, we hope that, in the future, other people might benefit from this study because the knowledge generated through this study may help inform policy and training of Marriage and Family Therapists.

4. POTENTIAL RISKS

There are no foreseeable physical, legal, or economic risks to participating in the study. However, the discussion may elicit some content that could cause emotional distress or discomfort. If you would like referrals to counseling or support groups in your area, please ask the researcher and these referrals will be provided to you at your request. The potential benefits of participating in the study are the opportunity to discuss your professional experience and insights, and provide knowledge to potentially be used to influence training and educational development within the field of mental health.

5. PRIVACY AND CONFIDENTIALITY

Your confidentiality will be protected to the full extent possible. The only foreseeable exceptions to confidentiality are in circumstances of suspected child abuse, elder or dependent adult abuse, potential harm to others, or potential harm to self. Because the researcher is a mandated reported, under these circumstances the researcher is required to breach confidentiality to safeguard your safety and/or the safety of others. Responses to interview questions will remain confidential. Your name will not be connected to the interview transcript within the research. All audio of interviews will be destroyed immediately following transcription. All interview transcriptions will be stored in password protected computer files for up to three (3) years. All other records, including this consent waiver, will be kept for at least three (3) years after the project closes. Only members of the Michigan State University research team, the University Institutional Review Board, or the Human Research Protection Program will be able to access your records. This findings from this study may be published or presented at professional conferences, however your identity will remain anonymous. In reporting and publication of study findings, all data will be aggregated in publications and presentations, so that no participant can be individually identified.

6. YOUR RIGHTS TO PARTICIPATE, SAY NO, OR WITHDRAW

Participation in this study is entirely voluntary and at will. You can stop and discontinue the interview at any point, including once the interview has begun. There is no penalty if you decide not to participate. You may choose not to answer any questions that you do not wish to answer and you do not need to explain why you do not want to answer that question. Refusal to partake in the study will not affect you in any way.

7. COSTS AND COMPENSATION FOR BEING IN THE STUDY

There is no cost to you for participation in this study. After completing the interview, you will receive a $40 gift card to your choice of Starbucks, Tim Hortons, or Panera Bread.

8. CONTACT INFORMATION FOR QUESTIONS AND CONCERNS

If you have concerns or questions about this study, such as scientific issues, how to do any part of it, or to report an injury, please contact the Principle Investigator, Dr. Adrian Blow.

Address and Contact Information: Dr. Blow can be reached by telephone: (517) 432-7092, e-mail: blowa@msu.edu, or regular mail: 552 W. Circle Drive, 3B Human Ecology, Michigan State University, East Lansing, MI 48824.

If you have questions or concerns about your role and rights as a research participant, would like to obtain information or offer input, or would like to register a complaint about this study, you may contact, anonymously if you wish, the Michigan State University's Human Research Protection Program at 517-355-2180, Fax 517-432-4503, or e-mail irb@msu.edu or regular mail at 4000 Collins Rd, Suite 136, Lansing, MI 48910.

9. DOCUMENTATION OF INFORMED CONSENT

By beginning this interview, you indicate your voluntary agreement to participate in this study. If you decide to participate, a doctoral student from Michigan State University will carry out the interview with you. *The interview will be audiotaped for accuracy, and audiotaping is required to be in the project.*

Appendix C: Interview Protocol

As a Marriage and Family Therapist myself I am really interested in why some therapists seem to be very comfortable directly asking their clients about abuse, while other therapists almost never think to do this. So, in this study I hope to explore what ***influences*** therapist' thinking about screening for identifying violence in couples. Today when I talk, I'm going to use the words violence and abuse interchangeably
…..and throughout the interview I may periodically veer the conversation back to that topic.
Review the consent waiver form, answer any questions, and ask if participants wish to continue in the study by participating in interview.

Remember, your participation is voluntary.

- **There is no penalty if you decide not to participate.**
- **You may skip any question that you do not want to answer.**
- **You can stop being in the study at any time without penalty**

Q1: What is your protocol for assessing violence with your clients? [Assess over phone first?]

What specific questions do you ask?

And how did you come to this routine? What training did you use to come to this process?

How frequent is it that you ask your clients about violence?
Is this consistent across the board or do you vary? Why some and not others?

Do you assess for physical violence only or other forms of violence as well? How do you explore the power and control dynamics in relationships?

Prompt: For example, many times female partner experience such an intense level of coercive control through emotional abuse and manipulation, non-physical forms of aggression, that they will respond with physical aggression. So, if we ask strictly about who hit who, or who hit first, an incomplete picture is gathered.

The times that you have *not* asked about violence, what do you think prevents you from doing that?

What do usually do with the information you gather? [Treatment goal, No-harm contract]
How does payment structures and getting reimbursements from insurance companies influence your intake and assessment process with couples?

Prompt: For instance, you suspect that there is some abuse going on, and you want to talk with the victimized partner in private, so that you are not asking those questions in front of the suspected perpetrator. However, the perpetrator is the IP. Many major insurances will not reimburse services that are coded as Family

Therapy without patient present- 90846, and will only reimburse for a 90837, individual session.

What do you think you would need, or what would help you to make asking about violence early on with clients a regular practice for you?

Very briefly, so that in our conversation I know what you are thinking of when we refer to it, can you please share with me your working definition of domestic abuse or partner violence? How do you define that?

Q2: There are a lot of different recommendations for how to assess for violence with couples, and many of these recommendations include 3 elements. I am going to ask you for your reactions to each of these 3 elements

1) A written assessment by both partners
2) Verbal interviews with each partner separately to do a private assessment as well
3) This should be done with all couple clients regardless of what is their presenting issue

How likely would you be to carry out those steps with your clients? Any why is that?

[Prompt] It sounds like you already do _____ in your practice; what do you think prevents you from….

What problems might you foresee in asking every couple about violence?

In your clinical practice what problems does doing a separate interview with each partner pose for you?

[Sub-question] To what degree would you worry about losing a potential client by including these steps in your intakes?

Q7: How do you think that your understanding of the need to identify violence has evolved over the years that you have been in practice?

(If needed) What do you think has brought about that change in thinking (or in attitude)?

How do you see your life experiences that you have shared with me today, influence your views on the need to ask couples about abuse before engaging them in treatment?

Q3: I'd like you to talk me through your journey, starting from an early point in your life to now, and what experiences have informed how you think about asking clients about violence. I'd like to know all about what has influenced your thinking, your feelings along the way, and any specific experiences that have been formative for you.

Thinking specifically about your professional and educational experiences, can you tell me about any formative experiences that you have had?

Q4: In the past, how many cases have you had in which there was some form of abuse? How frequent is that experience?

Tell me about the worst experience that you have had working with a couple that had a high level of aggression or violence? [worst= highest level of risk for the client, or greatest discomfort for you]

[Experience] What was it like for you to be the therapist in that case?

How did working with this case make you feel?

How was the violence first identified?

At what point was that in your career, how long ago?

How did that experience influence your current practice in working with couples?

[If needed] What were the lessons that you took away from that experience?

[If needed] What is different for you before and now after that case?

Would you say, that experience with that client makes you more likely (or less likely) to bring up the topic?

What about that experience has changed your practices for talking with clients about violence?

Q5: I'm going to ask you again about how your experience has shaped your philosophy and thinking about working with violence, but I ask you to expand your thinking to specifically to your personal, individual experiences, even early life.
Remember that you can choose not to answer any questions that you are not comfortable with, and that your name is not connected to this interview, so what you say is confidential.

____Personal ____Clinical ____Education ____Attitudes ____Others

You mentioned _____, can you tell me more about that?

Have you ever experienced partner violence in your relationships? Would you mind telling me a bit about that?

Have you had any personal exposure to violence in childhood or in your community?

How do think your religious background or cultural background have shaped your attitudes about talking with clients about violence?

Q5: As clinicians our thinking about clinical issues is sometimes influenced through connections to other professionals, even outside of the mental health field, both through our work experiences and through informal personal connections as well. Can you tell me about any other people that have influenced your thinking about asking couples about the possibility of violence?

Prompt: Some examples of this would be perhaps a co-therapist on a previous case, a former supervisor or colleague, or connections to law enforcement, domestic violence advocates, lawyers, nurses, doctors?

Q6: There is some debate in our field as to what is the role of an MFT within the wider issue of partner violence and couple violence. What do you think is the role of MFTs in the bigger picture of violence work?

You stated that you believe _____. What has lead you to this clarity?

To end I am going to ask a brief series of demographic and background questions so that I have a context for our conversation today.

1. Do you have other educational training outside of your master's program? (another career)
2. How long ago did you complete your graduate training?
3. What other mental health positions have you held in the past, prior to where you currently practice?
4. In what type of setting do you currently work (private practice or independent contract group)?
5. What is your current age?
6. What is your gender?
7. What is your ethnic background?
8. What is your religious background?

That is the end of my formal questions. As a little debrief, would you please tell me how it has been to answer these questions? What is it like talking about this topic with another clinician?

Appendix D: Researcher Memoing Template

Date: Interview #:

1. What was the setting for the interview?

2. What is the essence of the interview?

3. What keywords describe the interview?

4. What is the most interesting thing you learned?

5. What surprised you?

6. What connections do you see- to other interviews, to the literature?

7. Overall, how did the interview go?

8. What aspect of the interview went well? Why? Is there a way to incorporate this into future interviews?

9. What aspects of the interview could be improved? Why? How will those improvements be made?

10. What ideas, themes, or unclear statements should have been elaborated on?

11. Were there any significant non-verbal communications (i.e., body language, expressions, changes in tone of voice, gestures, etc.) during the interview?

12. What else?

Appendix E: Phases of Thematic Analysis

PHASES OF THEMATIC ANALYSIS
(Adapted from Braun & Clarke, 2006)

1. *Familiarization with data:*
   - *Data Collection:* The first author will complete all semi-structured individual interviews
   - During this early process, basic ideas and inquiries will be developed.
   - *Researcher Memoing:* Promptly following each interview, notes will be taken about each interview using the Researcher Memoing Template included in Appendix E.
   - *Transcribing:* Transcription will be completed by the first author in collaboration with a research assistant.
   - *Reading, and re-reading, noting down initial ideas:* The lead researcher will familiarize herself with the data by a minimum of 3 times before beginning a coding process of the transcript.

2. *Generating initial codes:*
   - Transcripts will be printed and initial coding will be done by hand. This systematic process will be implemented across the data set, categorizing the entire data in the appropriate code(s).
   - At this stage, sematic and latent levels of analysis will begin. The wording and phrasing of study participants will supply open coding of early data to generate an initial coding frame that is rooted in the data.
   - The semantic level of analysis will happen on the right side of the transcript margin and a latent (interpretative) level of analysis will be documented on the left side of the margin.

3. Searching for themes:
   - Nvivo software program will be utilized for the task of searching for themes.
   - After uploading the transcripts, the software will used for an additional round of coding to creating nodes and tree-nodes.
   - At this point, the nodes will be reorganized and re-categorized. The codes (nodes) will be collected and collated into prospective themes and the data related to each prospective theme will be grouped together.
   - Initial name of evolving themes will be reviewed and refined.
     Nvivo software will be used to draft a thematic map of the emergent themes.

4. Reviewing themes:
   - The researcher will review the accuracy of the initial coding frame in an iterative process by reapplying them to early transcripts.
   - Researcher Memoing notes will be revisited by the researcher to support the analysis process.
   - Refinement the thematic map will continue by classifying and re-classifying themes that are similar or unrelated to the research questions.
   - Finally, the researcher will identify major themes and sub-themes.

5. Defining and naming themes:

- The researcher will review thematic categories to identify patterns both within and across the data set.
- At this phase, the analysis will continue in order to attain refinement of each particular theme, and develop the general narrative that the data is perceived to be transmit. The researcher will discern more distinctive concepts and names for each theme.

6. Producing the report:

- Persuasive and powerful extracts will be selected.
- Then, the chosen extracts will be revised and analyzed, making connections between analysis and research questions.
- As the narrative of the results section is told through drafting, the process of writing the research report allows an additional review of the data analysis.

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CHAPTER 4: PAPER ONE

Why do therapists fall short of violence screening standards? A qualitative exploration of therapist practices and perspectives.

Abstract

It has been well documented that couple therapists do not follow recommended practices for universal violence screening, though a thorough understanding of why therapists fall short has yet to be established. This qualitative study of 15 couple therapists describes elements that influence these therapists' approaches to screening for partner violence. Study findings include inconsistent knowledge of IPV application to screening and assessment, inconsistent knowledge of screening recommendations, variations in training, contextual influences, misguided use of therapist intuition, and inconsistent practices over time. Implications for practice, training, supervision, and policy are discussed.

Introduction.

The problem of Intimate Partner Violence (IPV) is widespread and efforts to intervene and effectively treat IPV are ongoing, yet many problems exist when it comes to detecting IPV in relationships (Baig, Ryan & Rodriguez, 2012; Colombini, Dockerty & Mayhew, 2017). Many couples experiencing IPV seek help (Caetano & Lipsky, 2007; Simpson, Doss, Wheeler & Christensen, 2007), and many seek this help from couple therapists (O'Leary & Murphy, 1992) yet most clients experiencing IPV are unlikely to state abuse or violence as their primary concern when seeking services (McNutt, Carlson, Gagen, & Winterbauer, 1999). The majority of couples (50-65%) who seek couple therapy report some level of physical aggression, yet 90% of these couples do not perceive physical aggression as a major relationship problem (Ehrensaft & Vivian, 1996), instead reporting that communication issues have lead them to seek services

(Dutton, 1995; Silva, McFarlane, Soeken, Parker & Reel, 1997). In instances of abuse, many perpetrators will make direct efforts at deception and minimization of their abuses (O'Leary & Murphy, 1992), and the psychological defenses of denial and minimization may be highly prevalent in severely abused women as well as men who inflict the most severe abuse (Browning and Dutton, 1986; Campbell, 1995).

High rates of aggression among couples seeking treatment and low rates of detection among therapists suggest that therapists frequently treat violent couples though they may not realize that violence is present (Jose & O'Leary, 2009; Kamimura et. al., 2014; Madsen et al., 2012). Therapists have consistently been found to under-detect the presence of violence (Dudley, McCloskey & Kustron, 2008; Hansen, Harway & Cervantes, 1991; Harway & Hansen, 1993), and it is estimated that only 10-30% of partner violence is documented in therapist case notes (Howard et al., 2010; Nyame, Howard, Feder & Trevillion, 2013). Traditional couple treatment with undetected IPV runs a risk of increasing abuse and many argue that couple therapy should not occur before a thorough evaluation of all IPV related risk factors (Bograd & Mederos, 1999; Goldner, Penn Sheinberg & Walker, 1990; Jory, 2004; Stith, Rosen & McCollum, 2003). Screening for IPV drastically increases rates of detection (Duncan, McIntosh, Stayton & Hall, 2006; Freund, Bak & Blackhall, 1996; Hathaway, Willis, & Zimmer; 2002; Holtrop, Fischer, Gray, Barry, Bryant & Du, 2004; Krasnoff & Moscati; 2002), yet it is estimated that only 4% of couple therapists follow guidelines for routine screening of partner violence (Schacht, Dimidjian, George & Berns, 2009).

Research suggests that some presentations of abuse may be more responsive to clinical intervention than others (Horwitz, Santiago, Pearson LaRussa-Trott, 2009; Jory & Anderson, 2000; Lam, Fals-Stewart & Kelley, 2009; Stith, Rosen & McCollum, 2003; Stuart, Holtzworth-

Munroe, 1995) and several promising approaches to working conjointly with couples to lessen abusive patterns continue to gain empirical support (Cleary Bradley & Gottman, 2012; Karakurt, Whiting, Esch, Bolen & Calabrese, 2016; Simpson, Atkins, Gattis & Christensen, 2008; Stith, Rosen, McCollum, & Thomsen, 2004). However, clinical presentations of abuse are not homogeneous (Johnson & Ferraro, 2000), nor are perpetrators all the same (Holtzworth-Munroe & Stuart, 1994; Johnson, 1995). Michael Johnson proposed numerous typologies of IPV relationships including intimate terrorism, situational couple violence, violent resistance, or mutual violent control, clearly showing that IPV comes in different forms and with differing levels of risk to victims (Johnson, 1995; 2006). Further, not all couples fit the profile of a victim-perpetrator dynamic (Johnson, 2006; Rosen, Stith, Few, Daly, & Tritt, 2005), as some common couple violence is bilateral (Madsen, Stith, Thomsen & McCollum, 2012). It should be noted that even though common couple violence may be bilateral, it can still place members of the relationship, especially women, at high risk of physical and emotional harm.

Data on prevalence and type of couple violence highlights the need to identify when it is present in relationships and the kind of violence that is occurring. The likelihood of physical abuse is decreased in some circumstances by thoroughly addressing risk factors during treatment (Stith, Rosen, & McCollum, 2003), but clinicians must first ascertain the type of abuse and level of safety before continuing with conjoint treatment (Karakurt et al., 2016), or as Stith, McCollum, Amanor-Boadu, and Smith (2012, pg. 16) have described it, "accurate identification of IPV and risk assessment are the cornerstones of safe and effective treatment."

Universal screening for IPV, through the use of self-report measures and brief face-to-face interviews, has been widely recommended and discussed (Epstein, Werlinich, & LaTaillade, 2015; Hussain, Sprague, Madden, Hussain, Pindiprolu, & Bhandari, 2015; Schacht, Dimidjian,

George, & Berns, 2009). Todahl and Walters (2011, p. 357) defined universal screening by therapists as "a procedure that involves directly questioning—in writing and orally—every adult client, regardless of the presenting issue(s), about current and previous IPV victimization." It is commonly suggested that screening should assess for not only the presence, but also the type of IPV (physical, sexual, psychological, etc.), as well as the level of intensity of current abuse, and that providers gauge the degree of intimidation, fear and controlling behavior exercised by perpetrators (Gauthier & Levendosky, 1996). In addition to identifying the type of abuse carried out by the perpetrator (Gauthier & Levendosky, 1996), it is also important to assess for other psychiatric comorbidities and risk factors such as alcohol use disorders, depression, and posttraumatic stress disorder as these can all exacerbate violence (Gauthier & Levendosky, 1996; Schact et al., 2009; Stith, McCollum, & Rosen, 2011). Protocols for universal screening have been offered by the American Psychological Association (2002), and the Family Violence Prevention Fund (2004) among others, and universal screening procedures specific to couple therapists have been published by Bograd and Mederos (1999) and Todahl and Walters (2009; The IPV Screen and Assessment Tier (IPV-SAT) Model). Violence screening measures are also broadly disseminated, the most widely used of these (Costa &Barros, 2016) include The Conflict Tactics Scales (CTS), The Revised Conflict Tactics Scales (CTS2), the Abuse Assessment Screen and the World Health Organization Instrument. Despite availability of such resources, they are not widely used by therapists, and there are numerous roadblocks to their implementation.

Documented Barriers to Screening. Universal screening initiatives have been undertaken in numerous healthcare settings, most commonly obstetrics and gynecology, emergency medicine, family medicine, and community health centers (Sprague, et a., 2016). Screening practices vary

widely across practice sites as well as across individual clinicians (Phelan, 2007; Stayton & Duncan, 2005). Several barriers to use of universal screening procedures have been documented in these settings. Within organizations, inconsistency of protocols, lack of administrative support, and a dearth of mechanisms of accountability present contextual barriers to violence screening implementation (Campbell, Coben, McLoughlin, Dearwater, Nah, Glass, et al., 2001; Cohen, DeVos, & Newberger, 1997). Interactions with clients also present barriers including a lack of privacy from potential perpetrators, tensions about limited confidentiality, and clinician frustration when patients remain unsafe (Spangaro, Poulos & Zwi, 2011). Individual practitioner elements such as perceptions of prevalence of IPV in the patient population, fear of doing more harm than good (Dowd, Kennedy, Knapp & Stallbaumer-Rouyer, 2002), and lack of practitioner knowledge of IPV dynamics (Cohen, DeVos, & Newberger, 1997), have consistently been found to present roadblocks to consistent screening.

