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THERAPIST PERCEPTIONS OF INTIMATE PARTNER VIOLENCE: A REPLICATION OF HARWAY AND HANSEN2019;S STUDY AFTER MORE THAN A DECADE

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Abstract

More than a decade ago, Hansen, Harway, and Cervantes (1991) and Harway and Hansen (1993) conducted a research study examining mental health providers' ability to accurately perceive violence within couples presenting for therapy and to intervene in a manner in which to reduce the risk of danger to couples. The results were alarming, with 40% of therapists sampled failing to perceive intimate partner violence (IPV) and virtually no therapists intervening to reduce the risk of lethality. Harway and colleagues questioned how well-trained and informed therapists were in assessing IPV.

The present study replicates Harway and colleagues' study with the expectation that, over a decade later, therapists are better prepared to accurately identify IPV issues and intervene effectively to reduce the risk of lethality. Reproducing the two main procedures used in the original study, 111 psychologists, clinical social workers, and marriage and family therapists were asked to respond to a survey. Results show that therapists have indeed improved their ability to identify IPV issues. Twenty percent of therapists predicted an increase in conflict, compared to 4% in the original sample. However, almost no therapists accurately predicted lethality in either study. Implications concerning IPV training for therapists are discussed.

INTRODUCTION

Research on IPV has seen a drastic increase over the past 20 years (National Institute of Justice [NIJ] & Center for Disease Control and Prevention [CDC], 2000). Attention to this area of study has most likely been triggered by the general realization that IPV is pervasive and crosses ethnic, racial, age, sexual orientation, religious, and socioeconomic lines (Domestic Violence Statistics, n.d.). Even so, it has been shown that health care professionals often lack knowledge regarding IPV, including the ability to accurately assess the dangers inherent within families presenting with IPV issues (Goff, Shelton, Byrd, & Parcel, 2003; Smith, 2000).

Psychologists are no exception in their poor ability to assess for IPV within families seeking therapeutic services. Over a decade ago, Harway and Hansen (1993) and Hansen, Harway, & Cervantes (1991) studied the ability of therapists practicing in North America to correctly perceive IPV issues and intervene effectively in order to reduce the risk of lethality. Therapists read a real-life clinical vignette that included descriptors of IPV within a couple presenting for therapy, and afterwards stated how they conceptualized the case and what interventions they would choose. After initial formulations were made, therapists were then informed that shortly following the described therapy session the male partner raped and murdered his female partner. Therapists were asked to consider how this knowledge influenced their initial responses. Harway and colleagues found that 40% of the therapists sampled completely failed to identify the lethal conflict within the vignette, and 46% suggested interventions that were ineffective at reducing the risk of violence.

Today, current literature relating to IPV indicates that more is known about this societal problem than in the past. Information shedding light on the prevalence and incidence of IPV, dynamics of IPV, the impact of IPV on child witnesses, therapeutic interventions based on feminist theory, as well as interventions for perpetrators of IPV have all contributed to a better understanding of IPV. The purpose of the present study is to replicate the main procedures in a series of two studies completed over 10 years ago (Hansen, Harway, & Cervantes, 1991; Harway & Hansen, 1993) concerning the ability of mental health professionals to accurately identify and assess the presence of IPV within clients' lives. Accurate identification of such issues is likely to decrease the risk of therapists' choosing ineffective interventions that may inadvertently increase clients' danger.

The Importance of Intimate Partner Violence Training

Intimate partner violence, or IPV, is defined as violence committed by a spouse, ex-spouse, current or former boyfriend or girlfriend toward the other partner either currently in or formerly in an intimate relationship (National Center for Injury Prevention and Control, 2003). IPV is also commonly referred to as domestic violence, battering, and spousal abuse, and occurs among both heterosexual and same-sex couples (National Center for Injury Prevention and Control). Although the literature finds that both women and men are victims and perpetrators of IPV, research indicates that women are overwhelmingly more likely than men to suffer physical and psychological injuries, as well as death, at the hands of a male intimate partner (National Center for Injury Prevention and Control; Tjaden & Thoennes, 2000). One of the largest and most recent population surveys in the United States, the National Violence Against Women Survey (NVAWS), published statistics indicating that women are 22.5 times more likely to be raped than men, 8.2 times more likely to be stalked, and 2.9 times more likely to be physically assaulted by an intimate partner than men (Tjaden & Thoennes).

Following the alarming numbers that show women to be the primary victims in the vast majority of IPV cases, women are also shown to access mental health services much more frequently than do men (Addis & Mahalik, 2003; Rhodes, Goering, To, & Williams, 2002). Psychologists and other mental health professionals should be prepared to deal with female victims of IPV and the issues that surround IPV, yet disturbingly, research shows that these professionals often lack such knowledge, and may intervene ineffectively with these women (Hansen, Harway, & Cervantes, 1991; Harway & Hansen, 1993). The research sends a strong message that mental health professionals, including psychologists, are in need of IPV training within their professional training programs.

Theories of Intimate Partner Violence

Psychologists and other mental health professionals lack an understanding of IPV issues. Without this knowledge, ineffective and often dangerous interventions may be the result. For example, probably one of the most common interventions for a therapist to use when dealing with a female IPV victim is to strongly encourage the woman to leave the relationship immediately (Grigsby & Hartman, 1997). Therapists' choice of this intervention is usually underlined by a common question that most of society asks: "If these women are being abused, why don't they just leave?" Several theories regarding the incidence and prevalence of IPV have been proposed by researchers. The theoretical concepts of learned helplessness (Seligman, 1975), the cycle of violence theory as espoused by Walker (Walker, 1979, 1984), and, more recently, feminist theory (Holtzworth-Munroe, Meehan, Rehman, & Marshall, 2002), have been proposed to explain intimate partner violence. An explanation of each of these three theories follows.

Learned Helplessness Theory of IPV

The theory of *learned helplessness* was originally proposed by psychologist Martin Seligman in 1975. Through his research experiments with laboratory animals, Seligman and colleagues discovered that when caged dogs received repeated painful electrical shocks to their paws which they were unable to escape, they resigned themselves to the painful situation and ceased attempting escape even when escape routes were possible. Seligman realized that the dogs had not undergone any helplessness training prior to the experiments, and therefore their response to the shocks seemed instinctual. Seligman likened the dogs' learned helplessness to a type of human depression with particular cognitive, motivational, and behavioral aspects. It was hypothesized that the dogs' inability to predict or control the situation resulted in hopelessness. Later, Seligman and colleagues applied this theory of learned helplessness in laboratory trials with human subjects and found similar results. Human beings who were depressed seemed to hold negative, pessimistic beliefs about the efficacy of their actions and the likelihood of obtaining future rewards (Abramson, Seligman, & Teasdale, 1978).

Based on Seligman and colleagues' earlier studies on learned helplessness, Walker (1979) applied the theory to research with battered women. Walker found that battered women's experiences of violence in their intimate relationships, and their attempts to control or diminish the violence they experienced, eventually produced learned helplessness and depression (Walker, 1979). Similar to the repeated electrical shocks that the dogs suffered in Seligman's experiments, battered women's inability to predict or control repeated battering events eventually decreased their motivation to proactively respond to the uncontrollable violence in their lives.

Cycle of Violence Theory

Walker (1979, 1984) proposed another theory to further understand IPV victimization. From a tension reduction theoretical standpoint, IPV is neither random nor constant, but instead occurs in three phases, each of which repeats itself. In the first phase, called *tension building*, there is a gradual escalation of tension shown by cruel and intentional acts such as name-calling and/or physical abuse. The perpetrator of the violence usually expresses some dissatisfaction and hostility that is of a less violent form. The victim of the violence typically attempts to diffuse the perpetrator's anger by doing what she believes will please him and trying to avoid responding to his anger so as not to aggravate him further. The victim's use of anger reduction techniques may be successful for a while, contributing to her erroneous belief that she can control the violence. The victim's unrealistic belief only later contributes to her learned helplessness, as it becomes part of an unpredictable and uncontrollable response/outcome pattern (Walker, 1979, 1984).

As the tension continues to escalate, the violent cycle enters phase two, *the acute battering incident* (Walker, 1979, 1984). At this point, the victim realizes that her attempts to placate the perpetrator are unsuccessful and she begins to withdraw in order to avoid setting off an explosive response. As the perpetrator perceives the victim's withdrawal, he begins to move oppressively toward her to discharge the built up tension from phase one of the cycle. It is during this second phase that a verbally violent or physical battering incident inevitably occurs if there is no outside intervention. The victim perceives the inevitability of violence, and thus may position herself in a certain physical location and anticipate a particular time in order to minimize her injuries and pain from the attack. It is during this phase that law enforcement may be contacted. The battering incident only concludes when the perpetrator decides to stop, at which point he experiences a drastic physiological reduction in tension. Unfortunately, this natural satisfaction of a physiological need to reduce tension is reinforcing to the perpetrator, because it reaffirms to him that violence does work.

