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Marriage and Family Therapists' Endorsement of Couples Treatment for Intimate Partner Violence

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MARRIAGE AND FAMILY THERAPISTS' ENDORSEMENT OF COUPLES TREATMENT FOR INTIMATE PARTNER VIOLENCE

By

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TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

ABSTRACT

A six-group randomized experimental study was used to investigate the factors that are associated with a marriage and family therapist's decision to work with clients individually or as a couple when they present with intimate partner violence (IPV). Investigated factors included the type of IPV experienced by the clients, the therapist's accuracy in identifying the type of violence experienced by clients, and the therapist's experience with IPV in their own romantic relationships, as moderated by levels of differentiation. Participants included 275 members of the American Association for Marriage and Family Therapy. A chi square test revealed that participants who received vignettes portraying situational couple violence were more likely to endorse couples treatment as the preferred treatment modality than participants who received vignettes portraying intimate terrorism. Additional chi square tests revealed that among participants who received vignettes portraying situational couple violence, those who were accurately able to identify the type of violence portrayed in the vignette were more likely to endorse couples treatment as the preferred treatment modality than those who did not accurately identify the type of violence. Additional analyses, however, suggest that accurate identification and appropriate treatment choice may be more difficult in situations in which intimate terrorism is taking place, especially when women are the perpetrators of this abuse. Logistic regression indicated that there was not a significant relationship between therapists' personal experience with IPV and endorsement of treatment type. In addition, differentiation did not moderate the relationship between IPV experienced in participants' own romantic relationships and their endorsement of couples treatment. The current study indicates that marriage and family therapists are likely to make IPV treatment choices primarily based on the type of violence experienced by the couple. It appears that IPV treatment choice is not influenced by personal experience with IPV, but rather by the therapist's accurate identification of IPV type and the gender of the perpetrator of abuse. These findings ultimately highlight the need continued education on IPV, IPV types, gender biases with regards to IPV, and the importance of taking safety into consideration when making treatment decisions.

Keywords: counseling, differentiation, domestic violence, intimate partner violence, marriage and family therapy

CHAPTER ONE
INTRODUCTION
Study Purpose

Couples therapists working in outpatient settings are highly likely to be presented with clients who have experienced physical violence in their current relationship. Jose and O'Leary (2009), for example, found that between 36% and 58% of couples in regular outpatient couples treatment experienced male-to-female physical violence and between 37% and 57% of couples experienced female-to-male physical violence. Therefore, couples therapists are often faced with a dilemma when they see couples presenting with intimate partner violence (IPV) who wish to receive conjoint treatment. One option is to follow an "ideological course of action" (Stith & McCollum, 2011, p. 313) and refuse to work with the couple until the male partner completes a batterers intervention program. This means, however, that the client will likely receive services from someone else, and that by suggesting separate treatment and attempting to "prematurely sever the couple bond" (Istar, 1997, p. 97) the therapist may "instead sever the therapeutic bond, leaving the violent relationship intact."

Many argue that different interventions should be used to address different types of IPV (Babcock, Candy, Graham, & Schart, 2007), and with new research on the benefits of couples treatment for IPV (e.g., Stith & McCollum, 2011), many therapists realize that couples seeking voluntary treatment for IPV may in fact benefit from this type of treatment and may opt to provide conjoint treatment for the couple. Dudley, McCloskey, and Kustron (2008), for example, found that therapists' choice of couples treatment for IPV has become increasingly accepted, with endorsement of couples treatment using the same hypothetical vignette increasing from 28% in 1991 to 40% in 2008. Little research, however, has investigated the factors that are associated with a marriage and family therapist's (MFTs) decision to work with clients individually or as a couple when they present with IPV.

This study sought to investigate the factors that are associated with a MFT's decision to work with clients individually or as a couple when they present with IPV. Investigated factors included: 1) the type of IPV experienced by the clients, 2) the therapist's accuracy in identifying the type of violence experienced by clients, and 3) the therapist's experience with IPV in their own romantic relationships. Differentiation, or one's ability to maintain a sense of self that is

both separate from and connected to others (Bowen, 1978), was also investigated as a potential moderator of the association between experience with IPV and treatment choice.

CHAPTER TWO
REVIEW OF THE LITERATURE

The theoretical framework informing the current study will be presented in the following sections. First, the significance and prevalence of IPV will be discussed, followed by a discussion of Johnson's (1995) aggressor typologies. A review of the literature on the treatment of IPV will follow, including both single gender treatment approaches and couples treatment approaches. This will be followed by a discussion of therapist factors that may influence the treatment of IPV. Last, Bowen's family systems theory will be reviewed, with emphasis placed on the role of differentiation as a potential moderator in the relationship between a therapist's personal experiences with IPV and their likelihood of working with clients as a couple when IPV is detected.