The bulk of screening literature has emerged from medical care settings (Todahl & Walters., 2011) and generalizations to mental health contexts may be limited, for as Sprague et al. state, universal screening of IPV is "problematic when traditional screening criteria are applied because it is a complex social phenomenon rather than a disease (2016; pg. 2)." Limited research is available to understand the factors inhibiting wider use of violence screening protocols specifically by couple therapists. Many scholars have documented the difficulty therapists experience following disclosures of abuse including fears for safety of the clients, as well as anxieties and confusion about how best to proceed (Brosi & Carolan, 2006). Todahl, Linville, Chou, and Maher-Cosenza, (2008) examined the experiences of 22 MFT interns in a university training clinic following the completion of a required 10-week course on IPV which included instruction on IPV screening guidelines. Findings of intern responses to universal

screening included struggling with confidentiality, concerns that screening would escalate violence, frustration with assessment and techniques, a lack of confidence in conducting screens, feelings of sadness and being overwhelmed, an awareness of their own learning processes, engagement of therapist's own family values and past experiences, and belief that benefits outweigh risks of screening (Todahl, Linville, Chou, & Maher-Cosenza, 2008). Similar findings were echoed by Minsky-Kelly, Hamberger, Pape and Wolff, (2005) who conducted a qualitative study of barriers to domestic violence screening and referral in a health care setting following a hospital-wide training for universal violence screening, in which mental health service providers made up 20% of participant sample. Themes included questions about the appropriateness and value of screening given patient presentation and clinical setting, inadequate provider expertise resulting in feelings of frustration, concerns about time and workload priorities, anxieties about the process of screening, and concerns about the outcome and efficacy of screening (Minsky-Kelly, Hamberger, Pape & Wolff, 2005). Across both medical providers (Coker, Bethea, Smith, Fadden & Brandt, 2002) and therapists (Todahl et al., 2008), individual practitioner views of the practice appear to play a significant role.

What is missing in the current knowledge base is a thorough understanding of factors which influence couple therapists specifically with regard to violence screening practices. Despite exposure and awareness of widespread couple violence, and often despite receiving training on the need for identification of IPV, couple therapists specifically have not integrated screening procedures into regular practice (Wiist & McFarlane, 1999). Daire et al., (2014) have offered an (IPV) Protocol Readiness Model, which assesses counselors and clinicians to gauge their level of preparedness to assess IPV and manage disclosures of violence, though evaluations of rates of use and effectiveness of the model have yet to be reported. Why do therapists neglect

to follow widely recommended and available protocols for thorough and comprehensive screening for the presence of violence? Stith et al., (2012) proposed this question and an adequate response has yet to be established. Despite the availability of resources and recommendations, the gap between researcher and practitioner continues to loom large in this regard. Greater investigation is needed into practitioner perceptions and choices which inform daily practices.

Methods

This study explored the processes and approaches to violence screening by couple therapists. Clinicians licensed and practicing as Marriage and Family Therapists were interviewed about contextual elements and personal experiences that informed their thinking and choices about violence screening, and were questioned about the individual meanings ascribed to those choices. The research question driving this study is: *Why do some therapists neglect to follow recommended protocols of universal screening for violence in their work with couples?*

Participants. Purposive sampling was used to recruit participants who were 1) licensed and actively practicing Marriage and Family Therapists; 2) who regularly work with couples; 3) have at least two years of clinical experience post-graduation; 4) have obtained a master's degree or higher in a clinical program. Excluded from the study were participants who were trained but not actively practicing, who were licensed to work in the field but who were not engaging in direct client contact or who did not work with couples. Clinical practice in this study is defined as contact with couple clients for the purpose of talk therapy. Other forms of involvement with clinical work such as case management and supervision of therapy did not meet the inclusion criteria and these individuals were not selected for interview participation. Clinical work with couples is defined by a treatment focus located on the relational dynamics of the couple.

Clinicians who practiced within a setting that specifically targeted Intimate Partner or Domestic Violence services, i.e. shelters or advocacy, were excluded from the study because of the potential to produce a skewed sample.

A total of fifteen interviews were completed with participants; each interview lasted between 45 and 90 minutes. Participants were interviewed in their offices or through a secured video connection. The years of clinical experience within the sample ranged between 2 and 51 years. Table 4.1 provides an overview of participant demographic details.

Table 4.1 Demographic characteristics of participants

Demographic Characteristic	n	%
Gender		
Male	4	26.6%
Female	11	73.3%
Age		
20-29	1	6.6%
30-39	7	46.6%
40-49	1	6.6%
50-59	3	20%
60-69	1	6.6%
70-79	1	6.6%
80-89	1	6.6%
Religious Affiliation		
Christianity (no denomination identified)	6	40%
Catholic	4	27%
Agnostic	2	13%
Jewish	2	13%
Spiritual	1	7%
Ethnicity		
Caucasian	14	93%
Latino	1	7%
Years in Practice		
1-5 years	4	26.6%
6-10 years	4	26.6%
11-30 years	4	26.6%
31-60 years	3	20%
Current Practice Setting		
Private Practice	11	73.3%
Community Agency	2	13.3%
Private Practice and Community Agency	2	13.3%

Table 4.2 provides a visual summary of participant screening practices as reported in interviews.

Table 4.2 Summary of participant screening practices

Screening Activity	Participants
Universally Assess All Couples	6
Separate Interview with Each Partner	7
Some Form of Written Assessment	7

Data collection. Interviews were completed with fifteen participants. All interviews were carried out by the first author who is a licensed practicing clinician and a doctoral-trained researcher. Transcripts were read by the first author and were stripped of all identifying information. Participants were provided an informed consent prior to scheduling an interview, and conditions of anonymity and confidentiality of participant answers were reviewed before the interviews began. Pseudonyms have been used in this paper to protect the identity of participants; other details such as participant age have been omitted to protect participant anonymity.

Interview protocol. A semi-structured interview protocol was used to ensure some consistency across interviews, while also allowing for flexibility in responses and follow up prompts (Josselson, 2013). The interview guide was created following a review of the available literature in the subject area. The literature review informing the interview guide included an examination of prevalence of relationship violence clinical populations, therapist detection of implementation efforts for universal screening in a variety of contexts (e.g. clinical, medical, emergency room), identified barriers to use of universal screening, recommendations for universal screening of couple therapists, and therapist reactions to working with violence in couple therapy. All participants were asked a standard set of questions, with additional follow-up

question that emerged from participant responses. Interviews consisted of open-ended (descriptive) and close-ended (structural) questions to clarify participant responses and meaning. Researcher memoing was documented throughout the data collection phase, and an audit trail was kept throughout research activities. Table 4.3 presents a sample of interview questions.

Table 4.3 Sample of interview guide

Question 1	What are your norms and policies are around identifying or assessing for the presence of violence or abuse in the couples that you see? What is your common practice? How did you develop this routine? Is this consistent across the board or do you vary? Why some and not others?
Question 2	There are a lot of different recommendations for how to assess for violence with couples, and many of these recommendations include 3 elements: Written assessment by both partners Separately verbal interviews Completed universally regardless of the presenting issue. What are your reactions to those suggestions? What problems might you foresee in asking every couple about violence? In your clinical practice what problems does doing a separate interview with each partner pose for you?
Question 3	What experiences both in your personal life and clinical work, have informed how you think about asking clients about violence? I'd like to know all about what has influenced your thinking, your feelings along the way, and any specific experiences that have been formative for you.
Question 4	Can you tell me about any individuals that have influenced your thinking on asking couples about violence? Some examples of this would be perhaps a co-therapist on a previous case, a supervisor or colleague, connections to law enforcement, domestic violence advocates, lawyers, nurses, doctors.
Question 5	I'm going to ask you next about your beliefs around identifying and screening for abuse with couples. Can you tell me how you think about your role of an MFT in the bigger picture of domestic violence work?
Question 6	How do you think that your understanding of the need to identify violence has evolved over the years that you have been in practice? What do you think has brought about that change in thinking (or in attitude)?

Data analysis. The exploratory nature of this study lends itself to the use of thematic analysis, which is an approach to recognizing, then analyzing and representing recurrent patterns of certain themes in a defined set of data; thematic analysis organizes information from a data set around the structure of themes that are established in the existing literature on the topic, while also allowing for the addition and generation of new and different themes identified in the data (Boyatzis, 1998). Data analysis was carried out in a sequential process using both a semantic approach and a latent approach. A semantic approach involved identifying explicit language used by study participants, not interpreted by the researcher, but guided by existing knowledge of the topic (Patton, 1990). Initial semantic analysis was next augmented by latent analysis, which explored the assumptions and beliefs underlying the data (Braun & Clarke, 2006). Analysis was completed over time using Nvivo data software, which facilitated the creation and subsequent grouping of codes which emerged from the data set. Data were coded over time based on research questions, which provided the structure and organization for the interview guide. Data were analyzed by the first author, and punctuated by regular discussion with the second author. Data analysis occurred in an iterative process involving analysis, discussion, and writing throughout the overlapping phases of data collection and data analysis.

In accordance with guidance provided by Braun and Clarke (2006), the steps of thematic analysis were completed in a recursive step-by-step process. These phases were carried out as such: (1) *familiarization with the data* in which data were collected, and transcriptions were read, and re-read with initial ideas documented and discussed with the second author; (2) *generating initial codes*, which occurred systematically across the entire data set to collate statements relevant to codes identified; (3) *searching for themes* was carried out as data was collected and organized by collating codes. Highlighting of participant statements were used to illustrate

themes; (4) *reviewing themes* occurred recursively throughout data analysis and discussed at length with the second author; (5) *defining and naming themes* occurred as specifics of each theme were refined and a comprehensive story was obtained through the data. Analysis was an iterative process through organization and refinement of major and sub themes. Illustrative quotes and context considered for evidence of themes. (6) As this process was completed a final report was produced to tell the story extracted from the data in a coherent manner.

Results

Lack of a uniform knowledge base results in inconsistent screening practices. Each participant interviewed operated from a unique combination of beliefs and experiences, derived through many sources, which resulted in vast inconsistencies in the practices that they used for screening and identifying IPV among couples. Without external mechanisms of accountability which unify participant practices and provide a consistent rationale for completing the various components of a universal screen for violence, it appears that therapists' routines and practices are subject to the individual perspectives of each clinician.

Limitations in knowledge leads to heterogeneous screening practices. There were some notable consistencies in therapist knowledge in the study sample. Almost uniformly, participants expressed an understanding of different manifestations of violence such as Intimate Terror vs. Situational Couple Violence, though participants were not all able to use these academic terms to identify them. They reported that in working with couples they listen for levels of autonomy, attempts to control or limit a partner, and their assessment of power and equality within couples informed how they classify the couple dynamic and decide how to proceed with therapy treatment. Participant 6, Kristina: "In my mind if [abuse is] mild to moderate then I feel like I can still work with them as a couple as long as everybody feels safe. If it's severe I won't work

with them as a couple."

This knowledge influences practices of assessment in numerous ways. Among participants who do assess for violence regularly, many describe assessing for multiple types of abuse tactics- physical, sexual, emotional, psychological, and financial abuse- they understand that abuse is often underreported, so they attempt to assess thoroughly, they make efforts to identify specific emotions and behaviors that are red flags for partner violence (e.g. fear for safety, controlling money, various physical acts of aggression), and they are aware of the often transgenerational nature of abuse when gathering individual family histories.

However, for therapists with inconsistent IPV assessment practices, IPV knowledge does not seem to translate into screening habits. Different levels of knowledge about IPV dynamics frame participant thinking about screening and assessment, and so participants each end up practicing from a different understanding of IPV and how it manifests in the clients with whom they work. Two themes were identified as limitations to therapist application of IPV knowledge.

Cultural competency. Five participants expressed anxiety about approach and technique to violence screening in instances of cultural differences. They doubt themselves and their clients, and some questioned whether survivors from minority backgrounds have the agency to tell a stranger the abuse they are experiencing. As Participant 3, Nancy, stated:

> The only thing that stumps me up now is if it's a different culture, because people with different cultures are taught, or raised, to hide things more and to be more embarrassed, and to not betray their culture by admitting certain things. So that's the thing that I'm confused about, if there's a different culture and how that all plays into it.

Participant 13, Gretchen, expressed concerns with respecting the self-determination of clients and cultural values when intersecting with the dynamics of IPV: "[within reasonable safety] if this is working for the couple, it doesn't need to be changed just because it's not something that would work for me."

Participant perceptions of IPV prevalence based on socioeconomic status also got in the way of identifying violence. For example, participant 12, Melissa, questioned whether she is less vigilant about listening for violence with the higher income clients she sees in private practice than when she practiced in a community agency that served a low-income population,

> I found that there was higher incidents and normalization of physical abuse between couples [in the agency setting] and that has shifted as I've shifted the population that I work with…. I find that it's less frequent in terms of reporting it, it's less frequent and less normalized in [private practice].

In contrast, Participant 7, Joanne, works in an ethnic minority community setting with a historically high prevalence for domestic violence, and she stated that this knowledge of the community makes her more likely to ask about abuse with that population: "I think that knowing that there's lots of history [of violence in this community] makes me more aware and more likely to ask [about violence]."

Non-physical violence. Secondly, despite uniform awareness that abuse takes many forms (i.e. emotional, psychological, financial, sexual), participants described difficulty assessing non-physical violence. Numerous participants focus more attention in the screening process on physical abuse, as Melissa, stated "I would say that I prioritize physical safety first. That's definitely the front of the assessment." Several participants stated that they find non-physical abuse to be more difficult to discern with clients because it is more ambiguous in nature than a physical assault. As participant 10, Marie, explained, she finds non-physical abuse is frequently not identified by clients:

> Those ones are trickier to me than physical, because with physical abuse, people will clearly label it that way, I think, more times than not. Whereas mental abuse, people- I think there's still this very narrow definition of abuse in our society and so people don't always take ownership of that.

Lack of knowledge about screening recommendations impacts practices. There was great

confusion across participants about universal screening recommendations and how they should be carried out in clinical practice. Many participants make decisions about screening and assessment practices though they are operating from limited and unverified assumptions about how frequently and with what procedures a violence screen should be completed.

Universal screening is not warranted. For the small minority of therapists (four participants) who reported no systematic approach to screening for violence, there was a lack of awareness of the need to universally screen couples for violence. This represents a major barrier for these clinicians, such as for participant 9, David, who does not ask about abuse if the presenting issue does not involve violence "Unless I hear anything that cues me in to think that, I probably am not thinking about it. I guess that's not part of my checklist to make sure that this isn't going on."

Participants who do not adhere to universal screening guidelines expressed several reservations that it is not warranted in all cases. They believe that clinicians should remain flexible and tailor their practices to the needs of the particular client. Marie explained her stance: "the fear is that I feel I'm intervening before I even know that much, I think it's somewhat irresponsible because I don't know the context." Several therapists conceptualized a spectrum of readiness to talk about violence, and these therapists reported that they will not directly ask clients about abuse until they receive some indication from the client of readiness to discuss it:

> I find it's more powerful for them to come to their own realization. So, I'll do like a circular questioning to see if they're ready to get there, because if they're not it's sort of like waking a sleepwalker. It's just not going to happen. (participant 8, Carla).

Another participant echoed these sentiments: "You are doing a disservice to the client in forcing the conversation if they are not ready to talk about it" (Marie).

Screening is a clinical burden. The perception exists among some participants that

screening presents a clinical burden on the clinician and client leading some therapists to avoid the practice. Eight participants interviewed do not conduct individual interviews in screening, and several expressed concerns about time. Four of them specifically commented on the many and various requirements that clinicians must carry out during an intake. Marie explained:

> That's where I think it gets really difficult as a mental health worker because if like there are so many things that we're pressured to do universally, that we have an hour. Like I don't know how we would necessarily do all these things. And so, if that's not presented to me, I have a hard time justifying not just the time that they and myself are going to take, but also the cost associated with that for the client if that's not an issue they're presenting.

Negative client reactions. Concerns about client reactions influenced some participant's perceptions of the effectiveness of violence screening. Some participants reported that they do not directly assess for abuse within an assessment of the general relationship dynamic because it can seem out of "left field" after the more general relationship assessment, as Kristina, stated. In response to the practice of a universal screen for new clients, participant 14, Meghan, stated: "We don't want to put somebody off thinking like this is an assumption that we have for all of our couples coming in." An important concern expressed by participants was that individual interviews with partners may deter clients from continuing treatment, as Gretchen described:

> Couples, they finally make the step to call and come in, right? They've been talking about this for years sometimes that, you know, let's seek out some professional help. Let's call a therapist. And they finally get here, and they just want to talk in the same room together. They want an opportunity to be heard, and now here is the therapist, wait, pause, slow down. I've already made you fill all this paperwork. I've had to talk to you about all this confidentiality stuff, and now I'm going to split you up and make you wait 15 minutes in the lobby while I complete this assessment with your partner. I think that part of it sometimes is discouraging, to me, because I'm like, wow, I really want to help them feel comfortable here. I want them to feel heard and then that rapport piece.

Dislike for secrecy and triangulation. Three clinicians interviewed expressed a strong dislike for secrecy and potentially being triangulated by clients, which deters them from regularly carrying out individual interviews. In response to the procedure of an individual

assessment one therapist stated “I get extra information other than the violence issue which puts me in a difficult position going back and working with them as a couple so I avoid that as much as possible” (Kristina). Participant 15, Rebekah, expressed concerns about negative implications for the therapeutic alliance or as she stated: “I don't want to undermine the process of us all working together.”

Trust and ruptures to the therapeutic alliance. Alliance and building trust is at the forefront of therapists’ minds for many participants in this study, especially in the early sessions. Eleven of fifteen of participants expressed concerns that assessing violence without first creating a therapeutic context based on trust and rapport would threaten the alliance. These clinicians doubted the reliability of screening that takes place before trust is established, and they worried that screening without establishing an alliance with the clients may lead to premature dropout. Rebekah explained her concerns about impacting the joining process, specifically with written screening tools. She would prefer that violence screening be incorporated into standard intake paperwork:

> I'm against it, as you know, beyond my paper intake as a first level of defense. I like to join. I feel like if I'm going to get an honest answer, then they need to be talking to somebody who they feel connected to. So I don't think that that's a wrong practice, is to have those interviews. I just think in that case, joining is much more important. Putting it down on paper, it's a lot of questions. There's no joining. This is just process. You know? "Here fill out these forms." It's like going to the doctor. "Fill out these forms. Take it or leave it. You can answer what you want, what you don't want." I don't think that impacts the joining process.

Participants who do screen adapt their approach and technique to lessen the negative impact to the working alliance with clients. Participant 11, Olivia, explained how he introduces individual interviews to new clients:

> In my first session with couples, I explain my outlook on couples counseling in the first place because I think that there's a lot of myths and things around what couples counseling is and isn't going to do for people. And so I tell them, you know, at one point

> I'm going to make you mad. And my goal is not to be here for you as individuals. My client is your relationship.…The way then I then framed the individual sessions is ... I'm pretty direct about it. I just say, you know, sometimes we don't feel comfortable in front of our partners talking about some of the issues that we have, so I like to do individual sessions plus it gives me time to do more history gathering for each individual in their own lives, the patterns, and concerns that they bring into the relationship, so that we can better address the relationship itself.

Inconsistent techniques and style of individual interviews. Some participants are more adept at carrying out a violence screen than others. Throughout the process of screening, therapists moderate their approach according to the perceived discomfort level of the client by taking a conversational approach. Some prioritize empathy and understanding in assessment so not to hinder the alliance, as Marie stated:

> I feel like I kind of overemphasize some empathy to get them to open up a little bit. Try to get a little background information, what their history with abuse and violence is, it's a lot to do in one session but actually it's usually pretty manageable. And once you express compassion, for the most point, I find that they're receptive.