Once the battering in the second phase concludes, the violent cycle enters the third and last phase, called *loving contrition*. The perpetrator typically apologizes to his victim profusely, assisting her and showering her with kindness and sometimes gifts. The perpetrator may truly believe at this stage that he will never be violent again, and in turn the victim's strong desire to believe in the perpetrator's sincerity may influence her and renew her hope in her partner's ability to change. It is believed that this third phase of the cycle, with its absence of tension or violence, provides battered women with the positive reinforcement for remaining in the relationship (Walker, 1979, 1984). This vicious cycle is reactivated whenever tension or stressors resurface. Since Walker's theory was presented, more recent research contradicts the theory of violence among batterers as a cycle, instead explaining the batterers' violence as part of a pattern of behaviors aimed at exerting power and control over women, where it has been shown that the loving contrition period is largely missing from the behavior pattern (Pence & Paymar, 1993).

Feminist Theory of IPV

The more recent popularization of feminist theory and therapy has provided an understanding of IPV that focuses more on societal factors relative to interpersonal ones. From a social-constructionist perspective, feminist theory suggests that IPV, where women are primarily the victims, is caused by patriarchal social organizations in which men hold greater power and privilege over women (Holtzworth-Munroe et al., 2002). Men's economic advantage, adherence to traditional gender roles, and accepted use of violence (on both a small and large scale) contribute to male dominance in society and is supported by societal factors such as peer support, economic disparities between the genders, lack of or inappropriate police response to IPV, and minimal criminal sentences for IPV offenders (Holtzworth-Munroe et al.).

Most notably, feminist theorists have focused on the manner in which males and females are socialized by gender in order to provide an understanding of how violence among couples is perpetuated and maintained. According to Hansen and Harway (1997), in addition to physical force to maintain male dominance, gender-role socialization teaches and reinforces ways that males and females handle power in personal and social settings. In their review of earlier studies on gender differences, Hansen and Harway (1997) found that females are more interested than males in the well-being of others, tend to behave more passively in the presence of males, and consider the maintenance of relationships as more important. Societal rules characterizing female gender roles likely predispose women as a group to cooperate with and endure abusive and controlling behavior within intimate relationships.

Other theories of intimate partner violence exist as well (e.g. intrapersonal, interpersonal, and sociocultural, theories focusing on male violence) (Holtzworth-Munroe et al., 2002). For practitioners, an understanding of how and why intimate partner violence occurs, as well as consideration of the possible answers to the classic question 'Why don't women just leave abusive relationships?', can be provided by the theories discussed above as well as others. Adopting any one of the theoretical viewpoints can help guide therapists' conceptualization of male violence and have direct implications for treatment.

Risk Factors for Lethality of IPV

Critical factors exist which indicate greater risk of lethal outcomes in particular IPV cases. According to Kropp and Hart (1997) and McFarlane, Campbell, and Watson (2002), the following behaviors and beliefs of perpetrators of IPV should alert therapists to the high risk of perpetrator lethality:

1. Batterer's perception that the relationship is threatened and/or ending (e.g. infidelity, separation, divorce)

2. Past or present threats by batterer to kill self or partner (for example, represented by statements such as “I can’t live without you” and “If I can’t have you, no one will”)
3. Batterer unemployment (indicates that the batterer has little to lose)
4. Past or present batterer violence
5. Batterer stalking or monitoring behavior
6. Batterer drug or alcohol use (it has been found that intoxication is a common covariate with many IPV incidents)

Therapists must be aware of the risk factors which indicate imminent danger for women involved in relationships where they are victims of IPV in order to intervene to decrease victims’ risk of lethality. Campbell (2004) found that female victims of IPV who are at the highest risk of lethal violence by their intimate partners tend to grossly underestimate the seriousness of their situation. Campbell also found that female murder victims of IPV were more likely to be seen in the health care system instead of by domestic violence advocates during the year before they were killed. The implications of these findings are huge and raise serious questions for mental health professionals to consider with regards to their capabilities in assessing for IPV. If women fail to understand their high risk of being seriously injured, or worse, are killed by their intimate partners, how can therapists intervene effectively to decrease their chance of lethality when they themselves do not understand these risks? In addition, the urgency for IPV training becomes evident when considering the fact that victims of IPV are more likely to access mental health and other healthcare services as opposed to seeking out professionals who specialize in domestic violence intervention and treatment. All mental health practitioners should become more competent in detecting risk factors for IPV lethality and providing effective interventions in order to help ameliorate this social problem.

Lack of IPV Assessment Within the Healthcare Fields

Research shows that IPV has a significant and often negative impact on the physical and mental health of women. Therefore, it should come as no surprise that female victims of IPV present in significant numbers within the medical and mental health professions (Addis & Mahalik, 2003; Goff, Shelton, Byrd, & Parcel, 2003). The wealth of IPV knowledge, information, and screening tools that medical and mental health providers presently have at their fingertips should be more than enough to prepare them for the accurate and effective assessment of IPV victims. Unfortunately, numerous studies have shown this is not the case. Members of the medical and mental health professions appear ill-prepared to accurately assess their clients for IPV issues (Hansen & Harway, 1993; Hansen, Harway, & Cervantes, 1991; Goff et al., 2003; McCloskey, in submission; McCloskey & Grigsby, 2005).

Goff, Shelton, Byrd, and Parcel (2003) performed a qualitative study sampling physicians, nurse practitioners, and dentists working in a culturally diverse community to examine their educational experiences, screening practices, personal beliefs regarding how and when to screen clients for IPV, and their expected outcomes for screening for IPV. Goff et al. (2003) found that failure to screen for IPV was due to practitioners’ general lack of understanding or education about IPV, as well as the lack of standardized routine screening tools. The majority of medical practitioners surveyed did not feel that the topic of IPV was given adequate attention in their academic preparation, particularly the issue of intervening appropriately with female victims of abuse. Not surprisingly, due to the rate of females reporting physical injuries due to IPV, physicians reported the highest percentage of suspected IPV among their clients, and when, with whom, and how to screen for IPV varied among practitioners. Based on the results of their study, Goff et al. suggested that a relationship exists between medical practitioners’ formal education and their preparedness to

screen for IPV. The authors' suggestion was echoed by participants' statements that IPV assessment was not a part of their formal education.

Edin and Hogberg (2002) found that obstetricians also lack knowledge and the ability to correctly assess for IPV. The authors found that midwives in Sweden routinely failed to assess the women in their care for the presence of physical or sexual victimization. The midwives sampled, however, did voice a strong need for professional training of IPV and a willingness to include IPV assessment tools in their practice. Mental health professionals seem to be no better at assessing for IPV issues within their clientele and intervening effectively. Agar and Read's (2002) examination of treatment plans at a New Zealand community mental health center showed that although 46% of the files reviewed contained documentation of sexual or physical abuse as a child or adult, only 36% of clinical summary formulations mentioned abuse. In addition, the authors found that only 33% of those files included treatment plans that focused on the abuse, and only 22% of abused clients actually received treatment for the abuse.

Even medical practitioners specializing in trauma are ill-prepared to accurately assess for IPV in their clients. Davis, Parks, Kaups, Bennick, and Bidello (2003) found that within a California trauma unit, IPV victimization was not recognized nor reported by practitioners, even after a standardized screening procedure was developed for use. This finding supports Sherin, Sinacore, Li, Zitter, and Shakil's (1998) notion that the availability of such tools is no guarantee that their use will be implemented. Davis et al. (2003) concluded that the development and implementation of such screening tools for practitioners' use was simply not enough to increase accurate assessment of IPV. Practitioners must recognize the importance of the use of such tools, an understanding that can most effectively be provided through training within formal educational programs.

Mirroring the lack of training in IPV issues in mental-health related professional programs is training related to child abuse and neglect. Champion, Shipman, Bonner, Hensley, and Howe (2003) found that training in American Psychological Association (APA) – accredited clinical, counseling, and school psychology doctoral programs did not fully meet APA guidelines for minimum levels of competence, despite the fact that on average, students reported having some exposure to clients with child abuse and maltreatment issues, and child abuse mandated reporting is required throughout North America. Psychology doctoral students' lack of preparation in dealing with families with child abuse issues hints at their lack of preparation in dealing with IPV issues within adults. This notion is supported by research showing that where child abuse and maltreatment exist within families, domestic violence between adults is often present (Appel & Holden, 1998; Edleson, (1999; Lehmann & Rabenstein, 2002; Lewis, 2003). Research suggests that between 30% to 80% of women abused by a male partner have children who are also abused, maltreated, or neglected by either the male partner or mother (Appel & Holden, 1998; Edleson, 1999; Lewis, 2003). Hence, training in psychology doctoral programs concerning IPV issues can enhance students' ability to recognize not only the presence of IPV, but also where child abuse is overlapping. Lewis (2003) suggests that such training will lead to positive collaborations between domestic violence agencies and child protective services agencies by mental health professionals, and in turn more effective interventions with both populations of clientele.