Intimate Partner Violence

Significance and Prevalence

IPV is a problem that is experienced by couples across the world. IPV is defined as any form of physical, sexual, or psychological harm caused by an intimate partner or spouse (Centers for Disease Control and Prevention, 2010). Despite the attention that IPV has received in the literature, rates of violence within intimate relationships remain high, with over one-fifth of couples experiencing at least one episode of IPV over the course of a year (Schafer, Caetano, & Clark, 1998).

Traditionally, IPV was understood as a male phenomenon, with women being the sole victims of IPV, or only assaulting their male partners in an attempt to defend themselves (Stith, McCollum, Amanor-Boadu, & Smith, 2012). Men were viewed as being solely responsible for the violence, and interventions were focused on ending violence against women. Eventually, researchers realized that evidence supporting unilateral violence was being collected from studies using criminal justice and domestic violence shelter populations. Both of these populations contain a considerable amount of gender asymmetry, with more men than women being arrested, and more women than men seeking shelter in domestic violence shelters (Stith et al., 2012). As researchers began to collect data on IPV from community samples, they found that IPV is more gender symmetrical than originally thought, with both male and female participants reporting the perpetration of violence. Whitaker, Haileyesus, Swahn, and Saltzman (2007), for example, found that among 11,370 adults in the United States between the ages of 18 and 28,

almost 24% of relationships experienced some form of violence. Of those relationships characterized by violence, half of them were reciprocally violent, with both partners assaulting one another. Of those relationships in which violence occurred unilaterally, women were the perpetrators in over 70% of the cases. International research has also found that men and women perpetrate IPV at similar rates (Straus, 2004).

Although research now indicates that women report perpetrating violence more frequently than men (Whitaker et al., 2007), women remain at greatest risk of being injured both physically and psychologically by an intimate partner (National Center for Injury Prevention and Control, 2003; Tjaden & Thoennes, 2000). For example, even among a more gender symmetrical community sample in which both males and females were violent with one another, 62% of those injured by intimate partners were women (Archer, 2000). Physically, men tend to be stronger than women and run a greater risk of doing more physical damage in comparison with women when perpetrating violent acts, even when performing the same behaviors. In addition, while both men and women suffer poor mental health outcomes from IPV, the range of problems experienced by female victims appears to be greater than it is for male victims of IPV (Afifi et al., 2009). Research on reciprocal IPV, however, indicates that more injury is associated with this particular type of violence than with unilateral IPV, regardless of the gender of the perpetrator (Whitaker et al., 2007). While the consequences of IPV may be greater for women than they are for men, it has become increasingly evident that we must expand the focus of research and treatment to include both men and women perpetrators of IPV.

Aggressor Types

In response to the discovery that IPV is not a unilateral phenomenon, Johnson (1995) argued that there were two different forms of couple violence: common couple violence and patriarchal terrorism. These two types were later renamed situational couple violence and intimate terrorism (Johnson & Ferraro, 2000). In addition, two new types of IPV were identified: violent resistance and mutual violent control. These four types of IPV comprise one of the most widely studied typologies of violent relationships (Johnson, 2006).

Situational couple violence. Situational couple violence (formerly referred to as common couple violence) is the type of violence that is most often bilateral in nature and typically involves a dispute over a particular matter. This form of violence occurs when partners lack communication skills and resort to using verbal aggression which escalates into violence

(Johnson, 2006). While one or both partners are violent in situational couple violence, neither partner is controlling over the other and pervasive fear does not exist on account of violence perpetrated by either partner. Situational couple violence is the most common type of relationship violence, especially among the general population and among couples seeking couples therapy (Simpson, Doss, Wheeler, & Christensen, 2007).

Intimate terrorism. Intimate terrorism (formerly referred to as patriarchal terrorism) is the type of violence that most often occurs unilaterally, with the perpetrator displaying high levels of coercive control (Johnson, 2006). The partner of the perpetrator of abuse is neither violent nor controlling. In comparison with situational couple violence, victims of intimate terrorism are attacked more frequently, experience violence that is less likely to stop, are more likely to be injured, are more likely to experience fear and anxiety, and are more likely to exhibit symptoms of posttraumatic stress disorder (Johnson & Leone, 2005). Intimate terrorism and violent resistance are the most common types of relationship violence found among agency samples (e.g., domestic violence shelters, hospitals, jails; Johnson, 2006), with men being more likely than women to perpetrate intimate terrorism.