Participant 4, Anna, explained her stance that possible ruptures to the alliance caused by asking about abuse can be managed though clinical skills:

> I think if you address something that is really critical to address and you lose a client as a result, that doesn't mean you shouldn't have addressed it. I think that how you go about addressing it can make a difference in whether you lose a client or not, because you can alienate a client that you might potentially be able to help.

Participant knowledge or lack of knowledge about screening technique leads them to use a wide array of strategies and skills in IPV screening and assessment, which are guided by clinical intuition in the moment, ranging from very direct and overt questioning to an indirect style of questioning. Some participants take an overt and direct approach to addressing violence, which they do by using the terms like abuse and violence openly with clients, and using direct close-ended questions to ask about specific behaviors (e.g. have you ever been slapped, have you ever been pushed during a fight.) Therapists use direct approaches to set the tone that therapy is a place to talk about the abuse and other difficult topics and build comfort with talking openly.

Other participants take a more softened approach to complete a violence screen with clients. They do this by using indirect language or euphemisms for violence. For example, Melissa explained: “our intake forms do not explicitly ask about if they're being harmed or abused, but they do ask about if they have any fears within their current situation.” Or, therapists reported inquiring about a history of exposure but not asking about the current situation. Marie explained:

> Typically, I will frame it though, because I've found that people tend to clam up if you just say, "Is there abuse?" I'll say, "Has there ever been..." People for whatever reason seem to be more comfortable with that in my experience. So, we'll go into history versus present, so that's how I kind of get in there.

Inconsistent screening relies upon the behaviors of the client to determine whether to assess overtly for violence. Carla explained her system for deciding whether to proceed with more specific steps to assess for ongoing abuse:

> My initial intake appointment, I go through all my paperwork, and all the liability and all of that stuff, and then I ask them to tell me their story. So, it will pop up in the first session. If it's super apparent, I will say something.

Numerous participants reported that they evolve from indirect to more direct questioning about violence and use client reactions to guide how much to press for more information. They do this by asking about general couple communication then more specific questions about abusive behaviors. Melissa described how she gradually moves to more direct questions about conflict:

> I'll say things like ‘as I'm learning about the both of you I need to get an understanding of what uniquely this looks like between the both of you.’ As they begin to open up, I might ask more probing questions. ‘When you both argue, does this get intense, as in is there yelling? Is there name-calling?’ Right? Then, depending on how they begin to answer, then I might ask something like, ‘is there anything that results in physical altercation?’ And kind of let them go from there. I'll get specific if they give me inclination that there have been moments of physical altercation.

Eclectic experiences of training shape therapist perceptions of screening. Many participants did not receive uniform education and instruction about violence and violence screening. Rather they built knowledge through the combination of academic training, supervisory experiences, and other field trainings. This suggests that therapists are not receiving consistent messages about best practices of violence and screening, and that education is an ongoing process.

Participants gained greater awareness of abuse and violence at a macro-level through graduate-level education on social issues of power, class, race and gender connections to abuse, which fosters awareness of violence in a broader social level. Some also received focused learning in clinically focused training which fostered an awareness of abusive dynamics, as Rebekah stated: "And quite honestly, [I] went through my master's program and shifted my frame from sort of an intrapsychic to a more systemic viewpoint, I've just noticed a ton more. It's like a disease." Further, many participants drew specific screening practices directly from instructors, which they continued to use throughout their careers, as stated by Carla, "In school I was told this [IPV screening] was routine, so it's just become my routine," and echoed by Marie, "I remember they drilled into our head like, women first, women first, women first. That was something I really took away. So that's probably why I always see the female [partner] first."

Many participants identified receiving supervision as highly influential in their IPV screening practices. Marie stated:

> I had a supervisor who constantly, constantly,...expected that there would be DV, so we were always forced, it was like one of the first things we assessed for again and again and again and…in that job, I had to go through the power and control wheel with every single client. I think it's made me more cognizant [of abuse.]

Challenging supervision was identified by numerous participants as being highly influential in how they address the topic of abuse with clients, such as described by participant 2, Brett:

> I was hesitant or reluctant to ask…direct question[s] of abuse, [I was hesitant] to name it

> appropriately and have those conversations. Through supervision was when [my avoidance] was pointed out to me….so in that supervision and work done on myself like being able to …trust myself more about how I handle a reactive response by clients that might seem intimidating.

Several participants worked in contexts in which violence-related trainings were offered [e.g. family reunification, in-home therapy, offender treatment groups, domestic violence shelters]. For some, attending training about partner violence was helpful. Four participants stated that such training early in their careers shaped awareness of the prevalence of violence and also built relevant clinical knowledge, as Marie stated

> I went to trainings for DV and separating the difference between abusive relationships and domestic violence and how to kind of assess to differentiate the two of those…. And then I just came [to clinical practice] and I was like, "Well this makes sense in this environment.

David however described some violence-related trainings as limited in their clinical usefulness, as some facilitators were not open to discussing options for treatment with cases that involved violence:

> In some of my bigger trainings, there's some resistance to looking at complexity, and I've simply wanting to sort of say hey, we need to help people be safe, and if ever there's anything bad, then we need to get those people to the police.

Contextual elements of setting and infrastructure influence screening practices. The unique elements of each practice setting can directly and indirectly support or inhibit screening practices. Some participants practice independently, some practice in an agency context, and some work as independent contractors in a group setting, so there is little consistency within contexts across which therapy work happens and elements of context influence therapists both in their current practice setting as well as progressively over their careers.

Direct influences on screening. For Rebekah, the organizational attitudes toward cases of abuse presented a barrier for appropriate handling of cases with abuse. She described the

organizational climate: “Domestic abuse [work] was very fearful. [The fear was that] it created exposure for the agency”; in one circumstance the agency policy about engaging with cases of ongoing abuse overruled her clinical choices:

> I worked with a profound case of abuse, and they actually tried to bring the couple in together for conjoined therapy. Which was like, I did hit my head against the wall.…the fear around that was so awful that they ended up discharging [the clients].Such horrible care.

The context in which clinical work takes place can have direct bearing to how screenings are carried out. Several therapists stated that their intake routine is the standardized format and paperwork provided by the practice group, as described by Anna:

> I worked in three different agencies before I went into private practice, and that's not counting where I had internships. I had two internships prior to that. Every one of them had a different way of having assessments done. They had different forms that, as long as I was working in that agency, I had to do it their way.

Despite this, the contextual influences are still subject to the individual attitudes and priorities of the clinician. For example, a question about violence may be included in intake paperwork but what the clinician does with that information and how it is followed up with will be moderated by the individual clinician. As Gretchen articulated, the materials clinicians use in her agency are uniform, but she ultimately makes final decisions:

> It's the same assessment that everybody in our practice uses. We are all Independent contractors, but we use the same paperwork to streamline things. I am welcome to provide my own assessments. If I want to, I can use further documentation. I think it's thorough and it gives the information that I'm trying to grab.

Complexities of insurance coverage and paperwork influence the protocols and frequency of how individual assessments are carried out. Participants describe insurance reimbursement as a barrier that can be overcome and they find ways to receive payment, though complexities of insurance coverage and paperwork influence the protocols and frequency of how individual assessments are carried out. As Meghan explained:

> If [couples] don't have [shared insurance coverage], then I may structure the session a little differently, whereas opposed to doing two, maybe 50 to 55 minute individual sessions, I may have to spread that over a couple sessions… so the insurance can bill it.

Indirect influences on screening. Organizational culture influences how clinicians practice assessments for violence, which can make them more or less attentive to the possibility of abuse. Carla, who works within a rural agency serving a tribal community stated that the clinician will often have a record of prior services and prior reports of abuse related to certain clients, which influence her intake process: "Absolutely I think that knowing that there's lots of history [of violence] makes me more aware and be more likely to ask." Another clinician stated that when she was working in an agency setting, she was more active in assessing because the client was handed over with no information (Rebekah), but that in a private practice capacity, she gauges the level of risk through how client present themselves over the phone and throughout the scheduling process.

Social influences on screening. Support from others fosters greater awareness of violence and competence in assessment. Therapist perspectives about violence assessment are influenced by others around them to be more comprehensive in their approaches. Interactions with colleagues formally through case consultation and providing supervision to other clinicians, and informally through conversations has expanded therapists' need for exposure and has influenced participants' views of the pervasiveness of violence. Therapists report that other clinicians challenge them to not get settled in routine practices, help them to practice good boundaries in their work, ease anxieties of feeling overly responsible for clients, show them how to be more direct when talking with clients, and provide feedback and support for clinical errors along the way.

Hearing several other colleagues' perspectives on the same cases over time triggers

greater awareness of various issues including violence. Kristina described the wide net of cases that she is exposed to by supervising beginning clinicians, and how this impacted her view of the pervasiveness of abuse in client populations. One participant is a member of an EMDR consultation group that focuses on trauma, and stated that hearing the frequency of violence in those cases impacted her perception of the pervasiveness of abuse.

Informal interactions with colleagues also influence worldviews of therapists; as Brett stated, "having conversations personally with friends and colleagues" has evolved his perceptions about abuse to be more aware of prevalence, "not knowing, like fully getting how pervasive that is until hearing other views." Male participants reported being challenged in their working understandings of abuse and prevalence by feedback from female colleagues. Numerous participants made reference to the #MeToo movement as influencing their level of awareness and described this awareness progressing thorough greater societal exposure:

> I think people are more tuned into that years ago maybe…with the culture in the last few months have been pretty big as far as raising our awareness of ... okay this is not 1 out of 100 deal. This is a really big problem. We need to be asking and we need to be tuned into that (Brett).

Inconsistent routines despite a desire for safe practice. The fear of engaging violent couples in unsafe conjoint therapy does not translate into thorough and consistent steps to identify ongoing abuse in couples as recommended by experts. The majority of participants expressed a belief in the importance of identifying violence when it is present so as not to proceed with conjoint treatment when it is unsafe to do so; yet, this belief does not equate to consistent use of universal screening practices. All fifteen participants in the study strongly identified as marriage and family therapists, and viewed their treatment as focusing on the relationship. All participants identified the need to identify the presence of power in order to effectively treat relationships, yet only three therapists interviewed carry out all three of the recommended practices for screening

identified in the literature (i.e. use of a written screen, use of individual interviews, and IPV screening for all couples).

Participants were similarly resolute in the desire to meet ethical requirements for reporting of family violence where children were involved:

> If there is some kind of violence going on, I want to make sure that if it needs to be reported, it is reported. If there's children involved, getting them taken care of [is a top priority]. (Carla).

Nancy explained her clinical views on identifying violence within couples:

> "If you're going to leave that out of the equation of whatever they're in here for accomplishing, or their treatment goals, then you're ignoring the elephant in the room. You can't do that. Because if that's going on, you can't ... you're not going to get anywhere."

Yet she also reported that she does not use a written measure and does not screen for violence universally.

Only three of fifteen participants in the study reported that they follow the most widely recommended practices for violence screening by couple therapists (i.e. universally screening, using a written tool, conducting separate client interviews). These three participants believe that universally screening for violence is the best practice for all couples and view not assessing for violence as negligent practice. However, other participants who do not carry out all three best practices echoed similar sentiments. Brett reported that he does a separate interview with every couple he meets with, but who does not use a written assessment, explained his stance on screening for violence:

> "It's so relevant to the health and wellbeing of our clients so it's directly related to care and providing quality care, so we have to be asking about it…I think we should all be fully responsible for [screening].… if we're not asking about that, who is?"

This sentiment was echoed by Olivia who also carries out separate interviews though not systematically and does not use a written measure:

> I mean, I assess for suicide at every single intake appointment, and then periodically afterwards of course. So I do think that issues like this should be assessed at the beginning and as things continue to go on, just simply because if ... I guess it opens the door, in my opinion. It opens the door to be able to have some of those kinds of conversations where it's such a taboo, embarrassing, shameful, scary experience that if I'm not going to be upfront with it and out with it and say, "Is this something that's happening?" then they might not feel like there's a space for that to be discussed in the sessions. So yeah, I think that it should be assessed at every single appointment.

Therapists rely on individual intuition. In the absence of routine practices for identifying violence, therapists rely on their own intuition to detect the possibility of abuse in couples. For some clinicians, it is only cases that trigger suspicions of violence that then lead to more intensive screening for the presence of violence. Eight of fifteen participants in this study described a reliance on their instinct, intuition, or perception of clients to detect a possibility of violence in the relationship, which then informed additional screening practices. These participants believed that through contact with the client, observations during conjoint sessions, and their own clinical and life experiences, that they are able to detect abuse in the couples they meet. Marie explained this process:

> [It is during the] second session when I assess for conflict interaction patterns. That's usually when I get a sense of if there are any kind of red flags for violence. Even if I see some ... even the way they're communicating about the conflict, if one person is, I guess, presenting the power, talking over the other partner or correcting them, to me that's ... I'm very sensitive. The red flags, they can be something really, really small to me. Just because I feel like I do have to do my due diligence.

Carla explained a similar approach to violence screening:

> I think that's sort of a fluid thing. For me, it's a gut instinct, if there is a control dynamic in the relationship, that makes me feel uncomfortable. I find that I typically like all of my clients, unless there's something going on. Even if I know someone's lying to me and I still like them, then I know that something fishy ... they're just going through their own thing, and that's fine, but if I get a gut feeling that someone isn't being honest and I start to have just a feeling like something isn't right, or this person isn't doing what's right, I just go with that, and I'll question around whatever it is that they said that made me feel that way until I get my answer. I do find, for whatever reason, that gut instinct has pretty much always been correct. I'm not sure that that's something I was taught, or it's just something that I have, but I think going into this profession you really have to be able to

> read people and to just kind of know what you're looking at. I know that's not very scientific.

Inconsistent routines of screening and assessment. Inconsistencies in individual knowledge of violence in couples, combined with a varying knowledge between therapists of screening practices, and inconsistencies in elements of the practice setting, all together result in varying approaches to violence screening practices by therapists. This study found very little uniformity of approaches to identifying violence, as the fifteen participants each carry out their screening activities in a different style and fashion, and use different materials.

Inconsistent steps and sequencing. There is great variability in the frequency of screening. Most participants do not have a standard protocol for intake assessment around IPV. While several participants conduct some form of IPV identification in working with couples, only six of fifteen participants conduct comprehensive IPV assessment with all couple clients, regardless of the presenting issue. Further, the majority of participants reported doing some elements of screening, although not in the same way consistently across all couple clients. Some include probes about abuse and violence within a comprehensive intake assessment report, but they couch it within other clinical information gathering (e.g. trauma history, drug and alcohol use, suicide).

Participants who prioritize universal screening, i.e. screening for violence regardless of the presenting issue, believe the start of treatment is the optimal time to screen. They believe clients will not volunteer information unprompted, especially around sensitive or shameful topics, and Carla explained, "whatever brought them in is still extremely fresh, and they're a little bit more likely to be candid about what the issue is than they would be if their partner was in the room." Common practices for those who regularly complete violence screens at the outset of treatment are to, 1) begin by addressing client concerns for confidentiality and privacy, 2)

provide an informed consent, 3) offer clients a rationale for the violence screen (e.g. "I just tell them it's my standard practice, because I don't want to miss anything"(Brett), and 4) explain the separate interviews as information gathering in support of reaching treatment goals. Therapists report that they use time in individual interviews for many purposes, such as to build alliance with both partners, and to assess individual agendas for treatment.

Among those participants who do not practice a universal screen as a regular protocol, most will take some action to identify abuse eventually in the course of treatment, and the timing of when this occurs may vary greatly: "I do meet with couples separately, at some point in the therapeutic process, depending on the presenting issue" (Melissa). For many participants, the results of the written intake and the presentation of the couple influence when and if further screening takes place. This was echoed by the statements of Carla:

> I think every couple is different, just like every client is different….You kind of have to be where the client's at, and just kind of follow that path, and keep a mental checklist and check those things off kind of on your own. I think that that responsibility falls on the clinician.

Inconsistent use of written assessment. Seven of ten participants in this study reported the use of some form of a written screen for identifying violence consistently across couple clients- this varies on a spectrum from including at least one violence-specific question within standard intake paperwork to the use of a specific written measure in addition to standard intake paperwork. No therapists in this study reported the use of a standardized violence screen, and some participants had not previously considered use of a written measure for violence. Many participants offered opinions supportive of the practice- including those who do not currently use written screens (e.g. it may cut down on time needed for individual assessment, it may be more reliable than a verbal interview because people are more open.)

Two participants stated that they start with written surveys, which are completed independently and administered uniformly. Both of these participants look for discrepancies between partners in written reports, and use written assessments as a platform to create a problem inventory for treatment. The other participants have only one person complete the written intake. Written assessments address a variety of different topics, such addiction, affairs, agenda for therapy, trauma history, and drug and alcohol use.

Among participants who do not use a written screen, several negative reactions to the practice were offered. These included doubts as to the validity of results, expecting false negatives, doubting clients' written abilities in low-income settings, believing that it is unnecessary because they can get the same information by talking to the client, fears related to seeming too clinical or impersonal, and concerns that adding additional paperwork in an already laborious intake process will turn clients away. Brett explained his concerns about written materials:

> If I'm throwing papers at them early on ... maybe later at sessions three, four, five ... maybe later it would make more sense as there is more rapport and alliance built, then I would feel more comfortable with that idea. But right away I would rather talk and get to know them. With that concern maybe they won't come back and…. if they've been suffering through any sort of abuse for a while, I would hate them to leave my office and not get back in with someone else because they wanted to talk, and I throw them a paper. So that's really my concern.

One participant stated that it is not a good stand-alone practice without being also accompanied by an interview. Carla is not opposed to the idea and the intent behind using written assessments, though she doubts that a written intake would be completed for some clients, even if she gave it to them:

> I would do it. I don't have any reason not to do it, but I find that so many people show up here without their initial paperwork done, I'm not sure they're going to do that for me. You know? I find with that type of thing, it's easier for me to just memorize the form, and just ask them, and just kind of make little notes.

Inconsistent use of verbal interviews. Seven of fifteen participants interviewed conduct separate interviews of partners. Conjoint sessions are often used for diagnostic information obtained through observing the dynamics of the couple for indicators that they need to do an individual screen, as well as time for psychoeducation on violence. Anna described her approach to conjoint assessment for history and presence of violence: “I simply ask, "Have you ever, either of you, been exposed to violence?" Then I describe what I mean, that it could be verbal abuse, sexual abuse, physical abuse. I define that for them, that it includes those things, and I ask about ever, now, or at some earlier time.” Similarly, therapists carry out individual interviews for various reasons- to understand more about the couple dynamic, client emotions, history gathering, and to assess the individual agenda for seeking therapy. The use and timing of individual interview depends on the unique presentation of the couple. For some couples will be seen individually sooner in treatment than others, not during initiation of treatment, but three or more sessions into treatment depending on the presentation of the couple.

While this was done by some therapists in the study, many therapists admitted that they will not do an individual interview if there are not indications of control and power imbalance that arise during the conjoint interview. For example, Kristina explained that what she looks for when she first begins with a couple:

> I would say that it looks like both of them have a voice, and they both feel like they're interested in what the other person has to say. They're in tune with the other person. Those couples that feel like they're fans of each other. They're on the same team.

When couples present in this way, she is not triggered to carry out additional violence screening. Numerous participants use a combination of different factors to then determine whether they carry out steps to screen for violence, including red flags in family history, the presenting problem, and impressions of the couple. Gretchen explained her process thus:

> If I am not seeing that initially flagged, then I use my observations in my [conjoint] verbal interview to gather some more information, and I will just start out asking couples, what do disagreements in your relationship look like? Are there raised voices? Are there any physical issues? So, I don't have a cut-and-try method that I use for every couple. I use what they write, and my instincts to determine if I need to do a breakout session. I would say probably with 80% of my couples, I end up doing a breakout session because if I get any incline where there is a concern, then I'd rather be safe than sorry.