Other professions show that training in IPV issues can increase practitioners' ability to accurately screen for such problems. Smith (2000) found that physicians, nurses, certified medical assistants, radiology technicians, laboratory technicians, and social workers from a variety of departments who enrolled in a domestic violence workshop reported greater self-efficacy in assessing clients for IPV. Smith's study also indicated that fear of offending clients, a lack of clinical skills, and feelings of helplessness were factors contributing to the

reluctance of health care providers to accurately identify victims of IPV. On the other hand, nurses, dentists, and physicians in training indicate that the inclusion of IPV coursework in professional training programs can increase the likelihood of screening for IPV issues and accurately identifying the existence of IPV in clients' lives (Danley, Gansky, Chow, & Gerbert, 2004; Hayward & Weber, 2003; Korenstein, Thomas, Foldes, Ross, Halm, & McGinn, 2003). Evidence that professional IPV training can improve health care providers' ability to and confidence in accurately screening their clients for IPV has huge implications for professional psychology training programs. Without IPV training within professional programs, psychologists (and other health care providers) are at great risk for being unprepared to deal effectively with clients presenting with IPV issues.

Misdiagnosis of Battered Women

The inability of medical and mental health care providers to identify and accurately assess their clients for IPV issues can undoubtedly have an impact on case conceptualization, diagnosis, intervention, and prognosis. Myths about IPV need to be dispelled and effective assessment and intervention strategies need to be provided. For instance, many female victims of IPV present for therapy alone without their male partners, which may contribute to the array of misdiagnoses that are typically given to female victims by mental health providers. In addition, mental health providers' tendency to diagnose female victims of IPV without consideration for the context in which psychiatric symptoms arise contributes to the problematic assumption that IPV female victimization is an individual issue, while ignoring the widespread prevalence of IPV in society (Walker, 1984, 1994).

In examining couples with IPV, researchers have found that women report significantly more fear than their male intimates, as well as more psychological and physical injuries, more symptoms of anxiety and depression, and more medical ailments as a result of IPV (Langhinrichsen-Rohling, 2005). Walker (1994) discovered that about 60% of women presenting for mental health services had a history of physical abuse perpetrated against them, although treatment for physical abuse was not their presenting problem. She also found that mental health care providers tended to overlook the presence of physical abuse in clients' lives. In alignment with feminist theory, the pervasiveness of IPV in society and the silent acceptance of female victimization by a male dominated society affect the mental health field, and often lead to the failure of mental health providers to make appropriate inquiries regarding IPV (Hansen & Harway, 1997; Holtzworth-Munroe et al., 2002; McCloskey & Fraser, 1997; Walker, 1984, 1994).

Walker (1994) holds that in the absence of IPV context during initial interviews of females seeking mental health services, the psychological and emotional injuries that females experience as a natural result of IPV can be disguised as pathology that meet the common criteria for various mental health diagnoses. Gleason (1993) examined the prevalence of mental health diagnoses commonly diagnosed among female victims of IPV. High prevalence was found for psychosexual dysfunction, Major Depression, Posttraumatic Stress Disorder, Generalized Anxiety Disorder, and Obsessive-Compulsive Disorder, while other less frequently diagnosed disorders were Phobia, Simple Phobia, Agoraphobia, Social Phobia, Dysthymia, Alcohol and Drug Abuse/Dependence, Panic Disorder, Antisocial Personality Disorder, and Schizophrenia (Gleason, 1993).

The diagnostic symptoms commonly found among the population of female victims of IPV mirror the symptomology that Walker (1984, 1994) identified, which led to her development of the *Battered Women's Syndrome*. Walker (1984) found that the clinical presentation of women meeting the criteria for *Battered Women's Syndrome* includes symptoms of anxiety and depression, cognitive distortions such as memory impairment and dissociation, the re-experiencing of traumatic events, the disruption of interpersonal relationships, and sexual

dysfunction. Walker also found that the depressive symptoms reported by women meeting criteria for *Battered Women's Syndrome* typically persisted well after the incidence of battering had stopped.

Research implies that therapists must understand how the context of IPV victimization affects women's psychological functioning. Grigsby and Hartman (1997) proposed The Barriers Model as a treatment guide for therapists working with IPV victims. Instead of pathologizing victims of IPV, Grigsby and Hartman suggest that therapists give recognition to the external and internal factors that victims of IPV are faced with, which may account for their behaviors and symptomology. The Barriers Model suggests that therapists should address barriers to victims' safety found in the physical environment, within the family, socialization, role expectations, psychological consequences of exposure to violence, and childhood abuse and neglect issues. Use of such a treatment approach with victims of IPV may decrease the likelihood of victims being diagnosed with other psychiatric disorders that ignore the many other forces influencing clinical presentation. Taking into account the described barriers that exist in victims' lives and incorporating them into therapy can increase the effectiveness of therapists' interventions with victims of IPV.

The similarities that Walker points out between the symptomology of common diagnoses of female victims of IPV and the symptomology of *Battered Women's Syndrome* implies that mental health providers need to take a closer look at the personal backgrounds of battered women and the contexts in which they present for therapy in order to avoid misdiagnosing women with IPV issues. More accurate assessment and consideration for the major role that the experience of IPV could have in clinical presentation could lead mental health providers to make more appropriate diagnoses, such as complex forms of Posttraumatic Stress Disorder or partner abuse V-codes listed in the Diagnostic and Statistical Manual for Mental Disorders, Fourth Edition Text Revision (or DSM-IV-TR, American Psychological Association, 2000).

The Present Study

The lack of knowledge concerning IPV within the medical and mental health fields implies that despite the pervasiveness of this problem in society, it remains virtually invisible. Because the field of psychology shares this problem with other health care fields, IPV training in professional psychology and other mental health-related programs can increase mental health professionals' accuracy in assessing for IPV issues, increase intervention effectiveness, and reduce risk of danger. At the time of Harway and Hansen (1993) and Hansen, Harway, and Cervantes' (1991) studies, the majority of therapists could not identify the severity of lethal violence indicated in the case study, let alone intervene effectively to reduce the chances of injury, or worse, death. The present study aims to compare responses of present-day therapists with those obtained by Harway and colleagues over 10 years ago. This study will examine global measures of therapist assessment and intervention strategies concerning IPV, as well as assess whether therapists' knowledge and approaches have progressed a decade later in light of the current existing knowledge regarding IPV.

The present study expects that therapists are now more well-prepared to deal with IPV issues and have an improved ability to accurately assess for IPV issues compared to 10 years ago. It is also expected that therapists today are capable of intervening more effectively with victims and perpetrators of IPV to reduce the risk of danger to their clients. Therapists' correct recognition and effective intervention is largely influenced by the preparation they receive through their professional training. Thus, it was expected that therapists today are more knowledgeable about IPV issues.

METHOD

Materials

An informed consent letter explaining the present study and requesting voluntary participation was mailed to respondents (see Appendix A for Informed Consent letter). A short survey requesting demographic information was attached to an actual case vignette concerning intimate partner violence which resulted in the rape and murder of the wife, which was taken verbatim from Harway and Hansen (1993) in order to replicate their studies (see Appendix B for Therapist Survey Questionnaire).

Procedures

Mailing lists of respondents were compiled from on-line websites currently maintained by 15 states within the U.S. consisting of independently licensed psychologists, clinical social workers, and marriage and family therapists (see Table 1). In order to create the mailing list, 20 names and addresses from each of the 15 states' licensing websites were randomly downloaded for the three different types of mental health providers. This selection approach was chosen to maximize the chance that active practitioners in the field were accessed.

The survey and study design received approval from the Institutional Review Board at the University of Hartford. Recruitment of respondents occurred by mail and consisted of a packet containing an informed consent cover letter and a copy of the therapist survey questionnaire. Informed consent was given by each respondent through the act of completing the questionnaire and returning it in the envelope provided (Appendix A). Questionnaires were numbered in order to track the mental health provider's state of residence. Hence, the numbering system was blind to the identity of the respondent.

After providing brief demographic information, respondents were required to read the case vignette whereupon open-ended questions required a written response. Afterwards, respondents were informed that the husband raped and killed his wife a few days after the therapy session. With this new information, respondents were then asked if they would change any of their earlier responses.

Data Management and Coding

Two independent raters coded all 111 of the returned surveys. Rating sheets were used to record keywords found within the written answers on the survey in order to identify emergent categories of responses, as well as code answers using the approach outlined by Harway and colleagues (for further explanation of coding procedures, see Results section). Rating sheets completed by the two independent raters were then compared. Any discrepancies were discussed by the two raters after they reviewed both the coding sheets and the survey simultaneously. Agreement was then reached as to the appropriate coding scheme. Once this was accomplished, data from the coding sheets were entered into an Excel spreadsheet and downloaded into SPSS 4.0 for further statistical analyses.

Of the 900 surveys mailed out, 270 were returned as undeliverable. Based on the sample of surveys that were delivered, the sample return rate was about 18%. The return rate ranged from a high of 23% from California and a low of 2% from Georgia. Different response rates by state could be attributed to variations in the quality of the licensing websites accessed (e.g. periodic maintenance, timely updates, etc.).

