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Current Practices of Intimate Partner Violence Assessment Among Marriage and Family Therapy Trainees at a University Clinic

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Research shows that the majority of couples presenting for couple therapy have experienced or are currently experiencing intimate partner violence (IPV) within their relationships. It is also known that few couples present for therapy with IPV as their main concern and seldom do couples spontaneously report IPV. A review of the literature that provides a rationale for the utilization of a universal screening process for IPV is provided. After which, the authors look at the current IPV assessment and screening practices of marriage and family therapists in a marriage and family therapy training facility. A logistic regression procedure was used to determine if an IPV assessment could be predicted based on risk factors of IPV from self-report intake information completed by participants. Unfortunately, only if clients actually indicated that physical violence within their relationship was a current issue were they assessed.

KEYWORDS *intimate partner violence (IPV), IPV assessment, MFT training*

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INTRODUCTION

The national Centers for Disease Control and Prevention (CDC; 2008) reported in 2006 that approximately 4.8 million incidences of intimate partner violence (IPV) occur toward women each year and 2.9 million incidences of IPV occur toward men each year. Intimate partner violence is defined as the "physical, sexual, or psychological harm by a current or former partner or spouse occurring among heterosexual and same-sex couples" (Todahl, Linville, Chou, & Maher-Cosenza, 2008, p. 28). IPV may consist of a single violent episode between partners and/or be situationally bound (commonly labeled as situational couple violence) or it may exist as ongoing threats or battering from one partner to the other and is labeled intimate or patriarchal terrorism (CDC, 2008; Greene & Bogo, 2002; Johnson, 1995).

IPV is common among couples and cannot be reliably predicted based on race, age, relationship constellation, socioeconomic status (SES), or education level (Barnett, Miller-Perrin, & Perrin, 2005). Although IPV is common, caution should be used when discussing IPV and making generalizations about violence among couples (Bograd, 1999). The CDC (2008) reports that nearly 25% of women and 7.6% of men in the United States have been raped or physically assaulted by a current or former spouse, cohabiting partner, or date. Annually, the CDC estimates that 1.5 million women and over 800,000 men are raped or physically assaulted by a partner, with many of these victims experiencing multiple assaults (2008). Additionally, men and women in same-sex relationships are likely to have a history of being physically assaulted by their partner. In same-sex cohabitating relationships, 21.5% of men and 35.4% of women reported having a physical assault history (Blasko, Winek, & Bieschke, 2007). Ethnic minority couples in the United States show high rates of IPV (Bograd, 1999). However, IPV often goes undetected by therapists despite several risk factors associated with IPV, regardless of majority or minority status (Blasko et al.).

Risk Factors Associated with IPV

Several factors contribute to the occurrence and prevalence of IPV. Factors that may contribute to incidences of IPV may include a personal history of abuse or trauma, higher rates of drug and alcohol abuse, anger, traditional views of gender roles, and high levels of relationship dissatisfaction (Arias & Ikeda, 2006). Problem drinking, hostility, jealousy, and communication conflicts have also been found to increase the risk of negative affect in relationships, which can in turn lead to verbal and physical aggression (O'Leary, 1999).

Marital discord was found to be the most accurate predictor of physical aggression against a partner, with the risk of IPV elevating with the amount

of marital discord (Stith, Rosen, & McCollum, 2003). Pan, Neidig, and O'Leary (1994) found that for every 20% increase in marital discord, the odds of mild partner abuse increased by 102%, and the odds of severe partner abuse increased by 183%. Stith and colleagues assert that women who use violence in relationships are at greater risk of being severely assaulted by their partners. Although both partners may perpetrate violence, in most cases the violence and the implications of violence are not symmetrical, as women are affected more negatively by aggression in relationships than are men (Vivian & Landhinrichsen-Rohling, 1997). Whiting, Simmons, Haven, Smith, and Oka (2009) investigated risk factors for individuals who witnessed or experienced violence within their family of origin and found that there are other factors that are associated with higher levels of violence, including low self-esteem, post-traumatic stress disorder within the previous year, and past year alcohol dependence.