Clinical practices and perspectives continue to evolve over time. Therapist approaches to identifying violence are continually in flux as they collect greater experience and knowledge about working with couples. How therapists interpret and then respond to new information leads them to either progress toward more thorough assessment or to digress away from thorough and consistent screening for IPV. How therapists feel about screening and how they carry it out changes over time. Based on their experiences in life and in work, it is continually evolving and the way in which they carry out their work is continually evolving. For some there are significant impactful moments in their journey, which greatly shift their approach, but for many in is a gradual and ongoing practice.

Beginning therapists in the study reported often feeling anxious when faced with the topic of abuse and violence in clinical work. As novice therapists, they described fearing client reactions including client anger when asking difficult questions about violence. They also reported doubting their ability to manage those client reactions, and feared making clinical choices essentially rooted in their anxieties, as Melissa shared:

> In the past, in the early years, I would immediately stop. I might even pull one person out and confront the partner who is the one engaging in this type of behavior, but I found having that type of reaction can really, not only damage the alliance, but it can increase shame. It really isn't helpful per se.

In contrast to these novice reports, more therapists reported getting better with experience. For many participants, exposure to numerous cases of violence over their years of practice expanded their understanding of the prevalence of partner violence, as Olivia stated,

"awareness of violence probably increased over time. Again, just seeing more and more people, and hearing more stories about violence behavior and relationships... I'm on the lookout a little bit more for some of that information." Over time however, exposure to abuse in clinical cases lessens the shock and alarm felt by therapists, as Melissa described, "When we hear things like, yes, there was shoving. This is actually quite common. You know, the experience has taught me to not overreact but to still help them take it seriously." This anxiety can both increase and lessen as therapists continue to have formative experiences. Most participants reported that their anxiety lessens over time. Kristina reflected:

> As a new therapist I think I was more skittish about addressing these issues, I think I've gotten stronger over time...Then I've also gotten either burned by missing some things or having some really tragic things happen in my experience too that make me go back to feeling more skittish.

As therapists gain more experience over time and work with numerous cases, they come to learn that abuse is often present when it does not appear so, and that clinicians cannot rely on their initial assumptions about a couple, as Rebekah stated, "I've come to understand the painstaking lengths people will go to, to hide abuse." Therapists reported adapting clinical techniques through practice and experience. They believe they get better at reading clients to know what approach to take:

> I just kind of found my groove as I developed experience working with couples. I don't like to have a very cookie-cutter approach. It really does depend on the sense, working with the couple from the get-go as to kind of what process needs to happen as more information comes out, as I'm interviewing them that first session (Melissa).

Therapists adapted their thinking over time as to how to engage with clients around the topic of abuse. They learn to manage emotional reactivity to cases of abuse, and learn how to manage fears about alliance ruptures, as David described:

> I think I've figured out ways … to be able to talk about behaviors in a way that still allows me to stay connected and join with them, while still drawing very clear and firm

> boundaries about what is appropriate and okay, and not. And so I don't feel nearly as much that I risk rupturing the relationship, the therapeutic relationship in exploring those things.

Through clinical experience, therapists feel more confident in their abilities to screen while not turning away couples clients and managing client reactions. Olivia explained how her clinical experience informs her level of comfort in addressing abuse with new clients:

> I haven't scared too many people away, I guess. So, that's success in that way of being able to talk about these kinds of things. And I think not even just with regard to assessing for violence and things, but I think that just over time, my confidence as a provider has increased, which then I think translates into being able to talk about the harder things or the things that people don't really want to have to talk about. Those things that are shameful or embarrassing or whatever the case may be. So I think that those are some of the things that influence [me].

Therapists who are more comfortable with screening and assessing for violence find that they are able to be more present and engaged with clients through the process:

> I actually think I'm able to be more supportive of the client, because I'm not freaking out so I can actually sit with them and go, okay well let's figure this out. And also I think it's helpful for them if they're feeling okay about this if I'm not going, oh my gosh this is horrible, I can't believe... That doesn't make anyone wanna open up. They don't wanna feel abnormal (Marie).

As therapists feel more comfortable with addressing couples, they can move away from recommendations from training and will follow their own protocols, as Melissa explained "Over time, I've evolved that that's not a clear-cut strategy, a recommendation. There's some gray areas within it."

Discussion

Lack of uniform knowledge results in inconsistent screening practices. When a patient arrives for an annual check-up, it is unlikely that a physician would rely on the outward appearance of that patient to determine whether to check his blood pressure. What is much more likely, is that a physician would be well versed in the need to check blood pressure regularly and

systematically using appropriate tools, because it is standard protocol among doctors, and heart disease is commonly understood as a leading cause of death.

IPV is one of the leading causes of death among women and three women are murdered by an intimate partner every day in the United States (Breiding et al., 2014). These deaths are often precipitated by a pattern of abuse and violence, and literature on IPV suggests that we have a consistent, pervasive, and preventable public health issue on our hands. Yet clinicians who interface with abuse regularly are not using rigorous or consistent approaches to identify it (Schacht, Dimidjian, George & Berns, 2009). The findings of study suggest that this is in large part because the messages clinicians receive about violence and screening are not uniform, but rather are incomplete, inconsistent, and often not rooted in empirical knowledge. Without unified and consistent education and training to support the use of best practices, and without other motivating factors outside of the inclinations of individual clinicians, therapist approaches to identifying violence are entirely left up to therapist values and their interpretations of what they should be doing with clients.

Having guidelines in place for practitioner accountability to screen greatly impacts adherence to universal screening practices (Campbell, Coben, McLoughlin, Dearwater, Nah, Glass et al., 2001; Cohen, DeVos, & Newberger, 1997), but currently there is little structure in place that would serve to motivate therapists or hold them accountable. All of the participants interviewed in this study meet with couples to offer therapy services, yet each of them enters into the interaction with different priorities, orientations, norms, and perspectives of what those services should look like. Clinicians appear to be drawing their own conclusions about best practices for identifying violence in couples, which are piecemeal assembled through the disjointed feedback mechanisms to which they are exposed. This is problematic because people

are drawing conclusions based on many other factors besides the best practices that are suggested by subject area experts. Essentially everyone is practicing within different circumstances, and following their own set of procedures because they all receive different messages about what they should do.

Limitations to application of knowledge leads to heterogeneous screening practices. Among participants, there was not consistent and uniform knowledge about IPV, and so each participant has a different idea of what they are looking for in terms of indications of violence when they meet with couples. Education and theoretical orientation play a significant role in therapists' ability to recognize IPV indicators (Dersch, Harris & Rappleyea, 2006) so it is of great concern that therapists are not operating from a unified understanding of indicators of abuse. Instead, there is flawed and faulty knowledge across participants about who may be experiencing abuse.

Therapist competence for carrying out screening practices appear to vary depending on the clients with whom they are working, and their preconceived notions about race and class colors therapist thinking about the need to screen. It is deleterious for majority culture and Euro-American therapists to approach IPV from an ethnocentric perspective. The culture-focused data in this paper highlights an ethnocentric view of some respondents, indicating an assumption that IPV is more prevalent in ethnic minority groups. This misapprehension perpetuates a colonizing view that Euro-American populations are not as equally impacted. Biases and misinformation about SES and IPV leave therapists less confident when assessing clients who are culturally different than themselves, and they lack knowledge to screen for violence in culturally competent ways. Further, it is alarming to consider that some therapists are more prone to shy away from screening for violence with ethnic minorities given literature documenting increased safety risks unique to ethnic minorities experiencing IPV (Cavanaugh, Messing, Del-Colle, O'Sullivan &

Campbell, 2011; Kaslow et al, 2000; Meadows, Kaslow, Thompson, & Jurkovic, 2005), and increased rates of IPV among sexual minorities (Messinger, 2011). Therapists appear to be missing the mark when assessing non-physical forms of abuse, which suggests that they may me getting an incomplete understanding of the severity of the situation, because there is often more than one form of abusive tactics used within IPV relationships (Garcia-Moreno et al., 2006).

Research suggests that it is vital to accurately assess the unique type and presentation of abuse when discerning the appropriateness and safety of working conjointly with couples (Johnson & Ferraro, 2000). Under-assessment of ongoing abuse can lead therapists into proceeding with treatments when they have erroneously assumed greater safety than what is actually present. Literature on coercive control as postulated by Evan Stark is noticeably absent in the therapists' conceptualization of IPV. Stark has challenged the IPV field in relation to its over-focus on IPV as an expression of physical violence and sexual assault, while overlooking many other forms of IPV (e.g., emotional abuse, abduction-like strategies used by abusers) (Stark, 2007). While several participants mentioned occasional use of the power and control wheel, initial screening practices reported overwhelmingly prioritize physical violence. This offers strong evidence to support Stark's critique of the field that therapists' clinical training and practice is not rooted in an understanding of coercive control, and as such ,they are not equipped to detect this kind of control. Therapists likely lack the common language to capture these complexities, which is perhaps sequestered to the realm of subject area experts. Educational requirements for competency around the topic of abuse and violence are lacking (Cervantes, 1993; Haddock, 2002; Stover & Lent, 2014), while it is not possible to predict the presence of violence based on race, class, religion, or economic standing (Archer, 2006), that is essentially what appears to happen for many couples who seek help when a universal method of screening is

not the standard of care.

Lack of knowledge about screening recommendations affects therapist practices. There are numerous sources of recommendations for the practice of universal screening by therapists (Bograd & Mederos, 1999; Todahl, & Walters, 2009). Yet across participants, there are wildly different understandings about what universal screening entails and how it should be carried out. Most of the participants interviewed are not familiar with recommendations for universal screening nor the tools and measures that have been developed for this purpose. Therapists are not receiving accurate or in some cases any current information about how they should be identifying violence in couples. Instead, many therapists are practicing following the limited knowledge that they have about how to identify violence, or they are discouraged from following more thorough practices because of erroneous assumptions and beliefs that have not been disconfirmed for them. This finding is similar to other research that provider attitudes and concerns impede them from screening (Dowd, Kennedy, Knapp & Stallbaumer-Rouyer, 2002; Minsky-Kelly, Hamberger, Pape & Wolff, 2005; Samuelson & Campbell, 2005). For example, several participants in this study were greatly averse to the prospect of using a written measure, despite recommendations from experts that the validity of a violence screen is greatly increased when a written component is added to an in-person interview (Aldarondo & Straus, 1994; Jory, 2004; Todahl & Walters, 2011). Many clinicians in practice do not have extensive knowledge about screening practices, and so clear guidance from regulating bodies is necessary.

The American Association for Marriage and Family Therapy (AAMFT) has included screening and safety planning for domestic and physical violence as a core competency in the domain of Clinical Assessment and Diagnosis, (AAMFT, 2004) though has not issued a recommendation for the use of universal screenings for IPV. Nor have they specified what

screening for violence should entail. It appears that the wealth of information about universal screening developed in academic circles has not been translated into the knowledge base of therapists practicing in their communities. This is a missed opportunity because all participants desire to practice safely, and they expressed a willingness to improve their practices. However, if they are going to change the routines they have been using possibly for many years, they will need clear and specific guidance about what they should do instead. Until therapists have uniform knowledge of what they are supposed to do and how to carry it out, their concerns about screening identified in this study will continue to be an impediment to more thorough and universal screening practices.

Eclectic experiences of training shape therapist perceptions of violence screening. There is very little consistency in the education and training which participants have received about screening for violence. Therapists are not learning about IPV and screening from only one source, and what they are learning is often inadequate. Each participant has a unique path to the knowledge that they use to make clinical decisions about identifying violence in couples, and this learning is not a one-time occurrence. Rather, clinicians are gathering information throughout clinical training, work experiences, conferences and other informal sources. Clinicians may then be receiving information that is contradictory, and perhaps in conflict with expert recommendations. Participants who have crossed paths with instructors or supervisors who are passionate about violence have made it a priority in their teaching and instruction. Clinical supervisors appear to present an avenue for individualized support for competent practice with couples and violence. Supervisors have played a significant role by sharing knowledge of best practices, as well as supporting therapists in clinical development. Addressing violence with couples makes new therapists highly anxious (Todahl, Linville, Chou & Maher-

Cosenza, 2008), and supervision around work with violence should support the self-of-the-therapist development relevant to such work, consistent with other findings (Karakurt, 2013.)

For a small number of participants, negative and traumatic experiences with clients have prompted individual motivation to revise their practices so as not to make similar mistakes moving forward. While these learning experiences have been significant for the participants in this study, these meaningful learning opportunities are a matter of change and opportunity, rather than the result of standardized instruction that all providers receive. There are no national standards of education in IPV or DV for social service providers (i.e. social work, marriage and family therapy, psychology, counseling), and required hours of training in this area are minimal across states (Stover & Lent, 2014). Avis (1992) has argued that a course on treating IPV in families be included in MFT training curriculum, though currently such a requirement is not in place. Such resources are available. For example, Haddock (2002) has offered a 20-hour curricula for use in training of family therapists for skills in assessment and intervention in partner abuse. Continuing education is one way to achieve this goal, although many states do not have CEU requirements, and mandating requirements of IPV content area may be difficult to achieve.

Insufficient training and supervision for carrying out violence screens has been documented as a common barrier to implementation of screening (Iverson, Wells, Wiltsey-Stirman, Vaughn & Gerber, 2013; Jaffee et al., 2005; Larkin, Rolniak, Hyman, MacLeod & Savage, 2000; Sugg & Inui, 1992), yet avenues for creating standardized knowledge of abuse and screening, namely through requirements for education and requirements for licensure, are not currently being maximized to support provider competency in this area. In the absence of clear and consistent messaging about the best practices they should follow, clinicians are instead

piecing together a story about what they should be doing. This situation is problematic for the field of MFT because currently these are not reliable avenues for producing uniform knowledge and standards of care among the vast number of clinicians working with couples.

Eclectic experiences of work settings shape therapist approaches to assessment. Though individuals have agency in how they adapt to the contextual and organizational factors that affect their protocols, the context in which therapy occurs presents numerous variables that both support and hinder violence screening activities. There are benefits and drawbacks to a more structured environment. More structured practice settings support more consistent screening practices, similar to other findings on the importance of institutional support (Allen, Lehrner, Mattison, Miles & Russell, 2007; O'Campo, Kirst, Tsamis, Chambers & Ahmad, 2011; Tower, 2003) and greater flexibility also means that therapists have little external motivators to screen for violence, and are unlikely to do so if not internally motivated. However, settings in which therapists have greater flexibility with their practices allows them to use time with clients as they see fit and they are able to choose and modify their intake materials as they wish. Beyond this, we also find organizational culture plays a role in supporting screening practices, because clinicians talk to each other and share best practices and lessons learned through experience.

Gremillion and Kanof (1996) have offered four categories of screening barriers experienced by physicians, and identified institutional and legal barriers, such as constraints of time and reimbursement structures as relevant factors. This study has echoed this conceptualization, and found that elements of insurance reimbursement presents a complicating factor for carrying out individual interviews with clients. It is concerning that there may be instances where limitations on reimbursable services by insurance companies have the potential to supersede the clinical needs of couples. The participants in this study who do prioritize

spending individual time with partners to ascertain the level of safety in a couple, have adopted a "Where there's a will, there's a way" approach to getting reimbursed for their time spent with clients which highlights the tension between perspectives of providers and perspectives of third-party payers. We know that ascertaining the presence of violence is imperative in determining appropriate avenues for care (Johnson & Ferraro, 2000), so why is it not similarly valued by insurance companies who are invested in supporting the health and safety of their clients?

If universal screening is the ultimate goal, we cannot rely on the practice setting to enforce the practice, firstly because there are vast differences across practice settings and not all couple therapists are practicing in agency settings, and secondly because even in group and agency settings, the perspective of the individual clinician plays a very significant role in how routines are carried out. If universal screening is to become the norm for all MFTs. regardless of the setting in which they practice, then requirements for universal screening must transcend the contexts in which clinicians practice.

Inconsistent routines despite a desire for safe practice. It is very important to note that all clinicians interviewed in this study agree that it is unsafe to attempt couple therapy when there is ongoing abuse. Consistent with other findings (Wiist & McFarlane, 1999), knowledge about violence itself does not motivate clinicians to change their practices. So, while among therapists there is strong support of the concept of screening in the abstract, it does not appear to be of sufficient value that motivates changes in practice behaviors for many therapists. This study found that therapist knowledge of screening practices often does not align with recommended practices. Considering the tremendous gap between what researchers say therapists should do, and the guidance actually provided to therapists in practice, it is not surprising that support for screening does not fully translate to adherence to universal screening recommendations.

Perpetrators deceive and minimize the abuses they commit (Sugarman & Hotaling, 1997) and are unlikely to disclose to a therapist an imminent plan for future assault, yet in the absence of a clear and imminent plan of physical violence toward another individual, therapists are not mandated to report adult abuse. This is a missed opportunity given that 65% of women who are murdered by their partners are physically abused by their partners prior to the homicide (McFarlane, Campbell, Wilt etc., 1999), and prior domestic violence arrest are associated with lowered risks for intimate partner femicide (Campbell et al. 2003). Therefore, one of the best approaches to decrease intimate partner homicide is to identify and intervene with battered women at risk.

Some domestic violence experts have argued for mandated reporting laws that apply to IPV abuse as a vulnerable party (Cervantes, 1993; Cervantes & Hansen, 1997; Jory & Anderson, 2000; O'Leary & Murphy, 1992). Mandated reporting laws for health care providers have been enacted in all but three US states, though applying mandatory criminal injury reporting laws to is arguably not in the best interest to those living with IPV (Durborow, Lizdas, O'Flaherty, & Marjavi, 2010). The most essential services that health care providers can give offer survivors are ongoing and supportive access to medical care, addressing safety issues, and guiding patients through available options, yet laws mandating screening by health care providers currently exists in only three US states (Durborow *et* al., 2010). Studies have found that when providers believe they are obligated to screen for violence they are more likely to do so (Coker, Bethea, Smith, Fadden & Brandt, 2002), and a lack of mechanisms of accountability hinders rates of universal screening (Allen et al., 2007; Campbell, Coben, McLoughlin, Dearwater, Nah, Glass, et al., 2001; Larkin, Rolniak, Hyman, MacLeod, & Savage, 2000.) Because therapists are not required by the state to assess for adult abuse and history of violence, requirements for safe practice are

left up to the interpretation of the individual clinician. This study instead has found that most therapists believe they are meeting requirements for safe practice, which may be in part because the actual practice requirement placed on therapists have set the bar very low with regard to violence screening.

Therapists rely on individual intuition. Most of the participants interviewed in this study leave some aspect of their violence assessment process up to own ability to sense the presence of violence. Because therapists are not receiving a clear and consistent message about the necessity of universally screening all couples for violence, they instead see violence screening to be an as-needed practice, and rely only on themselves to sense when it is needed. Essentially, they discern the possibility of abuse which then motivates them to take action and assess the couple specifically for history of violence. It has been repeatedly found that abuse often goes undetected by therapists (Hansen, Harway, & Cervantes, 1991), and that therapists are very likely to underreact to indicators of abuse when they are present (Froerer, Lucas & Brown, 2012; Hansen, Harway, and Cervantes (1991.) Apparently, a consistent rational for the universality of violence screening is evidently not reaching therapists and as long as clinicians operate from the understanding that they can reliably detect abuse unaided, it is unlikely that they will buy into the necessity of universally screening all couples regardless of presenting issue.