RESULTS

Analyses

Demographic Information—As seen in Table 1, there were more female respondents than male respondents, as well as more doctoral-level respondents than masters-level, but these differences were not statistically significant. The mean age of 55 for the present sample was about 5 years older than the mean age of 50 found in Harway and Hansen's (1993) sample. The other study (Hansen, Harway, & Cervantes, 1991) did not report mean age from their sample so no comparison could be made.

Time from the highest degree was approximately 21 years, suggesting that the present sample consisted of mental health providers who had been independently licensed on average for about two decades. In addition, respondents from the states of CA, NY, and WA represented about 40% of the entire sample, while another 13 states made up the remaining 60%.

Psychologists made up about 44% of the entire respondent sample, followed by clinical social workers, marriage and family therapists, and those not easily categorized (Table 1). In addition, those respondents who stated their theoretical orientation was eclectic and/or integrated constituted the largest percentage of the sample (34%), followed by those endorsing systems theory, cognitive/behavioral, psychodynamic, other, and existential/humanistic.

Gender by Type of Mental Health Profession and Level of Education

From Harway and Hansen's (1993) study using primarily a sample of psychologists, only 29% were female while 71% were male. Harway and Hansen explained this discrepancy by stating that family therapists were primarily master's level clinicians equally represented by gender, whereas psychologists were primarily doctoral level clinicians over-represented by males. However, in the present sample, slightly over 40% of psychologists were female, suggesting an increase in female representation for psychologists of about 10% (Table 2). It is possible that the gender discrepancy for psychologists found in Harway and Hansen (1993) is not as evident in the present sample due to the increase in females within psychology over the past 10 years (see the American Psychological Association (2001) website for the most recent data on gender representation).

From a sample of family therapists, Hansen, Harway, and Cervantes (1991) found that 53% of therapists were female and 47% were male. The present sample showed that 58% of family therapists were female and 42% were male (Table 2), representing a slightly larger representation of females than that of Hansen and colleagues. However, clinical social workers were predominantly female (about 71%, which was statistically significant).

In addition, Harway and colleagues also found that males were more likely overall to hold mental health-related doctorates, while females were more likely to hold master's level degrees. Table 2 shows that the present sample virtually replicates this statistically significant pattern even though approximately 10 years had elapsed between studies.

Gender and Theoretical Orientation

In their sample consisting primarily of psychologists, Harway and Hansen (1993) found a variety of orientations: 22% cognitive, 21% psychoanalytic, 12% existential/humanistic, 8% behavioral, and 7% family systems, with another 30% reporting other lesser-known orientations. They did not report whether or not theoretical orientation varied based on gender (probably because their sample was 71% male). Table 3 shows that the present

sample also reflected an array of orientations reported by psychologists: eclectic or integrative (35%), cognitive/behavioral (27%), existential/ humanistic (12%), psychodynamic (12%), systems (10%), and other (4%) orientations. In the present sample of clinical social workers, the most often endorsed orientation was eclectic or integrative (41%), similar to psychologists. This orientation was followed by psychodynamic (17%), other orientations (17%), cognitive/behavioral (15%) and systems (9%).

In their sample of primarily marriage and family therapists, it was not surprising that Hansen, Harway, and Cervantes (1991) found that about 60% of their sample reported family systems as being their primary theoretical orientation. They found virtually no differences in theoretical orientation based on gender. Table 3 shows that once again marriage and family therapists predominantly identify systems theory as their theoretical orientation at a statistically significant level (63%).

Identifying Relationship Conflict

Presence/Absence of Conflict—Hansen, Harway, and Cervantes (1991) showed that psychologists addressed conflict in the vignette about 50% of the time, while other mental health therapists did so only about 38% of the time (overall, 40% failed to address conflict at all). For a direct comparison, percentage of recognition of relationship conflict by different mental health profession is shown in Table 4.

As can be seen, only about 13% of all mental health providers failed to address relationship conflict at all, representing a 27% improvement in detection within the present sample. In addition, the slight superiority in identifying conflict by psychologists in Hansen, Harway, and Cervantes' study was not statistically replicated.

Type of Conflict

While about 87% of the entire respondent sample identified conflict within the vignette, it was not known what type of conflict was identified without examining written narrative responses. The survey's open-ended question "What is going on?" elicited an array of responses. Two independent raters ascertained what common categories were used, and 13 categories emerged: (a) violence/battering, (b) infidelity, (c) child abuse, (d) substance abuse, (e) trust issues (secrets, lying, betrayal, blame, etc.), (f) other abuse of partner, (g) power struggle in relationship, (h) denial of problems by adults, (i) anger, (j) out-of-control behavior, (k) lethality, (l) family of origin issues, and (m) further information needed/not able to answer (Table 5). Percentages were determined by type of profession, and no statistical analyses were attempted due to zero responses in some of the categorical cells.

Violence and/or battering behavior was identified by about 77.5% of respondents as a source of relationship conflict, followed by infidelity (32%), child abuse (28%), substance abuse (14%), trust issues (10%) and other partner abuse (9%). About 7% of respondents said they needed more information or couldn't answer.

Marriage and family therapists were almost 20% more likely to identify violence or battering than were psychologists, while psychologists were less likely to provide the wife's infidelity as a descriptor surrounding the conflict. Clinical social workers were the most likely of the professions to identify substance abuse as an issue within the conflict. Five percent or less identified denial of problems, anger problems, out of control behavior, or family of origin issues as a source of conflict. Disturbingly, only one respondent identified that possible lethality could underlie the situation presented in the vignette (Table 5).

Other descriptors were also seen in the survey responses, but could not be logically categorized under the domains mentioned above. These descriptors included: acting out due

to jealousy and/or obsessiveness (6 respondents, 5.4%), problems caused by impending separation/divorce (4 respondents, 3.6%), communication problems (2 respondents, 1.8%), provocative behaviors by the wife (2 respondents, 1.8%), increased conflict as the result of a manipulated therapist (2 respondents, 1.8%), systems pattern dysfunction (1 respondent, 0.1%), and the presence of psychosis (1 respondent, 0.1%).

Clinical Assessment of the Vignette

Reasons for Problems in the Relationship—Reasons for the on-going problems reported in the case vignette were coded by two independent raters as outlined above. Following the results of Harway and Hansen (1993), respondent answers were coded into the following four categories: (a) couple dynamics, (b) James' beliefs/behaviors, (c) Carol's beliefs/behaviors, and (d) not enough information. Percentages were determined by profession and theoretical orientation, respectively, while no statistical analyses were attempted due to zero responses in some of the cells (Table 6).

As can be seen, 43% of respondents said the reason for the relationship conflict within the vignette was problematic couple dynamics, while almost 40% said they did not have enough information to determine who or what was responsible. Approximately 12% said that James was responsible, and another 5% said Carol was responsible. Clinical social workers (59%) were the most likely to cite couple dynamics as the underlying reason for the conflict, while marriage and family therapists (47%) were the most likely to state there wasn't enough information. Interestingly, those with a family systems theoretical orientation were *not* the most likely to cite couple dynamics as the reason for conflict, and instead were more similar in their responses to cognitive/behavioral therapists. Eclectic/integrative, cognitive/behavioral, and family systems therapists were the most likely to state there wasn't enough information.

Possible Mental Health Diagnoses

Harway and Hansen (1993) found that the most common diagnosis in their sample was Marital Problems (23%), classified as a V-code within the DSM-IV (American Psychiatric Association, 2000). Next most common was diagnosing both James (Intermittent Explosive Disorder and Conduct Disorder) and Carol (Dependent or Self-Defeating Personality Disorder) with some sort of psychopathology. Sixteen percent diagnosed only James. A total of 36% claimed they did not have enough information to make a diagnosis. Thus, from the second open-ended question in the survey in the present study, a simple count was provided with percentages of all diagnoses (including refusal to diagnose) in order to replicate as closely as possible the above analysis using the following classification scheme: (a) couple's problem, (b) both James and Carol, (c) James only, (d) Carol only, and (e) not enough information to make a diagnosis.

A Marital Problem V-code (33%) was once again the most commonly reported diagnosis by the respondents in the present sample. However, approximately 10% more respondents gave this diagnosis in the present sample than did those in Harway and Hansen's study. Twenty-seven percent of the respondents provided separate diagnoses for both James and Carol, and 23% refused to give a diagnosis due to insufficient information. Interestingly, only 12% diagnosed only James, compared to 16% in Harway and Hansen's study. Six percent diagnosed only Carol.

Those who provided specific diagnoses gave nine different types for James and ten different types for Carol (Table 7). The most common diagnoses for James were Intermittent Explosive or other impulse disorder (27%), followed by Paranoia or other thought disorders (15%), unspecified Personality Disorders (15%), and Depression or Dysthymia (14%).

Compared to Harway and Hansen's (1993) results, diagnoses of the Intermittent Explosive type were once again quite common. In contrast, however, Conduct Disorder was not as prominent in the current data set.