Many couples who are experiencing IPV within their relationships may seek help or assistance with resolving issues and concerns from mental health professionals. It is vital for therapists and other mental health professionals to be aware of IPV trends, to be able to identify risk factors and incidences of IPV within relationships, and to adequately manage these issues within therapy. When IPV is not effectively addressed in therapy, the iatrogenic effects for the couple can be intensified or provide feelings of justification on the part of the perpetrator (Bograd & Mederos, 1999; Todahl et al., 2008).

IPV in Therapy

IPV is a therapeutic issue common in couples seeking psychotherapy (Blasko et al., 2007). With respect to partners seeking couples therapy, Cascardi, Langhinrichsen, and Vivian (1992) found that as many as 71% of the couples reported physical aggression in their marriage during the prior year. O'Leary, Vivian, and Malone (1992) report a similar statistic, citing that studies of typical family therapy client populations show partner violence rates as high as 67%. Additionally, researchers consistently report that physical aggression occurs with surprising frequency in both discordant and nondiscordant relationships (Vivian & Landhinrichsen-Rohling, 1997). Therefore, stereotypes and assumptions about what violent relationships look like, or even how violent partners may present in the therapy room, do not reliably hold up.

Although rates of IPV have been found to be high in several studies, research shows that IPV is commonly underreported by couples attending therapy (Bograd & Mederos, 1999; Todahl et al., 2008). Bograd and Mederos (1999) found that up to "two-thirds of couples presenting at an outpatient marital therapy clinic did not report domestic violence until specific clinical inquiry, due to embarrassment, fear, shame, social stigma, lying,

minimization, or defining other marital issues as more pressing" (Bograd & Mederos, 1999, p. 296). Doherty and Simmons (1996) present results from one study of practitioner reporting on the presenting problems of their clients. The practitioners in the study reported that of the 1422 cases they had seen, only 3.5% were presenting for therapy due to family violence. What may be even more concerning is that violence is overtly reported as the main concern in only these 3.5% of therapy cases, which means that the majority of couples who have experienced IPV are not seeking therapy to specifically deal with violence in their relationships. In fact, research shows that fewer than 10% of couples reporting for therapy spontaneously disclosed domestic violence to the therapist (Ehrensaft & Vivian, 1996).

It is important for mental health professionals, especially couples therapists, to recognize that there are several reasons clients may choose not to disclose violence that is occurring within their relationship. Recipients of IPV may feel that it is unsafe to disclose or discuss the violence, or may fear retribution if the violence is addressed in therapy. Clients may also feel that other matters are more pressing for therapy. Also, clients might not disclose IPV because they may not perceive an act that has occurred within their relationship as "violent." Additionally, clients may be unaware that discussing incidences of IPV in therapy is appropriate. Finally, clients may also choose not to disclose IPV to a therapist due to lack of rapport or trust in the therapeutic relationship.

Therapists may also contribute to an atmosphere in which IPV is not addressed. Jory (2004) outlined several reasons therapists may not inquire about IPV with their clients. These reasons may include a lack of training about the risk factors, clinicians viewing abuse as a secondary concern within therapy, and the "invisibility" of abuse within commonly marginalized populations such as gays and lesbians, individuals from of low SES, and elderly populations. However, because the rate of IPV disclosure is so low, the onus and responsibility fall upon the therapist to ask about violence within the relationship to ensure that the clients are safe throughout the course of therapy. Even with the responsibility, therapists are often trying to make estimations as to who may be dealing with IPV and who may not. This guessing game can significantly impact who is asked screening questions and who is not, ultimately impacting the safety in relational therapy. By using a structured and universal process of screening for IPV, the therapist assumes responsibility for addressing IPV and models that discussing it is important and will be handled with care. Additionally, a universal screening process allows for the therapist to assess *all* clients, rather than make guesses based on the client's presentation. Research shows that 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).