If the clinician also believes that screening for violence is both burdensome and potentially off-putting to clients as has been documented in this and other studies (Dowd, Kennedy, Knapp & Stallbaumer-Rouyer, 2002; Jaffee et al., 2005; Sugg & Inui, 1992), the clinician is unlikely to risk losing a client for a practice he or she does not believe is necessary. The result is that therapists often engage with couples experiencing ongoing abuse, though the therapist may not recognize it that it is ongoing (Jose & O'Leary, 2009; Kamimura et. al., 2014;

Madsen et al., 2012), and put both couples and themselves at risk. In so doing, therapists miss opportunities to intervene and offer resources, education, and other appropriate treatments that could be of benefit to the safety and wellbeing of vulnerable clients.

Inconsistent routines of screening and assessment. Given the inconsistencies in therapist knowledge and education about IPV in clinical populations, inconsistencies in therapist knowledge and education about violence screening practices, the inconsistencies in contextual elements imposed by the practice setting, and the lack of uniform beliefs in the necessity of universally screening for violence, it is not surprising to find that clinicians report vastly different practices. While we already know that there are great inconsistencies in screening practices across settings as well as across individual clinicians (Phelan, 2007; Stayton & Duncan, 2005), it also appears that there are great inconsistencies within what a single therapist does, as this can vary from client to client.

Therapists do not follow the same procedures in the same ways and sequences with each couple. Instead, they change what they do according to the presenting issue and their perceptions of the couple during intake and early treatment. It is possible that some clinicians are too aggressive in how they ask about abuse and don't attend to alliance, while others shy away from addressing the issue directly in fear of hurting the alliance. Both of these approaches can negatively impact the validity of information gathered.

Confusion, misconception, and doubt about violence screening complicates therapist perceptions of written screens and separate interviews. For several participants, a single item on a standard intake form with possible follow-up questions is the extent of screening activities. No participants stated that they use a standardized measure for violence screening. Despite availability of numerous violence-screening tools for clinical practice, they are not being used

broadly in community practice. Therapists are predisposed against using written materials, and see them as an additional step to be added into an already cumbersome and lengthy intake process. Despite similar doubts and confusion, more participants use individual interviews than use written screens. It may be that therapists are more confident in discussing violence with clients, yet less knowledgeable about written tools and how to use and score them.

Therapist practices for screening and identifying violence in couples appears to fall upon a spectrum from no established practices, to universally adhering to recommendations. This echoes similar findings on the low rates of adherence to recommended practices (Schacht, Dimidjian, George and Berns, 2009.) It seems that not only are there gains to be made in knowledge of how to address violence with couples but also for the universality of those practices.

Clinical practices and perspectives continue to evolve over time. Therapists continue to evolve in their views and practices as they gain greater experience. Discussing abuse with clients is a topic that makes many therapists highly anxious (Karakurt, 2013; Todahl, & Walters, 2009), and which impacts how the therapist caries out the screen. Those who do not effectively manage their anxieties around violence topics may be less equipped to take on regular screening practices. Those who learn to manage their anxieties over time feel more confident. Therapists need guidance on how to manage complexities of violence screening, rather than making clinical decisions rooted in anxieties. Some participants reported that they feel they have mastered the ability to assess for violence while also maintaining the therapeutic alliance throughout the assessment. Therapist reservations about validity of screening results may lessen as they develop in their ability to establish and maintain a strong alliance with clients throughout the process.

Consistent with other findings (Karakurt, 2013), the developmental processes of the

therapist have strong implications for the screening protocols that therapists use regularly. Early trainings are a time of opportunity for shaping clinicians and their practices. Modeling of practices by instructors and supervisors appears to strengthen clinical awareness as well as model some screening protocols, which many participants have continued to use throughout their careers. While discourse with colleagues and supervisors impacts general knowledge and awareness of violence, clinicians also need more direct instruction on how to carry out violence screens effectively, whether in training programs or post-graduation through continuing education and clinical supervision. Beyond the rote learning of approaches to screening, clinicians also need to be supported and guided on how to manage their emotions and anxieties when addressing the topic of abuse. Clinical supervision is an avenue to help clinicians' process fears and anxieties that prevent them from directly addressing violence with clients. Ongoing supervision can improve self-efficacy and feelings of confidence.

It would be simple to assume that as clinicians feel more confident having discussions about abuse with clients, that they would then screen more frequently. However, this is not always the case. Some of the participants in this study reported that as they became more comfortable with screening for abuse, they instead became less systematic in their approach to violence screening. Clinicians need guidance and support in their development of competencies when addressing violence with clients, so that they are guided in the direction of greater adherence to practice standards.

Limitations. The purpose of this study was to explore in depth and achieve rich descriptions from participants as to their processes for couple universal screening. This qualitative approach may be seen as a limitation if one views it from a quantitative lens, though that is not the view of this researcher. Concerns about confidentiality and anonymity and possible negative

consequences may affect participants' ability to be fully forthcoming in their responses (Anderson, 2010). This study was not intended to measure or track clinician practices, but rather explore their work from their own perspectives and insights. As such, this relies upon their perspectives and what they describe their practices to be. Sampling may also present limitations because randomization was not a consideration. All participants were all volunteers and an interest in the subject may have influenced participant's desire to participate. There was some homogeneity in the gender and ethnic makeup of clients, and demographic, experience, and age factors of the small participant pool present some limitations to generalizability. Further, the participants in this study are all licensed and practice in the same Midwestern state, which presents some limitations to the generalizability of findings, and it can be assumed that some degree of difference in findings would be found in a sample practicing in a different state and under different licensure requirements.

Conclusion and Implications

Standardization of best practices. All couple therapists need to receive the same message about screening and assessment for violence if rates of screening are to increase. There are significant gaps in what couple therapists know about IPV, gaps in what they know about screening and assessment, and inconsistencies in what they believe are best practices and ethical obligations, all of which contribute to the inconsistencies found in therapist practices. Therapists look to professional associations for guidance, and are willing to improve their practices, though uninformed about how to do so but have not received a decisive message about what they should do with clients.

There are numerous sources of recommendations from researchers on how best to screen for violence, but greater clarity is needed from the field of MFT to produce a uniform standard of

care, and dissemination efforts undertaken to reach all practicing clinicians. Firstly, therapists need unambiguous guidance about how to screen each partner privately, what information should be obtained at intake, and how best to gather that information. If screening for violence is built into therapist expectations for a comprehensive intake with couples, then rates of screening will likely become much more consistent. Secondly, if written screens are to be used more frequently then therapists need to be provided with instruction about what screening tools to use, they must be easily applicable to practice, and they must be made readily available to all therapists in practice. Thirdly, there is little relevance in having strong screening procedures if therapists do not have effective referrals to providers and agencies in their communities with the required expertise and commitment to serving populations affected by IPV. Communities need to have these resources to which therapists can refer, especially for high risk cases. IPV cannot be confidently addressed when therapists are not also armed with a strong network of services and key community agencies capable of supporting them in such difficult work. This is possibly as essential as implementing strong screening procedures. In any IPV detected situation, therapists must have access to immediate referrals to appropriate services to ensure the safety of survivors and children, as well as access to programs for abusers if perpetrators are receptive to the idea.

Standardization of clinical training and supervision. If screening practices are to become more uniform and rigorous all couple therapists should be receiving the same instruction and education about violence and screening, and so standardization is needed for clinical training and supervision of couple therapists. Currently the level and quality of education couple therapists receive about IPV and screening is a matter of chance. As a result, therapists are operating from very different sensibilities about IPV, and have very different ideas about how to identify it. Standards for accreditation should require thorough knowledge of typologies of IPV, culturally

competent screening and assessment for violence, and appropriate responses to various presentations of violence following initial screening. Clinical supervision should facilitate competent application of universal screening, and support beginning therapists to manage the complexities of screening as well as the anxieties that beginning therapists' experience. Therapists need uniform education not only on what to screen for but also uniform guidance about how to carry out that screen.

External mechanisms of accountability. External mechanisms are needed to produce therapist accountability to follow violence screening recommendations. We cannot rely on agencies or individuals to ensure that violence screening occurs because there are so many different variables in individual knowledge as well as contextual inconsistencies so other strategies of enforcement are warranted. Therapists take very seriously ethical obligations and state requirements about abuse and neglect of minors however, there are no clear legal requirements or guidance for identifying violence in adults in most of the US (Durborow *et* al., 2010). Requirements for continuing education and licensure can support long-term adherence to screening if it is included in requirements for competent care. If screening is not required of all clinicians it will continue to be an at-will procedure. Laws for mandating screening of adult interpersonal abuse should be created, and codes of ethics for competent universal IPV screening should be established.

The need for ongoing training post-graduation. If good practices are to remain consistent in the years following graduate training and obtaining licensure, couple therapists need ongoing reinforcement of current knowledge and best practices. In many states, such as the state in which this study was conducted, have no licensure requirements for clinicians to maintain updated practices. This study finds that therapists evolve their clinical practices and norms throughout

their years of practice and in order to ensure that this evolution furthers universal screening rates rather than erodes them, quality courses and continuing education should be available. Requirements for continuing education specifically relevant to IPV knowledge and screening should be put in place to ensure that all couple therapists are kept current and practicing form updated knowledge about violence.

The need for future research. Several possible areas for further investigation can be identified in the current study. A greater understanding of the implications for culturally competent screening of couples is needed, not only across ethnic groups but also with regard to non-heterosexual couples, as well as differences in SES and how therapist perceptions impact their clinical actions. An investigation of the role that gender plays in how therapists carry out their screening activities was not a major focus of this study, and warrants further exploration. Fears of negatively impacting the therapeutic relationship is a perceived barrier to violence screening, yet this study showed that some therapists have skills that allow them to ask these questions while also maintaining a positive therapeutic alliance. This is a finding that should be researched further to determine not only the accuracy of this perception but also identify clinical techniques that support alliance while screening for sensitive topics like IPV. Finally, therapist use of intuition and gut instinct emerged as an important finding. Therapist instinct is not to be disregarded, but should be further explored with regard to the topic of violence screening. This is especially important given the risks of therapists relying too much on intuition, when we do know from the literature that therapists are often mistaken in their perceptions of therapeutic processes. While participants in this study did not use the language of coercive control, it is possible that this is the phenomenon that they sense when describing the use of intuition. Regardless, a more nuanced understanding of how therapists use intuition when addressing

instances of violence and how this process differs across clinicians warrants further study.

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CHAPTER 5: PAPER TWO

The Influence of Therapist Experiences of Violence on Their Clinical Practices to Identify Intimate Partner Violence

Abstract

This qualitative study explored how therapists' life experiences of violence influence their approaches to screening for violence when working with couples. This study is part of a larger project which explored ecosystemic influences on therapist violence screening practices. In-depth interviews with fifteen licensed marriage and family therapists indicated that experiences of abuse and violence in early life, in adult relationships, and through clinical work with cases of abuse, all have a direct bearing on clinical practices of abuse, and that therapists develop strategies for managing their reactions. Implications for therapist training, supervision, and personal wellbeing are discussed.

Introduction

Intimate Partner Violence (IPV) is a tremendous public health issue affecting millions of Americans (1 in 5 women and 1 in 7 men in the US; Centers for Disease Control and Prevention [CDC], 2018), and in the US an estimated $7 billion is spent annually on medical and mental health care as a result of IPV (Brown, Finkelstein & Mercy, 2008). Exposure to IPV has detrimental and lasting effects on an individual's mental, physical and emotional wellbeing (Coker et al., 2002; Plichta, 2004; Sutherland, Sullivan, & Bybee, 2001), and overall leads to negative outcomes which increase in severity the longer one is exposed to violence (Bonomi, Thompson, Anderson, Reid, Carrell, Dimer, & Rivara, 2006). IPV is all too common within the general population, though the presence of IPV cannot be assumed or predicted based on race, age, relationship constellation, socioeconomic status (SES), or education level (Barnett, Miller-

Perrin, & Perrin, 2005.)

In therapy-seeking couples specifically, IPV is highly prevalent (Greene & Bogo, 2002), with an estimated 60% of couples experiencing physical abuse (Ehrensaft & Vivian, 1996). One study of therapy-seeking couples found that only 20% met the characterization of "no violence" (Simpson, Doss, Wheeler & Christensen, 2007), though presentations of IPV among couples are not homogeneous. Johnson and Ferraro (2000) introduced three typologies of violence including Intimate Terror, Violent Resistance, and Situational Couple Violence. While the majority of IPV presented by clients seeking outpatient therapy is low-level or Situational Couple Violence (Ehrensaft & Vivian, 1996; Jouriles & O'Leary, 1985; Langhinrichsen-Rohling & Vivian, 1994; O'Leary et al., 1992), and while there is encouraging research emerging for the effective treatment of abusive patterns in couples (Cleary Bradley & Gottman, 2012; Karakurt, Whiting, Esch, Bolen & Calabrese, 2016; Simpson, Atkins, Gattis & Christensen, 2008; Stith, Rosen, McCollum, & Thomsen, 2004), these positive outcomes have typically only been found when administered with Situational Couple Violence presentations. Attempting traditional couple treatments in cases of abuse remains unsafe for many clients, especially in the case of intimate terrorism (Friend, Cleary Bradley, Thatcher, & Gottman, 2011), and ethically risky for clinicians (Cervantes, 1993). Couple therapists are thus in the difficult position of needing to determine whether violence is ongoing, as well as the type of violence present in order to move forward with treatment safely and effectively (Blasko, Winek, & Bieschke, 2007; Rappleyea, Harris & Dersch, 2009).

In our companion study (Parker et al, under review), we concluded that some practicing clinicians rely on their own intuition and impressions of clients in their decisions to guide screening practices, a finding we critique as a dangerous practice in that much research suggests

that clinicians cannot reliably identify the presence of violence (Aldarondo & Straus, 1994; Dersch, Harris & Rappleyea, 2006; Hansen, Harway, & Cervantes, 1991). Adequately screening for violence is considered a clinical competency. For example, the American Association for Marriage and Family Therapy includes screening in their list of clinician competencies (American Association for Marriage and Family Therapy, 2004), and many have offered recommendations for the use of universal violence screening (Bograd & Mederos, 1999). Despite this, very few clinicians follow established guidelines for effective and universal identification of violence at the outset of treatment (Allen, Lehrner, Mattison, Miles & Russell, 2007; Daire, Carlson, Barden, & Jacobson, 2014; Schacht, Dimidjian, George & Berns, 2009), and as we discussed in our companion study, therapists who do screen have widely divergent approaches. Many therapists only actively assess for abuse if clients directly report that physical violence within their relationship is a presenting issue, something which most clients are unlikely to do without prompting, despite the presence of violence (Stith, Rosen, Barasch, & Wilson, 1991). Further, therapists may overlook overt indicators of abuse included in self-report intake materials (e.g., marking concerns about physical violence and controlling behaviors of a partner as a concern for therapy; Froerer, Lucas & Brown, 2012).

Investigations of use of universal screening finds that screening varies greatly according to the context but also across clinicians (Phelan, 2007; Stayton & Duncan, 2005). In the companion study (Parker et al., in progress), we found that screening practices vary greatly within a therapist caseload, and that in the absence of controls, practitioner elements become more significant, especially in environments where there is less external control or accountability enforcers. However, there is limited research to explain reasons *why* screening practices are so inconsistent at the level of the clinician (Todahl & Walters, 2011). The emotions and

preconceptions of clinicians appear to greatly influence therapist approaches to violence work (Brosi & Carolan, 2006; Todahl & Walters, 2011; Watson, Carthy & Becker, 2017).

Many therapists are driven by their own value-based worldviews, and many may not acknowledge how such values shape their decisions in the therapy room (Blasko, Winek & Bieschke, 2007; Inman and Baron, 1996). Inman and Baron (1996) concluded that one's perceptions are biased by specific expectations regarding prototypical perpetrators and victims, rooted in our most typical images of whom we are most likely to identify as perpetrators and victims. Blasko, Winek, and Bieschke (2007) applied this theory to the context of family therapy, and found that the prototypical perceptions of therapists have an effect on the therapeutic processes with clients in their assessment of and intervention with cases involving domestic violence. Therapists' personal conscious, unconscious, immediate, or delayed reactions to clients have long been understood as important to the process of treatment (Kernberg, 1965), and some research has extended the inquiries of therapist preconceptions of abuse beyond the cognitive level of bias, into explorations of countertransference or self-of-the-therapist work (e.g., Aponte& Kissil, 2014; Scharff, 1992) to understand from where therapists preconceived notions, biases, and emotional reactivity stems.

From early years of psychoanalysis to current approaches to family therapy, there has been consistent recognition that the person-of-the-therapist plays a meaningful role in the therapeutic process (Aponte & Kissil, 2014), and family therapists' experiences and their backgrounds cannot be separated from their professional selves (Yusof & Carpenter, 2015.) Countertransference results from various factors (Siegel, 1997), but it is described as the spectrum of reactions to transferences of clients, as well as the therapist's own displacements, projections, or distortions that occur in therapy, both consciously and unconsciously (Timm &

Blow, 1999). All therapists experience countertransference (Hayes, Nelson & Fauth, 2015) and the most common manifestations of countertransference reactions are anxiety, avoidance, and distorted perceptions (Gelso & Hayes, 2007). In general practice, countertransference reactions cause therapists to misperceive clients, leading to inaccurate diagnoses, mis-conceptualizations of cases, and possibly erroneous treatment choices (Hayes, Nelson, & Fauth, 2015). Failures in attending to countertransference reactions leave clinicians ineffective in resolving difficult impasses in therapy treatments (Moltu, Binder & Nielsen, 2010) which can result in premature terminations (Hill et al., 1996).

While not all clinical cases will trigger countertransference reactions (Fauth & Hayes, 2006), the topic of abuse and violence is consistently found to be anxiety producing for clinicians (Brosi & Carolan, 2006; Todahl, Linville, Chou & Maher-Cosenza, 2008; Todahl & Walters, 2011), and treatment of intense clinical issues such as partner abuse can bring about strong emotional feelings in the therapist (Goldner et al., 1990; Register, 1993). Watson, Carthy and Becker (2017) studied therapy provided to females experiencing IPV, and found that when therapist's emotions were heightened by thoughts of self-doubt, they demonstrated avoidance, made assumptions about client experiences, and focused on individual symptoms rather than the relationship abuse. Therapists' reactions to their clients and the management of their reactions affect the process of psychotherapy (Fauth & Hayes, 2006; Gelso & Hayes, 2007; Hayes, Nelson, & Fauth, 2015) most especially when client families are similar to the therapist's family of origin (Braverman, 1984; Titelman, 1987). Brosi and Carolan (2006; pg. 126) examined the ecological influences on therapist responses to partner abuse and concluded that "one's understanding of self is critical to successfully addressing and working clinically with partner abuse" and that countertransference reactions have the potential to interfere with a clinician's

capacity to be an objective member of the therapeutic process. A case study by Strawderman et al., (1997) examined reactions of a therapist trainee treating a battered woman and concluded that the ability to recognize personal variables is necessary in order to inform the specific therapeutic approaches chosen by therapists when working with issues such as partner abuse.

Of central importance in the understanding of countertransference is how therapists use their experiences of relationships (Flaskas, 2007), yet several authors argue that research of therapist variables in couple therapy are greatly neglected (Blatt, Sanislow, Zuroff, & Pilkonis; Blow, Sprenkle & Davis, 2007; Lebow, 2006; Najavits & Strupp, 1994), and this is true in the violence screening literature as well. The central goal of this study is to explore how therapists' personal experiences of violence influence their clinical work with couples, specifically around the identification and screening for the presence of IPV with couples. The current study examines the link between therapist individual experiences of violence and clinical work, to understand more about the processes by which couple therapists draw on their life experiences to guide their clinical choices.