The most common diagnoses for Carol were Depression or Dysthymia (21%), followed by Masochism, Conduct Disorder, or other blaming stance (20%), Anxiety/PTSD/GAD (17%), and Substance Abuse (14%). While Dependent or Self-Defeating Personality Disorder was the most common diagnosis for Carol in Harway and Hansen's study, it was much lower in the present study (4%).

Possible Legal/Ethical Issues

According to Harway and Hansen (1993), "...23% of therapists were concerned about the possible duty to warn the intended victim, 19% were concerned about providing protection for Carol, and 17% had a variety of questions about the role of the therapist in a situation that one described as "more legal than therapeutic"...8% were worried about issues of confidentiality or secrecy between the therapist and the members of the couple (a non-issue in the vignette), 5% were concerned about their duty to report child abuse, and 4% boldly indicated that the case raised *no* legal/ethical issues" (pg. 47). Thus, answers to the last open-ended question in the present survey were coded according to the following: (a) duty to warn, (b) duty to protect, (c) duty to report child abuse, (d) confidentiality issues, (e) secrecy amongst therapy participants, and (f) no issue identified. Table 8 shows that duty to report child abuse was the single largest legal/ethical issue listed by respondents (58%), followed by duty to protect (50%), confidentiality issues between the therapist and the couple (35%), and duty to warn (24%). Eleven percent reported ethical/legal problems surrounding secrecy between the couple. Interestingly, 12% indicated there were no ethical/legal problems within the vignette, representing an increase of almost 8% from those stating there were no ethical/legal concerns in Harway and colleagues' findings.

Suggested Therapeutic Interventions

Hansen, Harway, and Cervantes (1991) found that 28% of therapists would recommend traditional couples or family counseling, 48% would need further assessment to act, 60% would work on non-violence, and 45% would recommend crisis intervention (percentages sum to more than 100% due to multiple responses). Similarly, Harway and Hansen (1993) found that therapists could be categorized into three broad categories: (a) contextualists, who were more likely to provide some sort of crisis intervention to address the lethality in the case vignette, (b) communication interventionists, who were more likely to apply standard therapeutic techniques while missing the need to intervene in an immediate way, and (c) avoiders, who were hesitant to make any decisions without further information. Upon examination of the narrative responses to the third open-ended question in the survey, "How would you intervene?" the present study found that respondents also reported more than one type of intervention. Hansen, Harway, and Cervantes (1991) found that only 45% of their sample would recommend crisis intervention. However, 68% of the present sample explicitly used the phrase "crisis intervention" (Table 9), which represents a marked improvement. However, slightly over 40% of the current sample also explicitly stated they would use couple's therapy whether or not they were conducting crisis interventions, about 12% higher than that found in Hansen, Harway, and Cervantes.

Using the presence of lethality descriptors given by respondents prior to notification of Carol's rape and murder, two independent raters coded answers on the following 5-point Likert scale for increasing lethality and need to intervene: (1) did not recommend crisis intervention, (2) recommended crisis intervention but only intervened with Carol or the couple, (3) recommended crisis intervention and asked James about lethality or referred to

his dangerousness, (4) assessed James as lethal and completed a safety plan and/or non-violence plan for him, and (5) assessed James as lethal and considered calling the police or having him hospitalized (Figure 1). Often, an intervention was coded as crisis-related even if the respondent did not use that explicit phrase, especially when the action was intended to avert an immediate and negative outcome. Not surprisingly, very few respondents said they would attempt to secure a non-violence contract with James or consider calling the police or hospitalizing James (Figure 1). Instead, most respondents said they would intervene with either Carol alone or with Carol and James together, or would conduct an assessment of James to gather further information about his lethality.

When testing demographic variables (highest degree, age, years since graduation, profession, theoretical orientation) against the level of intervention coded on the 5-point Likert scale above, none of the relationships and/or differences proved to be statistically significant. While female respondents ($M=2.74$, $SD=1.15$) tended to rate the level of needed crisis intervention somewhat higher than males ($M=2.36$, $SD=1.28$), this difference was not significant.

Because of the narrative differences between the present results and those of Harway and colleagues, the categories of “contextualists, communication-interventionists, and avoiders” used to describe types of therapists did not fit well for the present sample. The 90 respondents who recommended some sort of crisis intervention usually gave more than one type of response. This explains why the total number of recommended interventions shown in Table 10 sum to greater than 90. Recommendations for some type of crisis intervention with Carol were the single largest category of intervention (79.3%). In contrast, there were only 30 recommendations for crisis intervention with James (27%). Interestingly, there were 31 recommendations for crisis intervention with both James and Carol (28%), with 18 recommendations for possible or immediate separation (16.2%).

The two approaches to the current data given above suggest that most of the time, therapists were recommending crisis intervention with Carol or with Carol *and* James, when in fact Carol was not the adult within the couple who had potential lethality issues. Surprisingly, only 14 times did therapists suggest that a lethality assessment of James might result in a call to police, and only five times was hospitalization for James suggested.

While it is certainly important that Carol be advised of concrete suggestions for keeping herself and her children safe (e.g., safety plans, protection/restraining orders, etc.), intervening with her alone or simultaneously with James only serves to send the message to both that she is equally responsible for his potential lethality. In addition, suggesting separation as a possibility or as an immediate recommendation suggests that therapists were often unaware of the severe risk for future violence that separation may bring.

Expected Outcomes

Results from Hansen, Harway, and Cervantes (1991) showed that not one therapist predicted lethality for a family member as a possible outcome of the case vignette; 23% expected some sort of negative outcome -- mostly divorce, denial, resistance, and more couple's problems -- but only 4% saw increased anger as a likely outcome and only one respondent predicted increased violence. Thus, answers to the open-ended question, “What outcome would you expect from your intervention?” were coded into the following categories: (1) reduction in conflict, (2) no change, (3) increase in conflict, (4) increase in violence, and (5) lethality. Percentages were calculated for expected outcomes by profession and theoretical orientation (Table 11). As can be seen, about 50% of the sample declined to answer this question, another 27% believed their interventions would result in a reduction of conflict, and about 20% believed there would be an increase in conflict and/or violence within the

couple. Because half the respondents refused to respond to the question, it is assumed that half the respondents did not know what the outcome would be although other alternative hypotheses for this result obviously cannot be ruled out. Only one respondent predicted the outcome would be lethal violence, one more than Harway and colleagues had reported 10 years earlier.

Possible Reformulation of Answers After Being Informed of Client's Murder

The final portion of the analysis concerned any changes that occurred to therapists' responses after being informed of the lethality of the situation. First, the last page of the survey was examined to see if respondents changed any of their answers after being informed of Carol's rape and subsequent murder by her husband. Each respondent had a dichotomous code assigned: (1) yes (any changes whatsoever), and (2) no (none). For those respondents who changed nothing, a simple count and percentage of the total sample was calculated and reported for this category (Table 12) and then those surveys were set aside.

For those who did change their answers, another simple count was completed for each of the five questions: (a) what is going on? (b) diagnosis, (c) interventions, (d) outcomes, and (e) legal/ethical issues. Thus, counts and percentages of the total sample were obtained for changes by category (Table 12).

As can be seen, almost half the sample would have changed their recommended interventions, followed by their answers to the questions "What is going on?" (35%). Slightly less than one-third did not change their answers at all.

DISCUSSION

Summary

In the past, lack of knowledge of IPV likely attributed to mental health professionals' inability to accurately assess for such issues within families seeking therapeutic services. However, over the past 20 years we have seen a dramatic increase in research on IPV and it has been recognized by society as a serious problem. Research has also shown that females are disproportionately more often the victims of IPV compared to men, and as a result access mental health services at high rates.

The aim of this effort was to replicate a study conducted over a decade ago by Harway and Hansen (1993) and Hansen, Harway, and Cervantes (1991). Harway and colleagues found that 40% of sampled psychologists, clinical social workers, marriage and family therapists, and other mental health professionals failed to identify lethality within a vignette, and 46% suggested interventions that were ineffective at reducing the risk of violence. In the present study, only 13% of the sample failed to identify conflict within the relationship and 81% suggested crisis intervention as a therapeutic approach. Hence, the overall results of the current study show a marked improvement from Harway and colleagues' study in mental health professionals' ability to correctly identify IPV issues within families presenting for therapeutic services and to effectively intervene in order to reduce risk of lethality. Disturbingly, however, the present study resembled the results of Harway and colleagues' study in that only one respondent in the current sample, a clinical social worker, identified possible lethality as a clinical issue.

Increased knowledge and awareness of IPV may have played a part in mental health professionals' improved ability to identify such issues within the mental health field compared to a decade ago. Although therapists have come a long way since Harway and colleagues' original study, the findings indicate that there is still more that needs to be done when it comes to accurately assessing and intervening with IPV victims in a safe and

effective manner. The results presented here suggest that increased training in and exposure to IPV is necessary in order to increase therapists' effectiveness in dealing with IPV issues.