Training Procedures

While IPV is a prevalent concern among many couples presenting for therapy, there has been no definitive assessment procedure for working with clients who have experienced violence. Winkle, Piercy, and Hovestadt (1981) called for standardization within training curriculum nearly 30 years ago, and this call has been echoed by numerous studies since (Bograd & Mederos, 1999; Gauthier & Levendosky, 1996). While many therapists, educators, and researchers agree that conjoint therapy is not the safest option with a couple who are actively violent (Gauthier & Levendosky, 1996), some studies still question whether couples therapy is or is not dangerous, unethical, or ineffective (Bograd & Mederos, 1999) when IPV is present. Hansen and Goldenberg (1993) assert that it is more important to create meaningful transactional exchanges between partners rather than focusing on insight about the wrongness of battering behavior, which in turn makes the case for treating a couple in conjoint therapy rather than separately. Shamai (1996) offers several reasons to treat the couple together rather than separately, stating that the violence occurs within the couple system and should therefore be treated with both individuals in the relationship. Stith and colleagues (2003) provided support that doing couples work around IPV is at least as effective as traditional individual approaches, and that doing so does not necessarily increase the risk for injury among the partners. There seems to be a consensus that safety should be a therapist's first concern when determining the nature of therapy. Johnson (1995) and others (Bograd & Mederos; Jory, 2004; Stith et al., 2003) state that conjoint therapy is generally appropriate when situational couple violence is occurring, but not if intimate/patriarchal terrorism exists. If researchers and seasoned therapists are still debating the most efficacious way to treat domestic violence, it can be assumed that a new therapist is operating without the necessary information in terms of ensuring client safety throughout the therapeutic experience. Since research has shown that IPV is prevalent even when not reported, new therapists are likely working with couples who have been violent without even knowing that they are doing so (Stith et al., 2003). It is critical, then, that training programs teach, and subsequently expect, IPV assessments as a routine part of treatment regardless of the presenting problem.

Universal Screening

In applying a structured and universal screening procedure, therapists are able to gain a more accurate and detailed picture about the presenting concerns but would also be able to adequately assess for violence. Bograd and Mederos (1999) assert that a therapist should work from the mindset that IPV is a possibility until it has been effectively *ruled out* by a structured interview that includes separate sessions with both partners. In adequately assessing

for violence, the therapist would be meeting their ethical responsibility (Cervantes, 1993) and ensuring that there is no imminent danger to the partners in these relationships (Gauthier & Levendosky, 1996) before engaging in ongoing conjoint therapy.

Bograd and Mederos (1996) recommend that therapists use a universal screening procedure with all couples presenting for therapy regardless of the presenting problem, stating that "therapists should assume risk for domestic violence in all couples and families that present for therapy until it is ruled out" (pp. 293–294). Universal screening procedures include 1) individually completed self-report questionnaires that are relatively quick and confidential (i.e., Conflict Tactics Scale 2 [Strauss, Hamby, Boney-McCoy, & Sugarman, 1996]; Intimate Justice Scale [Jory, 2004]; Propensity for Abusiveness Scale [Dutton, 1995]); 2) joint interview during the first session that addresses the relational history and context; and 3) individual sessions with each partner that specifically addresses IPV. If violence is present, assessment should include the severity, frequency, and types of abuse (Bograd & Mederos, 1999; O'Leary & Murphy, 1992).

Although research suggests that a universal screening may be important, at the bare minimum therapists should screen for IPV among couples who present with risk factors associated with IPV. The purpose of this study is to explore the assessment procedures of therapists at one university-based clinic. This study looks at data from the intake packets completed by both partners of couples seeking couple therapy, by investigating the current IPV assessment practices of trainee therapists at a nationally accredited Marriage and Family Therapy Program. Researchers were interested in 1) if therapists completed an IPV assessment and 2) if IPV assessments correlated with risk factors marked by individuals on their written intake questionnaire.