Methods

Clinicians licensed and practicing as Marriage and Family Therapists were interviewed about life experiences with violence that informed their thinking and choices with regard to universal screening for IPV. The exploratory nature of this study lends itself to the use of qualitative research and thematic analysis, which is an approach to recognizing, analyzing, and representing recurrent patterns of certain themes in a defined set of data; thematic analysis organizes information from a data set around the structure of themes that are established in the existing literature on the topic, while also allowing for the addition and generation of new and different themes that are identified in the data (Boyatzis, 1998). The research question guiding

this study is as follows: *How do therapist life experiences influence their approach to screening for violence with couples?*

Participants. Purposive sampling was used to recruit participants who were 1) licensed and actively practicing clinicians; 2) who regularly work with couples; 3) have at least two years of clinical experience post-graduation; and 4) have obtained a master's degree or higher in a clinical program. Participants were recruited for this study who met these inclusion criteria. Excluded from the study were 1) participants who were trained but not actively practicing; 2) who were licensed to work in the field, but who do not engage in direct client contact; and 3) those who do not work with couples. Clinical practice is defined in this study as engagement with couples for the purpose of talk therapy. Other forms of involvement with clinical work such as case management and supervision of therapy do not meet the inclusion criteria and these individuals were not solicited for interview participation. Clinical work with couples is defined by a treatment focus located on the relational dynamics of the couple. Clinicians who currently practice within a setting that is specifically targeted to Intimate Partner or Domestic Violence services, i.e. shelters or advocacy, were excluded from this study because of the potential to produce a skewed sample.

A total of fifteen interviews were completed with participants, and each interview lasted between 45 and 90 minutes. Participants were interviewed either in their offices or through a secured video connection. The years of clinical experience within the sample ranged between 2 and 51 years. Pseudonyms have been used in this paper to protect the identity of participants; other details such as participant age have been omitted to protect participant anonymity. Table 5. 1 provides an overview of participant demographic details.

Table 5.1 Demographic characteristics of participants

Demographic Characteristic	n	%
Gender		
Male	4	26.6%
Female	11	73.3%
Age		
20-29	1	6.6%
30-39	7	46.6%
40-49	1	6.6%
50-59	3	20%
60-69	1	6.6%
70-79	1	6.6%
80-89	1	6.6%
Religious Affiliation		
Christianity (no denomination identified)	6	40%
Catholic	4	27%
Agnostic	2	13%
Jewish	2	13%
Spiritual	1	7%
Ethnicity		
Caucasian	14	93%
Latino	1	7%
Years in Practice		
1-5 years	4	26.6%
6-10 years	4	26.6%
11-30 years	4	26.6%
31-60 years	3	20%
Current Practice Setting		
Private Practice	11	73.3%
Community Agency	2	13.3%
Private Practice and Community Agency	2	13.3%

Data collection. Semi-structured interviews were completed with participants. All interviews were carried out by the first author who is a practicing clinician and a doctoral-trained researcher. Participants were provided an informed consent prior to scheduling an interview, and details of the conditions of anonymity and confidentiality of participant answers were reviewed before the interviews began. Participants were first asked to describe their current routines and practices for identifying violence in couples, and then asked to identify elements that influenced

how they came to these current practices. Participants were asked specifically about education and training, personal experiences, and professional work that shaped their practices along the way. Table 5. 2 provides a sample of interview questions used.

Table 5.2 Sample of interview questions

Question 1	I'd like you to talk me through your journey, starting from an early point in your life to now, and what experiences have informed how you think about asking clients about violence. I'd like to know all about what has influenced your thinking, your feelings along the way, and any specific experiences that have been formative for you.
Question 2	Tell me about the worst experience that you have had working with a couple that had a high level of aggression or violence? [worst= highest level of risk for the client, or greatest discomfort for you] What was it like for you to be the therapist in that case? How did that experience influence your current practice in working with couples? What were the lessons that you took away from that experience? What about that experience has changed your practices for talking with clients about violence?
Question 3	I'm going to ask you again about how your experience has shaped your philosophy and thinking about working with violence, but I ask you to expand your thinking to specifically to your personal, individual experiences, even early life. Have you ever experienced partner violence in your relationships? Would you mind telling me a bit about that? Have you had any personal exposure to violence in childhood or in your community?

Interview protocol. A semi-structured interview protocol was used to ensure consistency across interviews, while also allowing for flexibility in responses and follow up prompts (Josselson, 2013). All participants were asked a standard set of questions, with additional follow-up question that emerged from participant responses. Interviews consisted of open-ended (descriptive), and close-ended (structural) questions to clarify participant meaning and responses. Table 5.2 presents a sample of interview questions used in this study.

Data analysis. Following guidance provided by Braun and Clarke (2006), the steps of

thematic analysis were completed in a recursive step-by-step process. These phases were carried by the first author, in collaboration with the second author: (1) *familiarization with the data* in which data were collected, and transcriptions were read, and re-read with initial ideas documented and discussed with the second author; (2) *generating initial codes*, which occurred systematically across the entire data set to collate statements relevant to codes identified; (3) *searching for themes* was carried out as data was collected and organized by collating codes. Highlighting of participant statements were used to illustrate themes; (4) *reviewing themes* occurred recursively throughout data analysis and were discussed at length with the second author; (5) *defining and naming themes* occurred as specifics of each theme were refined and a comprehensive story was obtained through the data. Analysis was an iterative process through organization and refinement of major and sub themes. Illustrative quotes and contexts were considered for evidence of themes. (6) As this process was completed a final report was produced to tell the story extracted from the data in a coherent manner.

Trustworthiness. In the present study, trustworthiness was sought in several ways. The credibility of this study was sought first by becoming well versed in the literature of universal screenings for intimate partner violence. Furthermore, prolonged engagement in the field of couple therapy by the authors supports the credibility of the study as they are intimately familiar with the topic and logistics of clinical practice. At the time of research design, key informants were asked to provide feedback on the interview guide. Interviews with multiple participants who have shared a common experience were collected (i.e. regularly providing couple therapy). Researcher memoing was documented throughout the data collection phase to enhance the development of consistent themes, and an audit trail was kept throughout research activities. Analysis and findings are presented using direct quotes by participants which support

transparency by allowing the reader to identify with the interpretation and to establish integrity of the data (Williams & Morrow, 2009).

Results

The responses provided by each of the participants provide insight into how these therapists' life experiences connected to abuse and violence are a part of their practices of screening for violence with couples. The designation of the primary themes that emerged for this specific study were developed from ten of the fifteen participants recounting influences on their current violence screening practices. The emerging and descriptive categories involved personal or family-of-origin experiences of violence, influential professional experiences of working with the topic of violence, and strategies which therapists developed to manage their emotions in light of these meaningful experiences. Sub-categories from the experiences of therapists were also described and included both positive and negative ways which therapists draw on prior experiences to guide current screening practices.

Therapists draw on personal experiences of violence which shape how they approach screening couples. Therapists who have a personal history of experiencing abuse draw on those experiences to inform various aspects of clinical work with couples. Five participants described exposure to violence within their families-of-origin and five participants recounted experiences with partner abuse in their adult relationships. The responses provided by each of these participants offers insight to how these life experiences shaped how therapists broach the topic of violence with couples and their thinking about screening. The quote below, taken from Gretchen, exemplifies this theme. She described physical and emotional abuse perpetrated by her father, and recounts a time when her mother took her to speak to a therapist. While completing the intake paperwork she checked 'yes' to a question which asked about exposure to violence:

> I checked yes. And my mother said to me, you can check that box if you want, but just know that there could be consequences to that, and I erased it. And the therapist never asked me about it. And I don't know if they noticed that it was erased or not, but it didn't ever come up in conversation…… So now, I recognize that written assessment can't be the only way that we're asking these questions. With that being said, had the therapist asked me in the first session, have you ever experienced these things? I probably wouldn't - I *know* that I would not have trusted her enough to…open up about that experience. And, that's why I think the rapport comes in and I know, from my own experience, that there has to be trust there to feel safe in sharing with a stranger. Even as I'm talking now, I guess I realized that's probably part of the reason that I don't follow this set procedure because I can imagine, from my own experience, that I wouldn't have talked about that, initially, without that rapport there.

This quote demonstrated the direct connection between a past experience and how she applies this experience to her current practices. In one sense, this has a positive influence on her screening practices because the therapist recognizes that a thorough and multi-modal approach to screening is necessary. In another sense, this application negatively influences her practices because the therapist has adopted an inconsistent approach in which she determines how she screens for violence according to the quality of the relationship she senses with the clients.

Similar such reflections from other participant's current screening practices rooted in personal experience have both supported thorough and consistent practices and hindered use of uniform and consistent violence screening protocols. The sub themes described below have been organized as both supportive and harmful ways that therapists draw on significant personal experiences.

Therapists draw on personal experiences in ways that hinder their screening practices. Therapists engage in meaning-making from past experiences of family and partner violence which they apply to their work with clients. In some respects this process has limitations. When therapists conclusions drawn from their lives and apply them too directly to their work with clients, it ultimately serves to hinder their efforts in addressing violence.

Therapists minimize and project their experiences of violence. In describing their own

experiences of abuse, some of the participants exhibited some degree of minimization of the abusive situations which they experienced. For example, participant 5, Tomas, explained his retrospective view of his mother and the attributions he makes to the abuse he experienced from her:

> My mother I think was overwhelmed with not having too much emotional support from my dad [who was an alcoholic and emotionally abusive to her] and overwhelmed with all that she had to do that sometimes she took her frustration out on me and I got hit from her…I do remember getting that kind of physical violence. I see that now as her being overwhelmed.

This is very similar to what was recounted by participant 4, Anna, who explained her perspective of her father and the physical abuse that occurred between her parents:

> He was just in over his head and beyond his ability to cope…..I was really literally living in fear that my dad would kill my mother for quite a few years. It depends on how much premeditation he would have involved, because I thought he was going to kill her by accident or in the heat of passion, but not that if you ask him in a quiet moment, "Do you want to kill her?" he wouldn't even in the privacy of his own mind think 'yes'

Participant 4 further explained how her experiences with her parents have shaped her thinking about assessment of violence in couples, and how she draws on that to guide her clinical work. In this example, the therapist runs the risk of projecting her own family-of-origin content onto the clients with whom she works. The dynamic reportedly improved between her parents, but that may not be the case for all couples and a false hopefulness can potentially color one's interpretations of a case.

> Some people… are just bullies to start with and will be abusive. They feel comfortable with it. In my father's case, he didn't feel comfortable with it, and it wasn't his usual way of being. It was because circumstances got him in a situation that was so high-stress that he didn't know how to cope with it. I could see that not every situation was alike. That doesn't mean that it was okay for him to be abusive. It wasn't, but it also means that I would assess the individual situation and decide if this can be fixed, if there's hope for that situation to get better, because I saw it happen.

Another participant reflected on her path to escaping an abusive relationship and how it

influences her approach to working with couples. Participant 3, Nancy, described a conversation that marked the beginning of the end of her marriage with an abusive husband, in which he had made a move to strike her and she stood her ground with him for the first time:

> [I told him] 'I don't want you to hit me to find out, but I'm letting you know, just so you know you have a choice. That if you hit me again, I will be pressing charges against you.' And he goes, 'I know you won't,'…He said, 'Because you like it when I hit you,' and I said, 'I like it?'…And I said, 'How do I like it?' And he said, 'If you didn't like it, you would have stopped me a long time ago.' And I went, 'Ahhh!'…. But see, I had to be ready. I had to be ready to press those charges, because if I would've said it, and not did it, then it would've gotten worse.

She described her retrospective view of herself as an enabler in an abusive dynamic, and an understanding of the interpersonal dance that violent couples get into, and states that this influenced her work with survivors:

> I was not doing my husband any good by letting him treat me this way. I was enabling him, and being a co-dependent. So, that's the other thing I work on with people. How are you enabling this behavior? How are you being a co-dependent to this behavior?....Now I don't know if that happens with everybody, but I want to help victims to understand that they can do that.... When they know they're ready, then they can make that statement, but don't make that statement before that. Because you can't make the statement and not follow through on it,... So I think I learned that the person getting empowered, the victim getting empowered, can really make a big difference.

For this participant, her path to escaping an abusive marriage was through recognizing her place in that dynamic. The danger here is that she may assume that this same path to help is the same for other survivors, which is a projection of her process onto others. This belies a lack of ability to differentiate her process from her clients and in some cases, this could put her clients at risk.

It is important that therapists who have experienced violence in their lives be supported in processing those experiences and healing from them. If therapists are not able to come to terms with their experiences, they may struggle in differentiating their experience from others' and this can negatively affect their work with couples in cases where they may become overinvolved and in other cases where they are too removed. In either way, the therapist's issues are having a

negative influence on the therapy process.

Some therapists believe they have a heightened ability to detect abuse in couples. Several therapists reflected on their ability to identify abuse in the couples that they worked with, and accounted this to a "sensitivity" to abuse that is a result of their own firsthand experiences. Nancy explained her thinking and further connected this experience to her clinical work with couples:

> I've learned throughout the years to recognize certain patterns in people where it clues me in that they're probably this type of person…. for instance, when my sister got divorced and then was dating this guy, five minutes after I met him, I'm like, "Oh, my God". You know, I just knew, and yeah, he turned out to be a severe abuser….Sometimes you can tell, even if neither one of them say anything, …you can tell that, if it's gotta be their way, if they're in control of everything…And I don't know, maybe because I've had that in my history, maybe that's why I pick up on it so quickly.

This theme highlights the need to support therapists in process and making meaning of their past experiences of violence. While it very possible that therapists who have experienced violence are more cognizant of the possibility of abuse in client populations, there is risk in assuming that one can detect it on a case by case basis.

Therapists draw on personal experiences in ways that support their screening practices. A theme that emerged from participant reflections, was that in some respects using their own personal experiences of abuse serve to expand what they do with clients with regard to screening and assessment. Motivation, empathy, perceptions of what constitutes abuse can be supported and extended as therapists connect to their personal memories and perspectives.

Therapists are motivated to work directly with couples and face difficult topics. Being subject or witness to violence is used as motivation to work with difficulty couples who many other therapists avoid. Within participant testimonies, a persistent theme emerged as a desire to be directly involved with affecting change in families and couples. This is most directly

illustrated by comments from Carla. She described a violent and controlling upbringing, which carried over into her adult relationships until she hit a turning point. For Carla, this turning point occurred during her graduate program and prompted her to change her graduate degree to a clinical track:

> I kind of got to a point where I just wasn't having it anymore... I realized I was not putting up with violence anymore, and I'm a new woman…..I'm sure that has shaped my work tremendously, and also shaped my kind of passion for helping to create kind of balanced relationships where both people feel heard and important and have a presence, maintaining self.…. I really just wanted to be more on the front lines doing the healing in the room. I think that's because of my personal experiences.

This theme demonstrates how therapist experiences of adversity can be harnessed as resources that sustain them and protect them from burn out.

Therapists develop great empathy for couples. A theme emerged involving therapist empathy toward survivors of partner violence when they encounter them in clinical work. Therapists believe that having some direct experiences in which they have been either receiving of abuse, or directly exposed through early life experiences of family violence, fosters their ability to withhold judgment, access empathy, and honor with patience the stage of change that clients are in with regard to dysfunctional relationships. This was exemplified by the comments of Kristina, who recounts how her background informs her approach with survivors and provides insight into the dynamics that maintain survivors in the relationship:

> It gives me empathy and compassion for the journey it takes to make that decision to finally leave, and how powerful that person [the perpetrator] can be when they're good. When they're good and it's honeymoon phase and they turn it all on, it's good.…Yeah, it gives me a lot of empathy for reasons why women stay in relationships that we probably instinctually know aren't healthy.

This was echoed by Marie, who describes that her background informs her ability to create a non-judgmental experience for clients:

> Because I don't come from a place like [thinking], this should never happen. I have

> experience with this [abuse] so I do think that that kind of helps probably soften my approach more than they expect…..So there's hopefulness in my message, too, that I think kind of just helps ease the process.

This theme exemplifies how important it is that therapists be supported in developing their ability to foster and maintain rapport and alliance when addressing violence with couples. If they feel more in control and see this as a tool they can use, there may be less concerns about losing clients because of screening.

Therapist expand their perceptions of abuse in clients. A sub-theme that emerged from participant responses was drawing on their own experiences of abuse and violence to expand definitions of abuse when working with clients. For example, Gretchen, described her father as highly intimidating and aggressive in his approach to discipline which was both physically and emotionally abusive:

> He didn't leave bruises and marks on us, but he would hit when he was angry and hit hard. He would be intimidating. He would yell in our face, like spit in your face because he was yelling so loud. Grab the back of your neck. He was angry and he was mean and his point was to instill fear.

She reflected on how these experiences in childhood inform her definition and understanding of abuse when working with her clients. When assessing couples, she explains that she listens for the presence of fear and intimidation as evidence of an abusive dynamic, regardless of level of physical aggressiveness:

> Because of my own experiences, and having those feelings [of fear and intimidation], then that becomes a red flag to me [when I hear fear and intimidation in couples] to say, whatever is happening, even if the intention isn't there, even if the physical violence isn't there, that feeling is still occurring. So, something in their relationship is unhealthy. I think knowing that's the legal definition [of abuse] that we use with parents and children, right? If…it doesn't leave a mark then it's not reportable [but] that's not how I practice in a clinical setting to define violence.

Professional experiences working with abuse and violence impact therapists and their screening practices. As therapists move through their careers, they work in different capacities

across a wide variety of clinical issues. The subject of abuse and violence is one that many therapists and social service workers intersect with regularly. A second theme emerged from the data in the form of participants reflecting on past experiences working with disclosures of abuse in couples, individual work with survivors of IPV, working with family violence, and other such clinical work connected to the issue of violence. Eight participants referenced significantly impactful work experiences. Participants made reflections on how these work experiences have shaped how they approach screening for partner violence in couples. These reflections offer insight to how therapists are shaped through the work that they do. This theme is typified by the observations of Tomas, who describes a situation in which he had not accurately ascertained the level of imminent threat for a female client and how the death of that client caused extreme feelings of guilt and remorse:

> I made a huge mistake in the [19]80's with a couple. I did not understand violence. I did not understand the risk that was involved …. I had a situation very sadly that I was not discerning of the problem. I found out six months later after I saw them twice that she ended up getting killed…. While I'm saying that, I'm really feeling it. I could feel it in my gut, in my chest.… I feel that I really let that lady down. I felt that if I had known what I should have known, I may have saved her life.

He reflected on how he responded to this terrible experience, and was motivated to invest years of study to finding an approach to engaging with couples that prioritizes safety:

> I felt so badly that I was not there for her, that I stopped seeing couples and I started studying. [I thought to myself] there's got to be a better way... I started reading lots of things…I really took about 10 years to really gear up, because I never wanted that to happen again… over time bit by bit as I gained more experience, as I took more course work and personal study, as I purchased supervision, I was able to gradually realize the best way that I can work [with couples] is to get the kind of information I need upfront and to do written tools and interview techniques that allowed me to get the information I needed upfront.

Tomas stated that he immersed himself in the work of experts who researched typologies and assessment of partner violence to understand how best to discern which couples are safe to work

with and which are not. He used that knowledge to create a screening and assessment protocol that he adheres to uniformly when engaging a new couple client.

This response from Tomas illustrates the emotional impact of his clinical work and how he has used it to inform his work as a clinician. In this example, his clinical practices of screening and assessment of couples has been positively impacted by resulting in more informed and uniform practices for couple violence screening. Other similar statements by participants have revealed themes related to how they process and respond to the work experiences they have relevant to the topic of violence, and how they use their experiences to inform future clinical work specifically when addressing violence with couples. Emergent themes have been organized according to possible positive impacts and then possible negative impacts that have resulted from clinical experiences of violence.

Negative impacts of past work experiences with violence on current practices. Past work experiences connected to abuse and violence stay with therapists and influence their thinking and approaches to working with violence in subsequent cases. In some respects, this can have a negative impact on a therapist's ability to effectively screen and identify violence with couples.