Violent resistance. Violent resistance is the type of violence that is performed in an attempt to resist intimate terrorism (Johnson, 2006). While the individual perpetrating violent resistance is violent, they are not controlling; their partner, however, is both violent and controlling. The primary motive of an individual perpetrating violent resistance may be that of protecting oneself or it may be an expression of anger or resistance to their violent and controlling partner.

Mutual violent control. Mutual violent control is the type of violence that is bilateral in nature and involves two equally coercive partners who are violent with one another (Johnson, 2006). In mutual violent control both partners strive for control over their partner and the relationship.

Again, traditionally, it has been argued that IPV is perpetrated by men in an attempt to dominate and control women (Johnson, 1995). More recently, others have argued that men and women are equally violent and that this bilateral form of IPV is often caused by conflict that has gotten out of control. Johnson (1995) proposes that both arguments are in fact correct, but that each argument is derived from empirical data focused on two different types of IPV. Johnson (2006) explains that those studying agency samples (e.g., domestic violence shelters, hospitals,

jails) are more likely to find participants who have experienced intimate terrorism. Those studying general survey data are more likely to find participants who have experienced situational couple violence. Thus, it is not appropriate to apply findings regarding IPV obtained from agency samples to community samples and vice versa.

Johnson and Leone (2005) argue that in order to fully understand IPV we must make distinctions among the different types of couple violence. More specifically, it has been suggested that in order to effectively intervene in individual cases of IPV, it is imperative that we identify and understand the particular type of violence experienced by the couple (Johnson, 2006). Accordingly, many argue that different interventions may be more appropriate for different types of violence (e.g., Babcock et al., 2007; Simpson et al., 2007). For example, perpetrators who engage in situational couple violence may benefit from systemic treatment, while those engaging in intimate terrorism may be more appropriately treated by individual and gender-specific group treatments (Babcock et al., 2007). It is unclear, however, whether or not therapists, and specifically MFTs, have begun to incorporate this research into their work by identifying the particular type of IPV that their clients have experienced and taking the type of IPV into consideration when choosing the appropriate form of treatment.

Treatment of IPV

In accord with the unilateral conception of IPV, court-involved IPV treatment in the United States has traditionally consisted of at least 26 weeks of mandatory all-male batters' intervention programs (BIPs) and voluntary victim support services for women (Stith & McCollum, 2011; Stith et al., 2012). BIPs have typically been designed to challenge male use of power and teach egalitarian ways of relating within romantic relationships. In cases in which police are involved in domestic disputes, even when there is evidence of mutual violence, an assumption is generally made that one partner is the primary aggressor and the other was acting in self-defense (Stith & McCollum, 2011). As a result, police are often encouraged to identify the primary aggressor. Even when both partners are mutually violent, most services for IPV in the United States only provide treatment for male offenders and female victims, and judges are generally prohibited from mandating couples treatment. A growing body of research, however, indicates that single-gender treatment approaches for offenders of IPV are limited in their effectiveness and that couples treatment may be appropriate and even more effective for couples experiencing particular types of IPV (Stith et al., 2012). While conjoint treatment for couples

experiencing intimate terrorism may be dangerous, it has been argued that the treatment of *only one* violent partner and ignoring the violence of the other partner with couples experiencing different types of couple violence (e.g., situational couple violence) may also be dangerous (Stith & McCollum, 2011).

Single Gender Treatment Approaches

Treatment of male offenders. Two meta-analyses have been conducted that offer information regarding the effectiveness of treatment of male offenders of IPV. Babcock, Green, and Robie (2004) reviewed 17 quasi-experimental and 5 experimental studies that investigated the effectiveness of male BIPs. For both experimental and quasi-experimental studies using police reports of recidivism, there was a significant small impact on recidivism, with an average treatment effect of d = .12 for studies with an experimental design and an average treatment effect of d = .23 for studies with a quasi-experimental design. For experimental studies using partner (i.e., victim) reports of recidivism, BIPs had a nonsignificant impact on recidivism (d = .09). For quasi-experimental studies also using partner reports of recidivism, BIPs had a significant but small impact on recidivism, with an average treatment effect of d = .34. Using the most conservative result of d = .09, Babcock et al. (2004) express concern that male BIPs are only responsible for about one tenth of a standard deviation improvement in recidivism, or only a 5% increase in the probability of remaining nonviolent in comparison with a man who does not receive treatment. This same meta-analysis found no significant differences in the effect size of recidivism outcomes based on treatment type.