METHOD

Participants

The sample for this study was drawn from couples seen at a southwestern university's Family Therapy Clinic between January 2004 and December 2006. After excluding couples in which at least one of the partners had not completed the intake packet and individuals who initially stated during the intake telephone call that they were interested in couples therapy but later presented individually, 101 couples remained. Two same-sex couples were excluded from the sample of this research due to the lack of representation in the overall sample, leaving 99 heterosexual couples. The couples included in this study all reported seeking therapy for a variety of couple-related issues. The data for this study came from the intake packets completed by each of the individual partners as well as the standard case notes completed by the MFT trainees upon the completion of each session.

The sample consisted of individuals who ranged in age from 16 to 82, with a mean age of 32 years. This sample was somewhat homogeneous in regard to ethnicity; 143 (72.2%) individuals self-identified as White, non-Hispanic, 32 (16.2%) identified as Hispanic, 7 (3.5%) as African American, 1 (0.5%) as Native American, 3 (1.5%) as Asian American, 4 (2.0%) as "other," and 8 (4.0%) individuals did not respond to this item on the intake packet. Of the 99 couples included in the study, 59 reported being married, 17 couples in the sample were living together, 13 couples had never married, 7 were separated, and 3 couples were divorced. Although SES information was not collected as part of this study, it is expected that many of the participants fit within a low SES, given that they were attending therapy at an inexpensive university clinic. Again, all couples were participating in therapy during the time the data for this study were collected. The couples had completed a various number of sessions, ranging from 1 session to 56 sessions, with the average number of sessions completed being 8.46.

All of the therapists seeing clients at the southwestern university clinic between 2004 and 2006 were included in the sample. The therapists included both masters (7; 25%) and doctoral (21; 75%) students. This sample included eight male therapists (28.6%) and 20 female therapists (71.4%). All therapists were participating in practicum courses and were actively supervised by approved supervisors while seeing clients in the clinic.

Procedures

The files for the 99 couples included in the study were obtained from the University Clinic database. Five variables from the intake paperwork were targeted as predictors of domestic violence within intimate partner relationships. The intake packet includes a list of 15 items individuals could check under the heading, "Problems that are a concern to you about YOUR RELATIONSHIP." Each of the five predictors for IPV is included in this list. The five variables include: "poor communication," "fighting/arguing," "physical violence," "demands sex too often," and "partner too controlling." Each of these variables is considered a categorical independent variable for this study and was coded with a "1" if the individual marked an item as a concern in their relationship, whereas the item was coded as a "2" if the item was not endorsed by the participant.

The first author read each of the case notes, in their entirety, completed by the therapist to determine if an IPV assessment had taken place and was recorded at any time during treatment. A statement such as "Assessed for domestic violence this session" is an example of an acceptable statement to be considered as indication of an assessment during treatment. If there was any indication in the case note of an IPV assessment, the case was included as a case that was assessed for IPV. For the purpose of this study, the variable for IPV assessment is considered the dichotomous dependent variable. Of

the 99 couples reviewed, it was determined that 20 couples were assessed for IPV while 79 couples were not assessed for IPV within their relationship (Table 1). Table 1 shows each of the independent variables and the raw number of couples who were assessed for IPV within each category.

Next, the data were transformed to consider the couple as the unit of analysis rather than considering the data collected from each individual as independent from their partner. For purposes of the transformation, the male partners were coded as partner 1, while the female partners were coded partner 2. Given that each partner completed the intake packet, there were responses from each of the partners on all five independent variables. Therefore, the two responses on each variable for each couple were treated as repeated measures throughout the analyses. Given this, there was a possibility of 10 independent variables. Frequencies were also run to determine if there was appropriate variability among the responses from the participants (Table 2). Table 2 shows some differences between how the male partners responded on the intake packet and how female partners responded. On four of the five predictors of IPV (communication problems, fighting and arguing, physical violence, and partner demands sex too often), females had higher endorsement rates. The only variable that male partners endorsed more often than female partners was, "My partner is too controlling." Also, it is interesting to note that although the endorsement rates were relatively small for both sexes, at least twice as many females reported the presence of physical violence and partners who demand sex too often as concerns within their relationships. However, given there was not at least a 10% difference among the responses by men on the "physical violence" and "demands sex too much" variables, these variables did not represent normal distributions of variance and were not considered independent variables for the study; therefore, only eight independent variables were included in the final analyses.