Therapists face concerns about their personal safety which inhibit screening practices. Therapists face real threats when they take on cases that are highly dysfunctional or volatile. Participants, many of whom are women, feel vulnerable when their boundaries have been crossed and assumptions of safety have been threatened. Participants shared that feeling afraid or intimidated in the moment has a direct impact on how they proceed with future clients. Carla identified a highly distressing situation of a couple with escalating levels of conflict in which the male partner was also bringing firearms into therapy sessions. She describes her reticence to face the topic of violence with the clients in this case:

> I don't feel safe necessarily talking about my personal opinions on things, because I don't feel safe in general with these extra layers.…That was actually a couple that I had to refer out to individual work, because it was very clear that there was abuse going on….I did not feel comfortable moving forward, because I knew he was bringing guns to session, and I knew that he just walked around with a gun on him, and he was not a police officer. There was no reason for it, but he had a concealed carry permit, so what can you do?

Kristina describes her experience doing in-home family therapy and how this high conflict environment produced in her a tendency to get overwhelmed, which she suspects has continued into her couple therapy work:

> There was a dad who raged on us about, "This isn't working. This isn't effective. It's a waste of my time," but he was just red-faced yelling in our face. I think I froze and I left and went out into the car and was crying. I didn't know what to do….I'm sure that it comes up now with those higher conflict [couples], especially men in session.

The challenges that clinicians face when working with volatile cases of abuse are myriad. Emotional safety, as well as physical safety is not assumed when therapists have had alarming exchanges with clients. The extreme experiences that therapist have with clients impact them and remain in their thinking as they continue to practice with subsequent cases.

Therapists develop fears and anxieties by working with volatile cases. For several therapists interviewed, clinical work with couples has involved numerous alarming incidents. Many participants described frightening experiences and the lasting impact they have had on them both as people and on their practices. For example, Anna received threatening voicemails from the abusive husband of a client she had worked with: “It made me nervous and a little afraid….because I was seeing first-hand what they were up against. I heard that person's voice on my voicemail. I heard their tone, and I thought if this makes me afraid, think what it's like for [his wife].” Brett described a client who had become increasingly erratic following an accusation of sexual assault of a minor, the fear and anxiety the situation caused this therapist:

> I saw them together and that night he went home, got super drunk, got guns out, took a picture of him with a gun in his mouth, texted it to his wife who sent cops to make sure

> he was okay...He went looking for her, said he was going to kill her. It was crazy.… Sitting in my room, sitting across from him, there was this desperation. He could do anything.... I remember telling some of the [other] therapists, if someone kills me, it's my 8 o'clock. It's this one here. I didn't know if he was going to hold me accountable for that because of the stuff that was coming out in the treatment or what…... This guy was so desperate and was drinking and seemed he had no care for his own life and because of that I didn't know what he was going to do.

Kristina explained that she has worked with two clients who have ultimately been killed by a violent partner, one of which is yet unresolved: "He hasn't been officially caught yet, but everybody knows it was him, just showed up and stabbed her numerous times. The police then showed up on my doorstep to get all that information." Kristina, reflected on the lasting fears and anxieties she feels when working with couples:

> I'm more nervous about walking to my car. More nervous about sitting in session. Really nervous for the women kind of involved. If it's one of those severe cases then I'll think about it outside of session….I think I'm always cautious starting with a new couple. I don't ever know what I'm walking into. When I walk down to the waiting area to meet them I feel ... there's anxiety with that, even though I've done this for so long because they're a blank slate at that point and you never know what … your journey's going to be with them. You could meet them for two sessions, or you can meet them for 100 sessions and one of them ends up dead, which has happened to me a couple of times.

Positive impacts on current practices of past work experiences with violence. Therapists draw on past work experiences that have involved abuse and violence, to build competencies to carry out violence screening and assessment. Technical skill and emotional preparedness to carry out future screens are gathered through trial and error, and gradually build greater confidence and self-efficacy to competently carry out violence screens.

Therapist seek out greater knowledge about violence screening. Experiences in which therapists have felt underprepared or inadequately trained for working with disclosure of abuse or violence results in intense emotions. For some participants, this discomfort has been channeled to a desire to seek greater knowledge and skill. Brett reflected on such a case during his graduate training, before he adopted a protocol for screening for violence:

> Three or four sessions in, recollecting their fight or something, it came out at that point. By then it felt like I didn't know how much that was coloring things for them. But hearing how their fights got to that point, physical violence, it made sense [of] some other dynamics, …and changed the treatment too. This isn't just we're unhappy and we don't get along sometimes, no there are some real problems. Like safety planning stuff I had missed and wife's living in fear for her safety, and this guy is doing this stuff I didn't know about and she didn't know about. If I had just asked early on. … That sticks with me.

He reflected on the impact that case had on him. Following that disclosure, Brett attended a class session in which the instructor explained common violence screening protocols. Here he describes how that early case followed by instructions about how to screen impacted him:

> I felt like an idiot!…there's so much you don't know of how the real way to be a therapist involves all these things that are super important to know and to do.… I heard more of the right way to do things. I was like, I know nothing, there's so much more I have to learn to be good at this. I better get practicing and get some help with that.

This theme demonstrates the need for quality education that thoroughly prepares therapists for the complex task of violence screening. Without adequate training, even the most well-intended clinicians are likely to make errors and misdiagnose couples with potentially disastrous consequences.

Therapists that have overlooked abuse learn to use more thorough and specific language when screening for violence. The technique and exact procedures for screening and assessing violence is greatly left up to the preferences of each therapist. Discovering that they have inaccurately assessed the relationship dynamics prompts therapists to reflect on how they ask clients about violence and revise their approach. For the participants in this study this often means a more thorough and specific approach to discussing and questioning couples. Brett described a case in which abuse was underreported at his initial screen because of the clients had different understandings of what of constitutes abuse:

> It happened with this very religious couple I had where the thought of the husband and wife, like the wives have to please their husbands sexually or this is the belief they had,

> this is biblical living to please their spouse that way, even if they don't want to. And so when I asked about abuse early on, nothing was said about it. But then, again, 12 sessions in she reveals that when they are drinking too much and she's passed out and she came to and he was having sex with her. Like raping her essentially. So, naming that [as abuse], doesn't fit whatever category your thinking of as being a good wife. That's actually rape.

This participant stated that this case highlighted for him the importance of assuring that clients have the same understanding of what constitutes abuse. Gretchen identified a similar experience of working with a woman who had been partnered since adolescence, and this reinforced for her the need to be specific in her language when screening for abuse:

> I think I am much more specific in my language, and I ask more direct and close-ended questions. So I don't just say, have you ever experienced physical violence in your relationship? Because that might, to them, mean I've been chocked or punched in the face and have a bruise, or I've had to go the hospital. I don't operate on the assumption that they would define that the same way that I would. So I think I'm much more specific in that way.……In working with her, I really recognized that I can't make the assumption that couples understand that these behaviors or interactions are unhealthy or dangerous, or are classified as violent.

This theme demonstrates that therapists are continually refining the techniques they use when talking about violence with clients. Outcomes and reactions of clients become feedback mechanisms from which therapist gather greater information about how best to talk about violence.

Therapists who have worked with survivors develop a contextualized understanding of what elements to screen for in couples. Therapists learn over time how to conceptualize abusive and violent dynamics in relationships, and build their own understanding about to should prioritize in their assessment of relationships. Firsthand experience with cases helps therapists to move beyond the rote knowledge of definitions of IPV, but through exposure to survivors, couples, and perpetrators, they further their working schemas of what contextual elements and what risk factors are important to assess. Rebekah, describes a case in which she worked with a female client for several years, sometimes as a couple with her husband and sometimes

individually, including through the eventual divorce from an abusive husband. Rebekah described how working with a survivor reinforced for her the need to assess the resources and the context of the survivor when first identifying violence in the relationship:

> Her husband was the most skilled abuser I have ever seen. He started with, and this was over years, isolating her. There was physical abuse, there was sexual abuse. But his most powerful and effective form of abuse was to isolate her from everybody else in the world….what I think I've tapped into with [this client] is the need for resources and support before anybody can make any change…So that's how my practice has been informed…I'm not just assessing for abuse. I'm also assessing for somebody's options against the abuse.

This theme demonstrates how the therapists build a working understanding of how abusive dynamics work within couples, and through this they also flush out their working understanding of what they should be actively identifying thought screening.

Therapists who have faced aggressive clients become less timid when facing abuse and violence in couples. Therapists are challenged through clinical work and must rise to the occasion. Difficult cases involving violence require therapists to push through their own hesitations and self-doubts, and ask difficult questions or stand up for vulnerable parties. As participants have found themselves in positions in which decisiveness and assertiveness are required, they become more comfortable with these tasks. Anna recounted an experience early in her career in a youth treatment facility where she worked, standing up to the threats of the father of one young client. Anna explained the lasting impact that this and other experiences working with family abuse in that center has influenced her ability to be calm and direct in her work as a clinician as a clinician:

> [The father] was upset about something,…he literally told me to my face, "I want to take him home because I'm gonna beat the shit out of him." That's what he said to me, and I just got right in his face and said, "You will not." He said, "You can't stop me," and I said, "Yes I can because I'll call the police. I'll call protective services. I will stop you. You're not going to do that." I did end up calling protective services...It got me mad enough to be over being timid…when something's as glaring as that- are you gonna back

down in a situation like that? Not me.

Marie, talked about her work in family reunification. In that context, she was required to do a domestic violence assessment with each family. And, she reflected on how the practice furthered her competency for the task as well as her own confidence:

> I think it just made me more direct than I would have been in the past. I think I would have tiptoed.... I think I would have been much more timid, but that wasn't an option in that [setting]. And a DV assessment was essential, we had to document that in their early treatment plan, that we had done a DV assessment,…so yeah it just became part of the work. I didn't feel like such a novice anymore at it, I was like okay, I can do this.

This theme underscores the developmental process that therapists undergo in their ability to manage the challenges of addressing IPV with couples. Therapists need to be supported in their developmental processes of feeling confident in facing the difficult topic of violence.

Therapists learn to manage feelings of intimidation of perpetrators. Two participants spoke at length about how their experiences working with violent offenders have greatly impacted their approach to working to address violence with couples, specifically with regard to those who perpetrate abuse. David, worked with a sex offender population and Brett ran domestic violence groups for individuals facing DV charges. Both reflected how these experiences have influenced their clinical abilities over time to work more effectively. David recounted that this experience taught him how to balance establishing alliances with condemning abusive behaviors, which has made talking with perpetrators less intimidating for him:

> I think just working long enough I was able to say, yeah, those things are not at all okay, and I do have feelings about that, but I'm also able to see these people for who they are, where they're coming from, how they learned to act and live that way and how they've gotten stuck and wrapped up in this pattern of coping and living. So, to be able to see past [the behaviors] has been helpful for me. I think that makes it feel a little bit less scary, talking about those things.

Brett offered a similar reflection. He developed a mental framework for offenders as flawed

though human, and through this view he was more able to overcome his fear and intimidation. When he began to see abusers not as unpredictable in their reactions, but responding with aggression to some emotional trigger, and as a result, perpetrators become less scary and he is more able to remain centered when working with them:

> That's my working framework and if I can see people from that framework and they fit in there somewhere, well then it's easy for me to talk about. Then I understand. If I see them as hurting too, not justifying any of those abusive behaviors ever, just help me understand this is a normal person and this happens even sometimes with normal people, things get out of hand.…. I can be direct and I can trust myself. I can ask about physical violence, about whatever it might be. It usually goes okay. Yeah, I'm infinitely more comfortable now, but there was a time where I was anxious, like "oh my goodness, can I ask that?" "I don't know if I can ask that," "what's he going to do?" but not anymore. "You're not that different than me, maybe," which is scary but also I think it helps working with people.

Therapists who have worked with perpetrators challenge minimization and manipulation. In addition to supporting his ability to remain calm and confident when asking direct questions about abuse, David also reflected that working with offenders has taught him the skills needed to navigate attempts at minimizing by perpetrators when he carries out a screen with a couple:

> There have been a lot of guys, a lot of guys, who have found ways to gaslight,…talk about things through minimizing, through projecting blame, or blaming someone else, that make it very difficult to help them get to a place where they take responsibility for their own actions. And I think a lot of the experiences I was talking about previously helped me to figure out how to cut through some of that.

Therapists adopt strategies to manage their own reactions in light of these personal and professional experiences. Therapists will face real threats both physically and psychologically in their clinical work, which interact with experiences of violence they have encountered in their lives. Some therapists begin to manage their own trauma by processing their experiences and reactions, through their own therapy, through supervision of self-of-the-therapist reactions and feedback in group supervision. It is important to understand how therapists learn to effectively cope with the stress that working with IPV creates. Some may master this process better than

others, but participants in this study have developed strategies to cope with the challenges of addressing violence with couples.

Therapists monitor for biases and prejudgments. Many therapists described their early family experiences as free from violence, and they felt naïve and ill-equipped to address the abuse and violence that they encountered in their first years of clinical work. One participant stated that she began her career "really fresh and unclear about what abuse is and its impact in a relationship." Therapists who lack personal experience with violence find that they have a lot to learn when first exposed to violence through their professional work. Initially, engaging with family violence can engage therapists' biases and preconceptions about perpetrators and survivors, as Melissa, stated, when she began working with cases in which abuse was disclosed she would respond with "knee-jerk reactions." She explained: "In the beginning, I could feel myself creating judgments and having my own personal bias come in about that particular client."

As therapists gain experience working with couples over time, they learn to manage these reactions. Rebekah, explained her process:

> I have to check my biases all the time. I'm pretty limited. My world has been pretty peachy-keen. I haven't seen a huge amount of dynamics in my personal life and in my larger social societal life that I often see in [therapy]. My antidote to that is to be extremely curious. I ask my clients a lot of clarifying questions. That's how I get there. I make no assumptions.

Remaining vigilant about monitoring for bias helps therapists to stay present and engaged with clients. Failing to do so can confound a therapist's ability to adequately assess the dynamics of different cases and miss out on important diagnostic information. Managing one's bias also facilitates clients feeling understood and can strengthen the therapeutic alliance. This theme points out the need for therapists to actively monitor their reactions when screening for violence

and managing client disclosures.

Therapists embrace self-reflection through their own therapy and Self-of-the-Therapist training. Numerous participants made reference to the journey they have taken in their lives and the "work" they have done to process their life experiences and personal attributes that counteract with their work as a clinician. Carla reflected on the intense intrapersonal work in her Person-of-the-Therapist training, which she believes has allowed her process her life experiences and work with couples:

> I was a little nervous to come forward and really kind of attack this particular issue… until I did that individual work to work through all of that….I become more and more aware all of the time, ways that [my parents] did not protect me, ways that, because I'm a mom now myself, and I think about the things that they did, and how I couldn't imagine doing that to my child, or allowing someone else to do it to my child,…and I don't think that I would have that mentality if I didn't go through Person of the Therapist. I think I was very, very fortunate to have this kind of training….I think maybe I am so direct about it, and so sensitive about it [with clients] because I've seen it and I've experienced it…but until someone really kind of shocks you and makes you want to do the work, you're not necessarily going to realize what happened.

Kristina, described her familial and religious culture as conflict-avoidant, "It was a lot of just not talking about things. Sweeping things under the rug" which she suspects impacted her early clinical work. Because it was so contrary to her background to create conflict, she struggled with conflict when it presents in clinical work, and she describes her strategy to manage that influence:

> I think I've had to do a lot of work on myself with therapy…to get to a place where I'm not just surface-y asking questions... I can go deeper. Well, it's that saying, right, 'You can only go as deep with your clients as deep as you've gone with yourself.' I feel like as I continue to do my work I can do more work with my clients.

This theme highlights the need for therapists to be supported in the process of building self-awareness. Therapists who do not embrace this work risk giving in to personal discomfort and anxiety, in doing so limiting their capacity to work effectively with couples.

Therapists monitor counter-transference. Counter transference reactions are an inherent aspect of clinical therapy. However, the degree to which a therapist is aware of their predilections for counter-transference greatly determines the impact it will have on therapy. Therapists who have been personally affected by abuse and abusers will naturally experience some emotional triggers when directly addressing the topic with clients. Tomas reflected on the feelings of guilt and responsibility that his early experiences of parental abuse created in him, while also resulting in a strong vulnerability for counter-transference that he monitors closely:

> I think it influences me two ways. I'm very concerned about the person who is powerless. I have this keen sense that shouldn't be and I'm responsible to make sure that somebody doesn't get hurt.…. The second thing that happens to me is I have a very strong countertransference that I really got to keep an eye on.…. I feel rage. I get this countertransference. I'm afraid that if I don't keep it checked, I will not think clearly.

This theme highlights the importance for therapists to reflect on appropriate boundaries when working with the challenging topic of violence. Having a clear sense of what is appropriate practice, may help therapists to know when they are at risk of following their emotional reactions to clients.

Therapists consider their own safety when working with clients. Alarming incidences while working brings safety to the forefront of therapists' thinking. In order to feel secure in their personal safety, therapists learn to be proactive about protecting themselves. Nancy recounted an alarming incident in which a couple session became very heated, and the female partner stormed out of the session. She explained that the male partner became physically threatening of the therapist, and reflected on how the experience of feeling physically intimidated by an aggressive client, has prompted to think strategically about her own safety when making decisions about future office properties:

> He got up and he shut the door. That instantly warned me that something wasn't right… Now, as soon as he shut the door and started walking this way, I screamed, … he turned

> the corner here, and he was coming at me with his hands, and I screamed, and my husband was immediately at the door, he opened the door, and he walked right in, and as soon as my husband walked through the door, [the client] immediately turned around…and ran right past my husband and just left…..I knew that when we were shopping for a [new] site, I knew that when I found the site and my treatment room, I had to have room where this desk ... Where I was not going to be without an escape…. In this setting, I'm never here by myself with patients, so I'm not afraid that somebody wouldn't be near, and so I think I feel safe because of that.

This theme highlights the need for therapists to attend to their own needs in order to be of service to others. Therapists who are worrying about personal safety when working with clients will be less attuned to clients, but they also run a risk of developing lingering anxieties around couples work, and become vulnerable burn out.

Discussion

Whether or not they themselves have encountered abuse in their own paths, therapist need to critically analyze their assumptions or paradigms they have developed through their experiences in order to usefully treat and assist their clients, and also to avoid professional problems of emotional and burnout from dealing with cases of violence. This study demonstrates the significant role that the personal well-being of the therapist plays, and how prioritizing self-awareness and self-care have bearing on the work that clinicians carry out with couples, specifically in their approach to addressing IPV.

The formative experiences of therapists have long been thought to shape how they respond to events later in life (Bowlby, 1969). This study finds that personal and professional experiences influence therapist violence screening in both positive and negative ways. Therapist's personal and professional histories frame how they see the world and they draw on their personal experiences, but they are also being influenced by those experiences. For most clinical work, this process unfolds naturally over time and very likely adds to the uniqueness of each therapist. However, working with violence is a different matter, with immediate

ramifications for the safety of clients. Therapists develop their own schemas of what violence is and how they should address the issue of violence, influenced by their own significant personal and professional experiences.

Therapists need to be informed and deliberate in how they address violence to manage their own emotional reactions triggered by their work, remain engaged and passionate in their work, and avoid burn-out. When therapist's life experiences are applied too directly in their clinical work they adopt a passive approach to screening for violence and run the risk of developing blind spots in practice. When therapists monitor themselves, and process the experiences they have, they can integrate new knowledge and create a nuanced internalized theory about violence. They are then able to move beyond their own self-of-the-therapist projections and develop purposeful and informed practices for addressing violence with clients. Therapists should be supported in identifying their beliefs and blind spots about abuse and violence, in order to develop protocols that are driven not only by accumulated insights but informed by knowledge and guidance of established best practices.