Implications of Findings on Professional Training

Recognition of Conflictual Relationship by Profession—Psychologists on a whole were less likely than clinical social workers, marriage and family therapists, and other therapists' to identify violence and battering as the conflict within the relationship, showing approximately a 10% decrease in their ability to identify IPV within families over the decade. This finding raises questions regarding doctoral-level psychologists' skills in IPV assessment in comparison to other mental health professionals with fewer years of professional training. The decrease in psychologists' ability to recognize IPV issues over a 10 year period may be attributed to a lack of academic and practical training which relates specifically to IPV assessment and/or intervention. Also, with the exception of the states of California and Florida, psychologists are not required to perform continuing education in order to maintain state licensure.

Reasons for Problems in the Relationship

Forty percent of sampled mental health professionals attributed couple dynamics as the reason for problems within the relationship, while another 40% said they did not have sufficient information based on the vignette to determine responsibility for problems within the relationship. Attribution of the problem to both partners was surprising, given that therapists who identified their theoretical orientation as family systems were not the most likely to cite couple dynamics as the problem. More surprising was the assignment of responsibility, or blame, that therapists gave to each individual partner. Only twelve percent of the sample assigned blame to James for the relational conflict, despite the fact that violence and battering had been earlier identified by therapists as the primary conflict in the vignette. Five percent of the sample assigned blame to Carol for the problems. This response implies that therapists lack an awareness of the severity of the couple's situation, which would directly influence their perception of the problem as non-lethal as well as their chosen intervention.

Although not significant, it is noteworthy that 47% of marriage and family therapists stated that there was not enough information to decide responsibility for the conflict. Frequently, situational and environmental factors, therapist-client dynamics, and managed care limit the frequency of visits that clients may have with practicing mental health professionals. Therefore, this response becomes significant in and of itself because it prompts the question "How many visits does a therapist require in order to feel confident with the information he/she has in order to make an accurate assessment?" Unfortunately, as in the case of the vignette, sometimes victims only get one chance to either indirectly or directly ask for help and therapists only get one opportunity to recognize when help is warranted and do what they can to provide safety for their clients. On the other hand, given the limited amount of information present in the vignette, the likelihood of therapists identifying risk factors that suggest a possible lethal outcome and their ability to accurately detect the presence of IPV is decreased.

Possible Mental Health Diagnoses

Similar to the results of Harway and colleagues' study over a decade ago, a Marital Problem V-code diagnosis was still the single most common diagnosis given in the present study. This diagnosis again reflects therapists' perception of the conflict in the relationship resulting from the couple dynamics between James and Carol. About a third of the sample diagnosed James with Intermittent Explosive Disorder or another Impulse Control Disorder, suggesting that therapists deduced from the information given in the vignette that he had a

high potential for violent behavior. The diagnoses given to Carol separately suggest that therapists were more likely than over a decade ago to diagnose Carol from an overall blaming stance, because Depression, Dysthymia, Masochistic Personality Disorder or Conduct Disorder were the most common diagnoses. In contrast, therapists in the present study were less likely to diagnose Carol with Dependent or Self-Defeating Personality Disorder. The diagnostic impressions that therapists formed for Carol suggest that therapists may not take into consideration *Battered Women's Syndrome*, whose clinical presentation includes many of the symptoms present in disorders such as depression. However, a diagnosis specifically focusing on abuse of an adult indicates that therapists acknowledge the violence and therefore may be more likely to focus on safety as opposed to resolution between victim and perpetrator.

Possible Legal/Ethical Issues

Therapists in the present study stated that the duty to report child abuse was the largest legal/ethical issue present in the vignette, representing a large increase from Harway and colleagues' study over ten years ago. This drastic increase is likely due to the advent of child abuse reporting laws that occurred in the early 1990s. Despite this fact, therapists in the present study were more likely to deny the existence of any legal/ethical issues as a separate category compared to Harway and colleagues' study.

Suggested Therapeutic Interventions

Crisis intervention was suggested by 81% of respondents, a marked improvement from Harway and colleagues' findings (45%). However, 40% of therapists in the present study recommended couples' therapy while only 28% of Harway and colleagues' sample did so. Crisis intervention with Carol only or with Carol and James together was recommended 119 times by respondents, while only 27% of all responses concerned crisis intervention with James only. A little over half of the respondents recommended possible or immediate separation of Carol from James, but only 14 times did therapists recommend contacting authorities with concerns of James' potential lethality and only five times did therapists recommend possible hospitalization for James. Even though Carol was not the adult in danger of acting in a potentially lethal manner and instead was the target of James' lethality, therapists overwhelmingly focused their interventions on Carol solely or otherwise included her in couples' therapy intervention, where proximity to her attacker may have made her vulnerable to his actions and given both the impression that Carol shares the responsibility for James' behavior. The tendency to intervene most often with the victim of IPV as opposed to the perpetrator is likely due to the fact that the victim is typically more willing and open to therapy, while the perpetrator is typically more resistant, refusing to believe that his behavior is a problem. This finding also reflects the hesitancy and lack of confidence that mental health providers typically report as a main hindrance to their direct questioning of IPV issues (Goff et al., 2003).

Predicted Outcomes of Interventions

Slightly over 50% of therapists failed to predict any outcomes resulting from their interventions. Twenty-seven percent expected a reduction in conflict as a result of their interventions, while 20% predicted an increase in conflict and/or violence regardless of their therapeutic interventions. Sadly, only one therapist predicted possible lethal violence in our sample compared to no therapists in Harway's study. Overall, although these results suggest somewhat of an improvement over the decade, they still indicate that therapists do not show great ability to predict lethal outcomes when the potential is clearly present. This implies that therapists may not be familiar with lethal IPV risk factors, which may be provided through training.

Possible Reformulation of Answers After Being Informed of Client's Murder

Results indicate that almost half of the sample would have changed their recommended interventions and 35% of respondents changed their formulation of what was happening within the vignette. Surprisingly, however, 32% of the sample did not change any of their original answers despite being informed of Carol's subsequent rape and murder. This may suggest that therapists perceive they have a lack of power in influencing the couple's situation. Failure to modify any responses may have also been due to therapists' faith and confidence in their responses, and an unwillingness to make changes. Obviously, this rationalization can pose a major danger to victims of IPV. Awareness of IPV within the mental health field needs to be raised through advocacy and training so that therapists can be encouraged to look more closely for signs of IPV in their interactions with clients.

Limitations of the Study

The present study had several limitations. First, the return rate of respondents was lower than expected, although within the range of that found in similar research studies (see Champion, Shipman, Bonner, Hensley, & Howe, 2003). Second, although the study sampled psychologists, clinical social workers, marriage and family therapists, and other unspecified mental health professionals, alcohol and drug abuse counselors were not included in the study. Research has indicated that there is a correlation between IPV and substance abuse, hence it is logical to assume that alcohol and drug abuse counselors may have significant exposure to clients with IPV issues within their area of practice. Future research may want to include this population within their sample to determine if they exhibit trends that are different from what the present research found.

Conclusions and Recommendations

The purpose of this dissertation was to assess therapists' ability to recognize clients' IPV issues and to respond appropriately so as to reduce the possibility of danger. As was expected, the overall results of the study show that therapists were more likely to identify IPV issues in a clinical vignette compared to 10 years ago, which indicates that training and exposure to these issues seem to be contributing to improvement in therapists' abilities. However, therapists still fail to adopt a non-blaming stance with victims of IPV and show a tendency to intervene in a manner which is likely to increase the victim's risk of injury or danger.

Therapists have indeed come a long way, yet the results of this study point to the fact that continued training is needed when it comes to assessment and intervention of IPV. If experienced therapists find difficulty in recognizing potential lethality when assessing clients with IPV issues, it may be safe to assume that the ability to do so may require specialized skills. Professional training programs should consider inclusion of such training within coursework, because therapists will be ill-prepared without specific focus on IPV assessment and intervention. The argument for inclusion of specialized IPV training within mental health-related graduate programs is strengthened by other research that has found that students who receive other types of health-related training are more capable of recognizing and dealing with issues of IPV (Danley et al., 2004; Hayward & Weber, 2003; Korenstein et al., 2003; Smith, 2000).

Mental health professionals need greater skill in assessing IPV as well as intervening effectively with clients in order to reduce risk and increase self-empowerment. Advocacy for the inclusion of IPV issues within professional training programs in psychology as well as other mental health disciplines must occur, especially given the results above that therapists are prone to making dangerous therapeutic decisions. Hopefully, advocacy for IPV training will lead to accreditation requirements and licensure laws that reflect the importance of

accurate IPV assessment and intervention by requiring the inclusion of IPV training within professional training programs.

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Figure 1.
Number of Respondents Recommending Specific Types of Crisis Intervention.

Table 1

Demographics of the Sample.