Additionally, Pearson correlations were completed to test for multicollinearity and ensure that the variables were not too highly correlated. Table 3 shows the results of these correlations. Although there are some significant correlations, none of the correlations were higher than 0.80, and therefore it was concluded that the assumption of multicollinearity was not violated.

This study investigated predictors of an IPV assessment, by completing a logistic regression and by using variables from the original data set. The dependent variable was measured based on the assessment activities of the therapist. Again, if the therapist performed an IPV assessment the case was coded with a 1, and if the therapist did not perform an IPV assessment the case was coded with a 2. In addition, the coding for all independent variables was left as it was originally coded in the data set where 1 is equal to the item being check on the intake packet or an assessment having taken place, and a 2 being equal to the item on the intake packet not being marked by

TABLE 1 IPV Assessment for Each of the Independent Variables

	Partner Number 1 (Males)									
	Communication 1		Fight/Argue 1		Physical Violen. 1		Demands Sex 1		Too Controlling 1	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Assessed (n)	17	3	17	3	4	16	1	19	6	14
Not assessed (n)	54	25	50	29	2	77	3	76	22	57
	Partner Number 2 (Females)									
	Communication 2		Fight/Argue 2		Physical Violen. 2		Demands Sex 2		Too Controlling 2	
Assessed IPV	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Assessed (n)	19	1	17	3	6	14	3	17	7	13
Not assessed (n)	60	19	55	24	6	73	7	72	17	62

TABLE 2 Frequencies: Partner 1's and Partner 2's Endorsement of IPV Predictors

	Assess for DV	Poor Comm. Partner 1	Fighting/ Arguing Partner 1	Physical Violence Partner 1	Demands Sex Partner 1	Partner Too Controlling Partner 1	Poor Comm. Partner 2	Fighting/ Arguing Partner 2	Physical Violence Partner 2	Demands Sex Partner 2	Partner Too Controlling Partner 2
Yes	20	71	67	6	4	28	79	72	12	10	24
No	79	28	32	93	95	71	20	27	87	89	75

TABLE 3 Correlations Among IPV Predictors

	Poor Comm. Partner 2	Fighting/ Arguing Partner 1	Fighting/ Arguing Partner 2	Physical Violence Partner 2	Demands Sex Too Much Partner 2	Partner Too Controlling Partner 1	Partner Too Controlling Partner 2
Poor Comm. Partner 1	.466**	.333**	.169	.027	−.162	.096	.094
Poor Comm. Partner 2	...	.352**	.426**	.187	.085	.204*	.109
Fighting/Arguing Partner 1	...	...	.498**	.190	−.127	.242*	.240*
Fighting/Arguing Partner 2	...	...	...	.227*	.130	.082	.188
Physical Violence Partner 2	...	...	...	...	.081	.110	.151
Demands Sex Too Much Partner 2	...	...	...	...	...	−.211*	.201*
Partner Too Controlling Partner 1	...	...	...	...	...	...	.220*

*Significant correlation at the level of $p = .05$.
**Significant correlation at the level of $p \leq .01$.

the client or an assessment not having occurred. The logistic regression was calculated with an alpha of .05. Odds ratios indicate the relative relationship between assessment of IPV and the independent variables. This is true given that an odds ratio of 1.0 indicates no relationship.