Therapists draw on personal experiences of violence which shape how they approach screening for violence in couples. Self-of-therapist counter-transference includes the "real" and "unreal" reactions, resulting from counselors' unresolved internal issues (Gelso & Carter, 1985, 1994; Gelso & Hayes, 2007). Individuals respond to experiences of violence in different ways (Cicchetti & Tucker, 1994). The personal influences in the way therapists approach screening has inherent bias. How we perceive and process experiences with violence are shaped by a myriad of factors- the impact of exposures to violence as a young child is different that experienced in adulthood (Zlotnick et al.,, 2008), the level of personal agency we have at the time of those experiences (Kulkarni et al., 2010), and the degree of cumulative trauma the

individual has experienced may all play a role in how individual clinicians make sense of their own experiences of violence. One's understanding of self is critical to successfully addressing and working clinically with partner abuse (Brosi & Carolan, 2006) and this includes one's strategies for identifying abuse.

With more emotionally intense issues like violence, self-of-therapist issues become even more influential in the process of therapy. If you had a depressed parent and you are working with depressed clients, this may not produce the same level of emotional intensity as working with a violent person if your father was violent. Undifferentiated responses to cases dealing with abuse impacts the quality of therapy that they can offer clients specifically for violence work (MacKay, 2017; Watson, Carthy & Becker, 2017). This is problematic for the field if the therapist is doing this because humans cannot always trust their personal experiences. Therapists have blind spots and beliefs that things can be okay because it was for them, or they believe they will be able to discern when abuse is present because they know how it feels, but this is often not the case (Hansen, Harway & Cervantes, 1991). Findings from the first paper presented in this study demonstrated therapist vulnerabilities to biases and prejudgments about violence in clinical populations, most specifically for ethnic minority clients (Parker, 2018)

In the absence of clear and definitive guidance and direction of protocols, individuals respond to the topic of violence according to unrecognized theories rooted in personal projections, similar to Yusof and Carpenter's (2015) assertions that therapists pull from internal working models in the course of clinical work. The field of family therapy has moved beyond the belief that one's past is a deficit that must be overcome in order to provide quality therapy. Rather, past experiences can be addressed in ways that support therapist development (Satir, 2013). Emotions connected to painful experiences can be channeled to further therapist self-

awareness and frameworks for self-analysis, as well as energy and commitment to the work, but this should be a guided process so that therapists do not go so far as attempting to complete the "unfinished business" of their own past (Figley, 1995). Therapist' personal wounds can be channeled into fostering therapist skills of empathic understanding, yet should be balanced so that empathy does not extend to over identification. The unique aspects of one's history of abuse can teach therapists to look beyond the outward presentation of couples, or, alternatively, limit therapist understanding of dynamics in which clients may be trapped.

Professional experiences working with abuse and violence impact therapists and their screening practices. Working with abuse and high conflict is difficult and affects therapists greatly. The effects of secondary trauma in helping professions are vast (Bride, 2004; Bride, 2007; Canfield, 2005; Cunningham, 2003; Connor et al., 2012; Figley, 1983; Rasmussen, 2012). Difficult and alarming experiences seem to be a common experience for therapists who work on the frontline with couples, and these work experiences add to secondary trauma, as well as trigger these responses. The clinicians in this study were exposed to real threats to their own safety and are acutely aware of the safety threats to their clients. These experiences can be channeled to support therapists in their work or it can have a lasting negative effect over the years that therapists engage in clinical work.

When therapists cannot find ways to effectively manage the anxiety working with couples causes them, it impacts them both personally and professionally. For some this triggers action, as in the case of participant 15 who devoted himself to the study of safe practice after the death of a client. The emotional distress of working with a case of abuse and violence was channeled into motivation to seek out greater knowledge. Therapists channel difficult cases involving abuse into lessons for how to better address partner violence in their work (e.g.

adopting specific language, expanding their thinking about what to ask, and becoming more direct and assertive). However, when clinicians are challenged to remain centered, they may experience a freeze response, such as described by participant 6, which may be a form of indirect trauma often experienced unwittingly by clinicians (Harr & Moore, 2011; Knight, 2013; Pill, Day & Mildred, 2016; 2017). Or it may be more akin to "The Family of Origin Freeze" as coined by McDaniel and Landau-Stanton (1991.)

It is very likely that therapists' personal histories of abuse and violence interact with the occupational distress that comes from working with cases of abuse. It is beyond the scope of this study to discern what that relationship may be, but these findings raise questions about therapist personal resiliency and ability to draw on one's internal and external resources (Ben-Porat & Itzhaky, 2015). Participants in this study sought out extra training and knowledge after negative experiences with clients, but ideally therapists are all able to access resources pro-actively and prevent burn-out and compassion fatigue (Choi, 2011).

Therapists adopt strategies to manage their own reactions in light of these personal and professional experiences. Not only do the practices that therapists use continue to evolve throughout their careers as found in Parker et al (in process), but how clinicians approach their work appears to evolve as well. As clinicians move through their careers they have formative emotional experiences with challenging cases, and they adapt to these challenges by developing specific strategies. For therapist who enter the field with little exposure to interpersonal violence, their understanding of abuse and violence feels underdeveloped and they may feel unprepared for working with these dynamics, which often causes great anxiety (Todahl, Linville, Chou, & Maher-Cosenza, 2008). These therapists begin by reacting to preconceived notions and stereotyped thinking. Work often begins by feeling anxiety and for many this is highly

distressing without sufficient coping mechanisms (Breckenridge & James, 2010; Bride et al., 2007; Litvack et al., 2010; Tarshis & Baird, 2018). This echoes other literature which has documented the uniquely emotionally challenging nature of working with couples and violence by trainees and therapists (Todahl, Linville, Chou, & Maher-Cosenza, 2008). As therapists gain greater experience, their preconceived notions and biases are disconfirmed and complicated, and they develop a working schema and understanding of abuse and violence in couples and families. Through this work they gain awareness of their own biases and pre-judgments.

Therapist learn the importance of self-monitoring when working with violent couples. They develop the skill of self-awareness to monitor themselves for times when they defer to biases and generalizations, or may be deferring to their own counter-transference reactions and projections as well. Holistic training methods that focus upon the whole person of the therapist have been supported (Blow et al., 2007; Mutchler & Anderson, 2010; Timm & Blow, 1999) and the findings of this study support this approach. Self-of-therapist work is often neglected in clinical training (Timm & Blow, 1999), but this is a missed opportunity to identify individual factors which inform how therapists address violence with clients. Similarly, they develop the self-awareness to monitor their own emotional states when working with couples. This is a significant finding in light of the extensive literature on the emotional toll that working with abuse and violence takes on clinicians (Baird & Jenkins, 2003; Ben-Porat & Itzhaky, 2015; Canfield, 2005), and the vulnerability for those with their own histories of trauma (Peled-Avram, 2017). Therapists need to take care of themselves, they need to feel safe physically and emotionally. When therapists neglect themselves, their wellbeing is sacrificed and their work with clients suffers (MacKay, 2017; Knight, 2013). When therapists don't figure out how to effectively cope with the taxing experiences of high conflict cases, they may themselves develop

tremendous fear and anxiety.

Limitations. The intent of this study was to explore how therapists' life experiences related to violence influence how they approach screening for couple violence. It was not the intent of this study to quantify those experiences and such an attempt would be premature given how little empirical research exists on this topic. Experiences of violence and the impact they have on individuals are so complex that this data set cannot fully capture the full depth of those experiences, and it should be assumed that other possible findings exist. As a qualitative design, the results of this inquiry may not be generalizable outside of the small number of therapists interviewed. Concerns about confidentiality and anonymity and possible negative consequences may affect participants' ability to be fully forthcoming in their responses (Anderson, 2010). This study was not intended to measure or track clinician practices, but rather explore their work from their own perspectives and insights. As such, this relies upon their perspectives and what they describe their practices to be. Participants were asked to reveal personal and potentially distressing experiences. This may have been more difficult for some participants due to the lack of feelings of comfort and familiarity with the researcher, as well as the need for the participants to be introspective about those experiences. Sampling may also present limitations because randomization was not a consideration. All participants were all volunteers with an interest in the subject which may have influenced participant's desire to participate. The gender and ethnicity of participants may have influenced findings in that trauma and violence are experienced in varied ways depending on these variables, and while there was diversity of age and level of experience within the sample, there was some homogeneity in the gender and ethnic makeup of clients, and so demographic factors of the small participant pool present some limitations to generalizability. Further, the participants in this study are all licensed marriage and family

therapists and practice in the same Midwestern state, and some degree of difference in findings can be assumed in a sample practicing in a different state under different licensure requirements.

Implications

Graduate program training. Clinicians too frequently approach violence screening in a passive way, informed by the lessons that they have accumulated from their own experiences and the often-inadequate education that they receive formally (see Parker et al., 2018). This passive strategy leaves therapists woefully underprepared to attend to the complexities of violence screening most especially the often undetected forms of coercive control as described by Evan Stark (2007). In our companion paper, recommendations were offered for greater consistency and uniformity of training for violence screening. Screening for violence is minimally mentioned in the AAMFT Core competencies, and should be expanded to be more specific about competencies for identifying and responding to violence. Therapist training should prioritize therapist self-awareness specifically for working with cases of abuse given the emotional intensity of the issue and the ramifications for clients.

Knowledge of violence and screening alone is clearly not sufficient to change screening behaviors in lasting ways (Waalen et al., 2000; Wiist & McFarlane, 1999), so supervision and training should be structured to identify therapist beliefs and philosophies as they integrate new knowledge about the need for screening and assessment. For several participants in this study a negative clinical experience provided an impetus for pushing themselves to expand their comfort level, but we cannot leave this up to whether or not the clinician happens to have such a case. Therapists in training should be supported in introspection to identify what their personal theories about violence are, how these theories relate to their personal experiences of violence, and how these theories are operationalized in their practices (MacKay, 2017). Students enter

training programs at various levels of knowledge and self-awareness and graduate programs should support therapist skill development in competency required for encountering and identifying violence, and actively engage trainees in identifying the personal barriers to competent work with violence.

The findings of this study align with other recommendations that clinical training settings should provide opportunities for therapists to continually recognize their own values, beliefs and personal development (Aponte, & Kissil, 2014; Brosi & Carolan, 2006; Kissil, Carneiro, & Aponte, 2018). Such training should be strongly connected to supporting trainees in recognizing and processing the emotional reactivity that working with abuse and violence produce. Education, clinical training, and supervision should prepare family therapists carry out screening and assessment activities as has been recommended in our companion paper and others (Froerer, Lucas, & Brown, 2012; Stith, Rosen, & McCollum, 2003), but it should also attend to the person-of-the-therapist histories which influence how therapists carry out their clinical work.

Post-graduate training. Therapists' perspectives and practices are ever evolving (Parker et al), and so clinicians cannot rely on graduate instruction as the last word in their development. The professional history that transpires after one enters the field causes therapists to think about their work in new ways. As such, therapists should be provided opportunities for support throughout their careers that help them remain grounded in good practices for addressing violence. They should attend to the accumulating distress of clinical work which can hold therapists back from practicing in purposeful ways. Supervision can mitigate the degree of secondary trauma and burnout of social service workers (Choi, 2011; Pulido, 2007; Sexton, 1999). The anxiety of facing violence and opening Pandora's Box is enough to cause some clinicians, consciously or not, to avoid asking about violence (Lavis, Horrocks, Kelly, &

Baker, 2005). Therapists need support to overcome this hurdle so that they may approach couple cases using procedures that are well-thought through and effectively carried out. Not only should therapists practicing in communities implement strong screening procedures, but it is equally important that therapists be confident in their procedures for immediate referrals and networks of support in instances in which IPV is detected. Arming therapists with the confidence to effectively ask these difficult questions is half of the battle, though they may not yield these weapons if they feel unequipped to manage the disclosures that occur.

Personal wellbeing of therapists. This study speaks to the need for clinicians to prioritize their self-care, for their own wellbeing and the quality of work that they provide to clients. It appears that for the most part therapists come to their screening practices in a passive way, but it should be a much more intentional process. This begins in clinical training programs but should be an ongoing process throughout one's career. As therapists, it is important that they reflect on their own opinions, beliefs and experiences with violence that they bring into clinical work. Therapists need to process this content in an ongoing way, and seek out needed knowledge so that clinicians move beyond the limits of their own experiences. This is what separates a lay person from a trained professional. Therapists should seek out opportunities to process reactions to cases, regularly updated their knowledge of best practices, engage in discussion and conversation with supportive colleagues, and make use organizational resources. Special attention and energy is required for the topic of violence, because it affects therapists so greatly, and because it is so commonly encountered in the field. Therapists who are working with couples, especially those who are working regularly with violence can become very personally affected, and should maintain self-care to prevent empathy fatigue, secondary traumatization and burn-out.

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CHAPTER 6: INTEGRATING PAPERS ONE AND TWO

Concluding Remarks

In this study, I set out to understand more about why so many therapists do not follow recommended practices for screening couples for violence. More specifically, I wanted to understand what elements were unique to the practice of couple therapy work across different contexts. By understanding the processes by which therapists come to their selected practices, we can better understand the barriers and facilitators that influence that process. Moreover, I sought to explicate the processes by which therapists arrive at their current practice norms, and how they integrate education and training, clinical and personal experience, and other elements as yet undocumented in available literature.

Paper One

In the absence of direct messages and accountability, it can be reasonably hypothesized that therapists are very much left to their own to decipher how important a uniform screen is and how it should be carried out. Paper one of this dissertation found great inconsistencies in therapist knowledge about violence, inconsistencies in their understanding of how screening for violence should be done, inconsistencies in the context in which these practices take place, and fluctuations in how they have approached screening over time. According to qualitative data, there is a high need to unify and standardize the training that therapists receive around violence screening. The study found that participants hold vastly different understandings of screening protocols which likely contributes to reports of low rates of therapist adherence to screening recommendations. In terms of implications, the first manuscript brought to light the need for more consistent and unified messaging about the importance of consistent protocols for violence screening. Therapists' experiences, both personally and professionally, once they enter the field,

are so varied that more explicit requirements are needed to unify practices across contexts, and throughout years of practice.

Paper Two

In the second paper, it became clearer that the unique experiences of each individual play a role in how violence screening protocols are integrated into practice routines. It was found that therapists are influenced by both personal and professional exposure to violence when formulating their approaches to identifying violence in couple cases, and that therapists develop strategies to cope with the emotions and challenges that actively addressing couple violence presents them. These findings highlight the need to support therapists in reflexively processing their beliefs and assumptions about violence. Moreover, these findings confirmed the impact and toll that clinical work can have over time on individuals who with couples. Several implications can be drawn from these findings. This study highlights the need for quality continuing education and supervision opportunities for therapists to process distressing emotions resulting from work experiences connected to violence, and to process life experiences that shape their attitudes and beliefs about violence which may impact clinical choices. Hopefully this study will serve to remind educational policy makers of the "human dimension" of mental health care providers and the broader context of clinical work, and highlight opportunities to support the personal development of therapists.

Integration of Findings

Findings described in papers one and two share a common overarching finding: more comprehensive and consistent support is needed to more uniformly improve efforts by therapists to identify violence in couples seeking therapy. What has been found is that therapist practices, their views and beliefs, and the ecological elements that surround them are continually evolving

and influencing each other. As therapist take in new information they revise beliefs and views, which drive their clinical choices, while time and experience continue to modify those views and beliefs of ever-changing practices in a simultaneous feedback loop. The effect of time and years of practice experience was demonstrated in participant reports of changing norms in their approach to addressing violence.

Ecological systems theory posits that individuals develop couched within a complex web of systems, micro-, meso-, exo-, chrono-, and macrosystems. This study found that participants are influenced across each of these ecological systems in ways that are continually in flux. At the macro-level, participant exposure to gender and violence related social issues of the times have distal influences on levels of awareness and attunes to the prevalence of violence. At the chronosystem, all of the factors which influence participants change over time, and participants themselves continue to evolve around the topic of violence screening, in their knowledge, views, perceptions, and actions. The exosystem of clinical practice has both direct and indirect bearings on participant screening, according to the context in which such work occurs. This refers to insurance structures, agency policies and norms, obligations put forth by licensing and other governing bodies, and mandates for training and education. At the mesosystem level, highly intriguing effects were found in how therapist experiences with other microsystems- family of origin, past clients, past work contexts- influence participant perceptions of current work. And at the level of the microsystem, it was found that who the therapist is, their unique collection of emotions, thoughts, and experiences, greatly informs how they carry out their work. The exploration of participant understanding of their roles with regard to violence screening revealed that participants are practicing according to their perceptions of required practices. However it

was also found that participants have very different perceptions of what those requirements include.

Based on research results, target outcomes should include establishing more explicit standards for training, best practices, and holistic supervision intended to strengthen therapist competency for screening and assessing violence. With regards to relevant areas of intervention aimed at producing more consistent screening activities by couple therapists, current findings corroborate the need for unified messaging in therapist training that is supported after therapists enter the field, and the relevance of therapist life experiencing which frame their approach to addressing violence. Therapists should engage in exercises and activities to support the process of self-awareness in an on-going way. This process may not require years of therapy nor occur every day, but as therapists gain greater experience throughout years in practice they would benefit from refresher workshops or self-of-therapist support along the way that helps therapists remain grounded in best practices.

Contributions to Existing Research

The present study addresses several key limitations to the existing body of research. First, the preponderance of research conducted to date on universal screening has focused on various medical contexts (Todahl & Walters, 2011), and limited research is available that explores mental health therapists (Samuelson & Campbell, 2005), specifically those who work with couples (Todahl & Walters, 2011). This is unfortunate, as engaging with couples presents specific complexities with regard to ethics, therapeutic alliance, and insurance reimbursements not experienced by other members of the medical field. Moreover, understanding the experiences of couple therapists provides the additional benefit of identifying inconsistencies in therapist understanding of screening practices.

Second, the present study's focus on couple therapists with varying levels of experience contributes to a significant gap in the present research on universal violence screening. As was made clear in the review of existing research on therapist screening, the vast majority of research to date has focused on family therapy trainees and their experiences of screening for violence (Brosi & Carolan, 2006; Froerer, Lucas & Brown, 2012; Todahl, Linville, Chou & Maher-Cosenza, 2008). But these studies were not able to capture the effect that field exposure and diverse practice contexts have on therapist practices. Far less has been written about the experiences of therapists who are several years removed from graduate training, and who have practiced independently and undergone formative work experiences that have contributed to the ongoing evolution of therapist sense of confidence and perspective about identifying violence.

Third, the present study differs from other studies of therapist screening, because therapists interviewed were not conducted following a common unifying educational experience such as Todahl, Linville, Chou and Maher-Cosenza (2008), nor within one identified practice setting (Brosi & Carolan, 2006; Froerer, Lucas & Brown, 2012; Rose et al., 2011). Participants in this study received different educational experiences over a wide spectrum of years. While it is clearly essential to identify and thoroughly study barriers to therapist screening, this limited focus documents only one half of the equation when considering long term practices of therapists.

Finally, through the present study's focus on such a seemingly philosophical construct as therapist view of their role, these results will hopefully serve to enlighten the research community of the breakdown that is occurring within current dissemination efforts. Namely, that therapists have already bought into the need to identify violence, but there is a disconnect between these intentions and concrete practices. This finding corroborates a study by Samuelson

and Campbell, (2005) which found that 95% of psychologists in their study believe it is their responsibility to assist clients experiencing IPV, but fewer than 19% routinely screen for domestic violence. The participants in this study were all LMFT therapists, who focus on relational dynamics, yet surprisingly this same incongruence between therapist intent and practices are echoed in this study. While the current study does much to establish a framework for identifying previously unexamined elements which contribute to the low rates of screening as reported by Schacht et al. (2009) and others, to obtain a deeper understanding of their motivations and struggles, further research is warranted to gather therapist' perspectives on concepts identified in this study.

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