Gender*		Highest Degree*	
Female 62 (55.9%)	Male 49 (44.1%)	Masters 49 (44.2%)	Doctorate 62 (55.9%)
<i>Age</i> Mean=55.01 SD=9.27 Range=29–84		<i>Years Since Degree</i> Mean=21.08 SD=10.35 Range=3–48	
<i>Professional Identification</i>		<i>Theoretical Orientation</i>	
	<i>N</i>		<i>N</i>
Psychologists	49 (44.1%)	Eclectic or Integrative	38 (34.2%)
Clinical Social Workers	34 (30.6%)	Systems Theory	23 (20.7%)
MFT	19 (17.1%)	Cognitive/Behavioral	21 (18.9%)
Other	9 (8.1%)	Psychodynamic	13 (11.7%)
		Other (brief, gestalt, etc.)	9 (8.1%)
		Existential/Humanistic	7 (6.3%)
<i>Respondents by State (N)</i>			
CA=14	NJ=9	NC=6	PA=5
NY=13	VA=9	FL=5	IL=3
WA=12	TX=8	MA=5	GA=1
OH=9	MI=6	MD=5	Unknown=1

* Chi-Square not statistically significant.

MFT = Marriage & Family Therapist.

Table 2

Gender Profession and Level of Education.

Profession *	Gender		Total
	Male	Female	
Psychologist	29 (59.2%)	20 (40.8%)	49 (100%)
Clinical Social Work	10 (29.4%)	24 (70.6%)	34 (100%)
MFT	8 (42.1%)	11 (57.9%)	19 (100%)
Other	2 (22.2%)	7 (77.8%)	9 (100%)
<i>Total</i>	49	62	

Degree Level**			
Doctoral Degree	37 (59.6%)	25 (40.5%)	62 (100%)
Master's Degree	12 (24.5%)	37 (75.5%)	49 (100%)
<i>Total</i>	49	62	

* $\chi^2 (3, 9.274) = p < 0.026$.

MFT = Marriage & Family Therapist.

** $\chi^2 (1, 13.744) = p < 0.0001$. More Doctoral degrees for males than Masters degrees.

Table 3

Theoretical Orientation by Gender for Psychologists, Clinical Social Workers, and Marriage and Family Therapists.

Psychologists*	Gender		Total
	Male	Female	
Orientation			
Eclectic or Integrative	11	6	17 (34.7%)
Cognitive/ Behavioral	9	4	13 (26.5%)
Existential/Humanistic	3	3	6 (12.2%)
Psychodynamic	4	2	6 (12.2%)
Family Systems	2	3	5 (10.2%)
Other	0	2	2 (4.1%)

Clinical Social Workers**			
Orientation			
Eclectic or Integrative	4	10	14 (41.2%)
Psychodynamic	2	4	6 (17.6%)
Other	0	6	6 (17.6%)
Cognitive/ Behavioral	4	1	5 (14.7%)
Family Systems	0	3	3 (8.8%)

MFT***			
Orientation			
Systems Theory	4	8	12 (63.1%)
Eclectic or Integrative	3	2	5 (26.3%)
Existential/Humanistic	1	0	1 (5.2%)
Other	0	1	1 (5.2%)

* $\chi^2 (5, 19.499) = p < 0.002$. Ecl/Int and Cog/Beh larger than other orientations.

** $\chi^2 (4, 10.412) = p < 0.034$. Ecl/Int larger than other orientations.

*** $\chi^2 (3, 17.00) = p < 0.001$. Systems Theory larger than other orientations.

MFT = Marriage & Family Therapists.

Table 4

Recognition of Conflictual Relationship by Profession.

Profession	Conflict Addressed	Conflict Not Addressed [*]	Total
Psychologists	40 (81.6%)	9 (18.4%)	49 (100%)
Clinical Social Workers	31 (91.2%)	3 (8.8%)	34 (100%)
MFT	18 (94.7%)	1 (5.3%)	19 (100%)
Other	8 (88.8%)	1 (11.1%)	9 (100%)
<i>Total</i>	97 (87.4%)	14 (12.6%)	111

* Chi-Square not statistically significant for Profession.

MFT = Marriage & Family Therapists.

Table 5

Description of Conflict by Profession.*

Profession	Violence/ Battering	Infidelity	Child Abuse	Substance Abuse	Trust Issues	Other Abuse of Partner	Power Struggle
Psychologists N=49	34 (69.4%)	14 (28.5%)	13 (26.5%)	2 (4.1%)	4 (8.2%)	6 (12.2%)	3 (6.1%)
Clinical Social Workers N=34	27 (79.4%)	11 (32.5%)	9 (26.5%)	9 (26.5%)	3 (8.8%)	2 (5.9%)	3 (8.8%)
MFT N=19	17 (89.5%)	7 (36.8%)	4 (21.1%)	2 (10.5%)	4 (21.0%)	0 (0.0%)	1 (5.2%)
Other N=9	8 (88.8%)	3 (33.3%)	5 (55.5%)	2 (22.2%)	0 (0.0%)	2 (22.2%)	1 (11.1%)
Total (N=111)	86 (77.5%)	35 (31.5%)	31 (27.9%)	15 (13.5%)	11 (9.9%)	10 (9.0%)	8 (7.2%)
Profession	Denial of Problems	Anger	Out of Control	Lethality	Family of Origin Issues	More Info. Needed/ Can't Answer	
Psychologists N=49	0 (0.0%)	1 (2.0%)	1 (2.0%)	0 (0.0%)	0 (0.0%)	3 (14.3%)	
Clinical Social Workers N=34	3 (8.8%)	3 (8.8%)	4 (11.8%)	1 (2.9%)	0 (0.0%)	0 (0.0%)	
MFT N=19	2 (10.5%)	1 (5.3%)	1 (5.3%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	
Other N=9	1 (11.1%)	1 (11.1%)	0 (0.0%)	0 (0.0%)	1 (11.1%)	1 (11.1%)	
Total (N=111)	6 (5.4%)	6 (5.4%)	6 (5.4%)	1 (0.1%)	1 (0.1%)	4 (3.6%)	

* Percentages sum to greater than 100% due to multiple descriptors given by respondents.

MFT = Marriage & Family Therapists.

Table 6

Reasons for Problems by Profession and Theoretical Orientation.

	Reasons for Problems in the Relationship			
	Couple Dynamics	James	Carol	Not Enough Information
<i>Profession</i>				
Psychologists N=49	17 (34.7%)	9 (18.4%)	2 (4.1%)	21 (42.8%)
Clinical Social Workers N=34	20 (58.8%)	2 (5.9%)	2 (5.9%)	10 (29.4%)
MFT* N=19	7 (36.8%)	1 (5.3%)	2 (10.5%)	9 (47.4%)
Other N=9	4 (44.4%)	1 (11.2%)	0 (0.0%)	4 (44.4%)
<i>Theoretical Orientation</i>				
Eclectic or Integrative N=38	19 (50.0%)	1 (2.6%)	1 (2.6%)	17 (44.8%)
Family Systems N=23	8 (34.8%)	3 (13.0%)	3 (13.0%)	9 (39.2%)
Cognitive/Behavioral N=21	7 (33.3%)	3 (14.3%)	2 (9.5%)	9 (42.9%)
Psychodynamic N=13	7 (53.8%)	3 (23.1%)	0 (0.0%)	3 (23.1%)
Other N=9	5 (55.5%)	1 (11.2%)	0 (0.0%)	3 (33.3%)
Existential/Humanistic N=7	2 (28.6%)	2 (28.6%)	0 (0.0%)	3 (42.8%)
<i>Total (N=111)</i>	48 (43.2%)	13 (11.7%)	6 (5.4%)	44 (39.7%)

* MFT=Marriage & Family Therapists.

* No statistical tests performed due to empty cells. Percentages sum to greater than 100% due to multiple descriptors given by respondents.

Table 7

Types of Diagnoses for James and Carol.

<i>James (N=85 diagnoses)</i>	
<i>Type of Diagnosis</i>	
Intermittent Explosive or Other Impulse Disorder	23 (27.1%)
Paranoia, Delusions, Thought Disorder, Psychosis	13 (15.3%)
Personality Disorder Not Otherwise Specified	13 (15.3%)
Depression, Dysthymia	12 (14.1%)
Antisocial Personality Disorder	7 (8.2%)
Substance Abuse	6 (7.1%)
Child Abuse	6 (7.1%)
Physical Abuse of an Adult (perpetrator)	3 (3.5%)
Anxiety, PTSD	2 (2.3%)
<i>Carol (N=70 diagnoses)</i>	
Depression, Dysthymia	15 (21.4%)
Masochistic, Conduct Disorder, Other Blaming Stance	14 (20.0%)
Anxiety, PTSD, Generalized Anxiety Disorder	12 (17.1%)
Substance Abuse	10 (14.3%)
Physical Abuse of an Adult (victim)	9 (12.8%)
Dependent Personality Disorder	3 (4.3%)
Borderline Personality Disorder	3 (4.3%)
Personality Disorder Not Otherwise Specified	2 (2.8%)
Child Abuse	1 (1.5%)
Sexual Abuse (child and adult victims)	1 (1.5%)

Table 8

Legal/Ethical Issues by Profession and Theoretical Orientation.