RESULTS

A logistic regression analysis was performed with the assessment for IPV as an outcome variable with eight predictor variables: poor communication for partners 1 and 2, fighting/arguing for partners 1 and 2, physical violence for partner 2, partner demands sex to much for partner 2, and partner too controlling for partners 1 and 2. A test of the full model with all eight predictor variables was not statistically significant, χ^2 (8, N = 99) = 11.852, $p = .158$. These results indicating that the predictor variables, as a set, do not reliably distinguish between couples who were assessed for IPV and those who were not assessed. The χ^2 statistic and its significance level indicate the probability of obtaining the χ^2 statistic given that the null hypothesis is true. The Cox-Snell R^2 of .113 indicates a small effect size. This is consistent with the χ^2 results as it does not predict the model. According to the predicted and observed values as reported in the classification table (Table 4), of the overall predictions, 81.8% were correctly predicted. The predicted value of those assessed was correctly predicted at the level of 25.0% and the predicted value of those not assessed was correctly predicted at the level of 96.2%. These findings indicate that even if clients endorsed IPV predictors on their intake packets, it did not increase the likelihood that they were assessed for IPV by their therapists.

Table 5 shows the regression coefficients, Wald's statistics, odds ratio, and 95% confidence intervals for odds ratios for each of the eight predictor variables. These results show that only one independent variable contributed to the overall significance of the model; it is when partner 2 marks physical violence on their intake packet. The significance for the physical violence predictor variable is $p = .050$.

TABLE 4 Observed and Expected Frequencies for Assessed and Not Assessed for IPV

		Predicted Assess for IPV	
	Observed	No	Yes
Assess for IPV	No	76	3
	Yes	15	5
Overall percent: 81.8%			

TABLE 5 Logistic Regression Coefficients, Odds Ratios, Significance Values, and Upper and Lower Confidence Intervals

	β	S.E.	Wald	*df*	Sig.	Exp(B)	95.0% Confidence Interval for Exp(B)	
							Lower	Upper
rcomm.1(1)	−.581	.805	.521	1	.470	.559	.115	2.710
rcomm.2(1)	−1.089	1.210	.810	1	.368	.337	.031	3.605
rfighting.1(1)	−.741	.801	.856	1	.355	.477	.099	2.290
rfighting.2(1)	.221	.833	.070	1	.791	1.247	.244	6.382
rviolence.2(1)	−1.373	.699	3.857	1	.050	.253	.064	.997
rexcessex.2(1)	−.570	.939	.368	1	.544	.566	.090	3.564
rcontrol.1(1)	.262	.630	.173	1	.678	1.299	.378	4.466
rcontrol.2(1)	−.293	.622	.222	1	.637	.746	.220	2.524
Constant	1.387	.736	3.548	1	.060	4.004		

These results indicate that the only statistically significant predictor of an IPV assessment is if couples mark that physical violence is a problem in their relationship. Therefore, the assessment of couples who mark that physical violence is present in their relationship is significantly distinguished from those who did not mark that physical violence was present in their relationships. For every unit of increase in presence of physical violence (from marked on the intake packet to not marked), we expect a −1.373 decrease in the log odds of assessment for IPV, holding all other independent variables constant. Therefore, the odds of being assessed for IPV decreases by 2.95 times when the participants did not mark physical violence as a problem within their relationship. This result shows the only predictor variable that statistically predicted if couples were assessed for IPV is if women endorsed that physical violence was a concern within their relationship. Women who marked this on their intake packets were approximately 3 times more likely to be assessed for IPV than couples who did not indicate this as a concern on their intake packet. However, it is important to note that not even all couples in which women endorsed this item were actually assessed for IPV by their therapist.

DISCUSSION

This study investigated if marriage and family therapy interns assessed for IPV with their clients and, more specifically, if the occurrence of IPV assessment was predicted by the endorsement of red flags for IPV by clients on their intake paperwork. Based on these findings, it appears that only one in five couples (20 of 99) were assessed for violence by intern therapists. This low rate of assessment is alarming given the research that indicates couples

attending therapy are generally experiencing IPV at a rate higher than 20%. It appears as though the therapists in this study overlooked IPV as an issue in the majority of these cases, despite the presence of red flags and overt indicators of conflict. However, this study did not investigate the type or level of assessment being completed by the interns; therefore, conclusions cannot be made about the thoroughness or scope of the IPV assessments that were performed.