	Legal/Ethical Issues				
	Duty to Warn	Duty to Protect	Duty to Report Child Abuse	Confidentiality Between Therapist and Couple	Secrecy Between Couple
<i>Profession</i>					
Psychologists N=49	18 (36.7%)	21 (42.8%)	27 (55.1%)	27 (55.1%)	4 (8.2%)
Clinical Social Workers N=34	8 (23.5%)	22 (64.7%)	18 (52.9%)	18 (52.9%)	2 (5.9%)
MFT* N=19	1 (5.3%)	8 (42.1%)	15 (78.9%)	15 (78.9%)	5 (26.3%)
Other N=9	0 (0.0%)	4 (44.4%)	4 (44.4%)	4 (44.4%)	1 (11.1%)
<i>Theoretical Orientation</i>					
Eclectic or Integrative N=38	12 (31.6%)	17 (44.7%)	20 (52.6%)	16 (42.1%)	5 (13.2%)
Family Systems N=23	5 (21.7%)	13 (56.4%)	17 (73.9%)	7 (30.4%)	4 (17.4%)
Cognitive/Behavioral N=21	4 (19.0%)	8 (39.1%)	12 (57.1%)	7 (33.3%)	0 (0.0%)
Psychodynamic N=13	4 (30.8%)	7 (53.8%)	8 (61.5%)	5 (38.5%)	1 (7.7%)
Other N=9	0 (0.0%)	5 (55.5%)	5 (55.5%)	2 (22.2%)	0 (0.0%)
Existential/Humanistic N=7	2 (28.5%)	5 (71.4%)	2 (28.5%)	2 (28.5%)	2 (28.5%)
Total (N=111)	27 (24.3%)	55 (49.5%)	64 (57.7%)	39 (35.1%)	12 (10.8%)

* No statistical tests performed due to empty cells. Percentages sum to greater than 100% due to multiple descriptors given by respondents.

MFT=Marriage & Family Therapists.

Table 9

Type of Intervention by Profession and Theoretical Orientation.

	Type of Intervention			
	Crisis Intervention	Individual Therapy	Couple's Therapy	Not Enough Information
<i>Profession</i>				
Psychologist N=49	30 (61.2%)	19 (38.8%)	19 (38.8%)	5 (10.2%)
Clinical Social Worker N=34	29 (85.3%)	16 (47.1%)	12 (35.3%)	0 (0.0%)
MFT* N=19	11 (57.9%)	12 (61.3%)	10 (52.6%)	1 (5.3%)
Other N=9	6 (66.7%)	5 (55.6%)	5 (55.6%)	0 (0.0%)
<i>Theoretical Orientation</i>				
Eclectic or Integrative N=38	32 (84.2%)	22 (57.9%)	14 (36.8%)	0 (0.0%)
Family Systems N=23	16 (69.5%)	11 (47.8%)	12 (52.2%)	2 (8.7%)
Cognitive/Behavioral N=21	11 (52.4%)	9 (42.6%)	9 (42.9%)	2 (9.5%)
Psychodynamic N=13	8 (61.5%)	7 (53.8%)	7 (53.8%)	1 (7.7%)
Other N=9	6 (66.7%)	2 (22.2%)	1 (11.1%)	1 (1.11%)
Existential/Humanistic N=7	3 (42.8%)	1 (14.3%)	3 (42.8%)	0 (0.0%)
<i>Total (N=111)</i>	76 (68.4%)	52 (46.8%)	46 (41.4%)	6 (5.4%)

* MFT=Marriage & Family Therapists.

Table 10

Types of Crisis Interventions by Category.

<i>Crisis Intervention</i>		
<i>None</i>	<i>Total</i>	21 (18.9%)
<hr/>		
<i>With Carol Only</i>		
Carol/children to shelter or family/friends		39 (35.1%)
Have Carol get a restraining/protection order against James		23 (20.7%)
Safety plan with Carol		18 (16.2%)
Have Carol call the police		6 (5.4%)
Non-violence contract with Carol		2 (1.8%)
	<i>Total</i>	88 (79.3%)
<hr/>		
<i>With Both Carol and James</i>		
Separation (possible or immediate)		18 (16.2%)
Non-violence contract with both		7 (6.3%)
Safety plan with both		6 (5.4%)
	<i>Total</i>	31 (27.9%)
<hr/>		
<i>With James Only</i>		
Therapist calls police if James assessed as lethal and have him arrested		14 (12.6%)
Anger management or batterer's treatment referral		8 (7.2%)
Hospitalize James		5 (4.5%)
Non-violence contract with James		3 (2.7%)
	<i>Total</i>	30 (27.0%)
<hr/>		

Table 11

Types of Expected Outcomes by Profession and Theoretical Orientation.

	Type of Expected Outcome				
	Reduction in Conflict	No Change	Increase in Conflict	Increase in Violence	Lethality in Answer
<i>Profession</i>					
Psychologist N=49	15 (30.6%)	2 (4.1%)	7 (14.3%)	3 (6.1%)	1 (2.0%) 23 (46.9%)
Clinical Social Worker N=34	7 (20.5%)	3 (8.8%)	7 (20.5%)	3 (8.8%)	0 (0.0%) 19 (55.9%)
MFT* N=19	5 (26.3%)	3 (15.8%)	1 (5.3%)	0 (0.0%)	0 (0.0%) 9 (47.4%)
Other N=9	3 (33.3%)	0 (0.0%)	1 (11.1%)	0 (0.0%)	0 (0.0%) 5 (55.6%)
<i>Theoretical Orientation</i>					
Eclectic or Integrative N=38	13 (34.2%)	2 (5.3%)	9 (23.7%)	3 (7.9%)	0 (0.0%) 17 (44.7%)
Family Systems N=23	6 (26.1%)	2 (8.7%)	3 (13.0%)	1 (4.3%)	0 (0.0%) 12 (52.2%)
Cognitive/Behavioral N=21	5 (23.8%)	2 (9.5%)	2 (9.5%)	1 (4.8%)	1 (4.8%) 11 (52.4%)
Psychodynamic N=13	2 (15.4%)	0 (0.0%)	1 (7.7%)	1 (7.7%)	0 (0.0%) 9 (69.2%)
Other N=9	2 (22.2%)	1 (11.1%)	1 (11.1%)	0 (0.0%)	0 (0.0%) 5 (55.6%)
Existential/Humanistic N=7	2 (28.6%)	1 (14.3%)	0 (0.0%)	0 (0.0%)	0 (0.0%) 2 (28.6%)
Total (N=111)	30 (27.0%)	8 (7.2%)	16 (14.4%)	6 (5.4%)	1 (0.1%) 56 (50.4%)

* MFT=Marriage & Family Therapists.

Note: Some rows may not sum to the category N-size due to multiple responses.

Table 12

After Notification of Lethal Outcome: "Would You Change Your Answers?"

	Changed Responses					No Changes
	Answer to “What Is Going On?”	Diagnoses Given	Interventions	Expected Outcomes	Legal or Ethical Issues	
<i>Profession</i>						
Psychologist N=49	18 (36.7%)	11 (22.4%)	25 (51.0%)	17 (34.7%)	10 (20.4%)	15 (30.1%)
Clinical Social Worker N=34	13 (38.2%)	11 (32.4%)	16 (47.1%)	9 (26.5%)	7 (20.1%)	11 (32.4%)
MFT* N=19	4 (21.1%)	6 (31.6%)	9 (47.4%)	2 (10.5%)	3 (15.8%)	7 (36.8%)
Other N=9	4 (44.4%)	2 (22.2%)	5 (55.6%)	4 (44.4%)	0 (0.0%)	2 (22.2%)
<hr/>						
<i>Theoretical Orientation</i>						
Eclectic or Integrative N=38	13 (34.2%)	10 (26.3%)	23 (60.5%)	11 (28.9%)	5 (13.2%)	7 (18.4%)
Family Systems N=23	5 (21.7%)	7 (30.4%)	11 (47.8%)	7 (30.4%)	3 (13.0%)	7 (30.4%)
Cognitive/Behavioral N=21	10 (47.6%)	6 (28.6%)	10 (47.6%)	8 (38.1%)	7 (33.3%)	9 (42.9%)
Psychodynamic N=13	4 (30.8%)	4 (30.8%)	5 (38.5%)	2 (15.4%)	3 (31.1%)	5 (38.5%)
Other N=9	4 (44.4%)	3 (33.3%)	4 (44.4%)	3 (33.3%)	1 (11.1%)	3 (33.3%)
Existential/Humanistic N=7	3 (42.9%)	0 (0.0%)	2 (28.6%)	1 (14.3%)	1 (14.3%)	4 (57.1%)
Total (N=111)	39 (35.1%)	30 (27.0%)	55 (49.5%)	32 (28.8%)	20 (18.0%)	35 (31.5%)

* MFT=Marriage & Family Therapists.

Note: Some rows may not sum to the category N-size due to multiple responses.