There are some limitations in this study that should be considered. The results are representative of one training clinic and present the practices of trainee therapists. These findings should not be generalized to all clinics, other training therapists, or experienced therapists. Also, the lack of variability of responses among the participants limits the inferences that can be drawn from this data. Third, this study only reviewed archival data. A more complete picture of the screening practices could be gathered by accessing multiple avenues such as repeating the study through current investigation or interviewing both clients and practitioners about their experience and the level of assessment. In addition, this study only assessed if any type of assessment was conducted and recorded by therapists; the nature of the assessment was not investigated. Therefore, what was considered as an assessment within this study could have ranged from a single question about IPV to multiple comprehensive questions. Despite these limitations this study has sought to provide information about the current trends and practices of MFT trainees and their lived screening practices with regard to IPV.

Despite these limitations, this study provides new and useful information. One particular concern identified by this study is that despite the presence of red flags for violence in many cases therapists are not addressing IPV. The values from table one indicate several alarming results. First, eight individuals (two males and six females) indicated that physical violence was a concern within their current relationship and their respective therapists made no mention of having completed any type of IPV assessment or screening. Additionally, 39 participants (22 males and 17 females) endorsed that their partner was too controlling, a significant red flag for IPV, and were not assessed for violence within their relationship.

The results of the logistic regression correspond with the other results previously discussed. Given the insignificant χ^2 results from the logistic regression we can conclude that despite the presence of self-reported predictors for IPV, MFT trainees are not universally or systematically assessing for IPV. It appears from the logistic regression that the only predictor that regularly corresponds to an IPV assessment is if the couple marked "physical violence" on their intake packet. However, even though this was a significant finding, their respective therapist was still not assessing some of the clients who endorsed the physical violence item on the intake form. We urge therapists to consider best practices in regard to screening. Additionally, we

urge therapists to consider if asking clients about current violence is sufficient, or if there are other indicators of an effective and thorough screening (Todahl & Walters, 2011). Clinicians could implement one of several written screening measures such as the Revised Conflict Tactics Scale (CTS2; Straus et al., 1996) or the Danger Assessment Scale (DAS; Campbell, 1995) in order to add measures to their intake procedures. However, as Jory (2004) points out, adequate screening is more than asking behaviorally focused questions. For this reason, the Intimate Justice Scale (IJS; Jory) can offer clinicians an assessment tool that is rooted in understanding the distribution of power in the relationship.

The results of this study generate several implications for training. In most master's level clinical programs, students are not even required to take a course on violence. At the very least, training programs should provide students with the tools to effectively perform IPV assessments and how to thoroughly document such assessments. This training should be akin to how we train students in suicide and crisis assessments. From our view, the existence of violence in a relationship is a major concern that requires therapists to be adequately trained and able to navigate the inherent complexities.

Further research is needed to know why/when therapists choose to screen for domestic violence and why/when they do not. The majority of the therapists' records included in this study were completed by female therapists (20 of the 28 therapists). This study did not consider how the gender of the therapists may have impacted the findings; however, it is possible that such an impact may exist. It would also be helpful to have additional research that looks specifically at therapists' gender, as well as ethnicity and other cultural demographics, to determine if/how these demographic differences impact therapists' assessment practices. Relatedly, future research could also investigate when therapists are demographically similar to or different from their clients and if these commonalities or differences impact assessment practices of therapists.

As mentioned earlier, several factors, including lack of training and assessment practices, lack of agreement within the field about the necessity to screen for IPV, a belief or fear that addressing violence may exacerbate the occurrence, lack of standardized training methods in graduate programs about how to conduct an IPV screening, and a lack of awareness that violence could be a concern, may all contribute to why therapists are not universally screening for domestic violence.

Stith and colleagues (2003) stated, "Family therapists are already working with violent couples. Unfortunately, they are often not aware that they are doing so. . . . Family therapists need to become more aware of domestic violence as an issue and make assessment for violence a routine part of treatment regardless of the presenting problem" (p. 422). We echo this statement and believe the results of this study urge clinicians to consider both their IPV assessment practices and documentation procedures.

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