Feder and Wilson (2005) reviewed 4 experimental and 6 quasi-experimental studies that investigated the effectiveness of male BIPs. For experimental studies using police reports of recidivism, there was a significant small impact on recidivism, with an average treatment effect of d = .26. For quasi-experimental studies using police reports of recidivism with men who were mandated to treatment, there was a nonsignificant effect (d = -.14). In comparison with men who were rejected from treatment, did not attend, or dropped out of treatment, men who completed mandated treatment had significant and large average treatment effect (d = .97). Feder and Wilson (2005) warn, however, that there may be something different about treatment completers in comparison with noncompleters (e.g., fear of criminal justice sanctions) that may confound the treatment effect. For experimental studies using partner reports of recidivism, there was a nonsignificant average effect size near zero. For quasi-experimental studies using partner report

of recidivism, a nonsignificant small and negative average treatment effect was found. Again, treatment effects for male BIPs appear small if they are even found at all.

Treatment of female offenders. With the development of mandatory arrest policies, women are now arrested with increased frequency and mandated to complete IPV treatment that is often the same or similar to BIPs designed for male offenders (Carney & Buttell, 2004; Dowd, Leisring, & Rosenbaum, 2005). Some have argued, however, that female perpetrated IPV may differ from male perpetrated IPV, therefore making BIPs inappropriate for female offenders (Kernsmith, 2005). Unfortunately, there are no strong experimental studies that investigate the effectiveness of treatment for female perpetrators of IPV (Stith et al., 2012). Carney and Buttell (2004) investigated the effectiveness of a traditional BIP for a group of 26 women using a single group pre-post design. They found that in comparison with before treatment, participants who completed the program were significantly less passive or aggressive and less likely to be physically violent against their partners. At a 12-month follow-up, only one participant who completed the treatment had been rearrested. The dropout rate for this program, however, was 55%. More research is needed to determine the effectiveness of programs designed for female offenders of IPV (Stith et al., 2012).

Couples Treatment Approaches

In response to the limited effectiveness of single gender treatment approaches for IPV (Stith et al., 2012) and in light of the identification of differing types of IPV (Johnson, 2006), many have argued that treatment should be tailored to the needs of each couple (Stith & McCollum, 2011) and that couples treatment for IPV is appropriate for couples who wish to remain in their relationship and who pass a screening process (Stith et al., 2012). When both partners are violent with one another, both partners need to end the violence in order to stop its reoccurrence. Many have argued that if both partners are violent, only treating one partner and not the other is less likely to stop IPV than if both partners receive treatment (Stith & McCollum, 2011). In addition, many couples in violent relationships prefer and seek couples treatment rather than single gender treatment approaches. Advocates of couples treatment for less severe forms of IPV (i.e., situational couple violence) argue that by working with couples to enhance their ability to resolve conflict non-violently, couples therapy may enhance client safety (Stith & McCollum, 2011). This led to the first hypothesis that MFTs will be more likely to endorse couples treatment as the preferred treatment modality when given a vignette portraying situational couple

violence than when given a vignette portraying intimate terrorism.

The primary goal of conjoint treatment of IPV is to end both physical and psychological violence experienced in the couple relationship (Stith & McCollum, 2011). Bograd (1999) and Stith, Rosen, and McCollum (2003) have offered guidelines for screening couples for IPV. Only after a thorough assessment can it be determined that conjoint treatment is safe and appropriate for a couple experiencing IPV (McCollum & Stith, 2008). Couples should be screened by interviewing each partner individually and assessing them with both written questionnaires (e.g., the Conflict Tactics Scale; Straus, Hamby, Boney-McCoy, & Sugarman, 1996) and interviews. Assessments should determine the severity of the violence and its context (e.g., self-defense). If it appears that either partner is fearful of the violence escalating, conjoint treatment is not deemed to be appropriate (Stith & McCollum, 2011). If either person blames their partner for their own perpetration of violence (except in cases of self-defense), individual or group treatment is typically deemed necessary before conjoint treatment begins. Assessment for other mental health or substance abuse issues that could potentially get in the way of safe participation in conjoint treatment should also be conducted prior to the onset of couples therapy (Stith & McCollum, 2011). In addition, ongoing assessment helps to determine whether conjoint therapy can be conducted safely.

When therapists work conjointly with couples who have experienced IPV, it has been suggested that safeguards are needed to enhance safety (Stith & McCollum, 2011). Shamai (1996), for example, suggests that therapists working with violent couples should sometimes have individual meetings with partners and even sessions with other significant people in the family system. Cooper and Vetere (2005) suggest that therapists include a "stable third" in their work with violent couples who can help to support the couple and enhance their safety.

In a review of the treatment of IPV, Stith and colleagues (2012) found that couples treatment of IPV can in fact decrease the incidence of IPV and its risk factors without an increase in risk to partners. Couples treatments found to be effective in the treatment of IPV include Behavioral Couples Treatment (BCT), Domestic Violence-Focused Couples Treatment (DVFCT), Couples Abuse Prevention Program (CAPP), Circles of Peace (CP), and Motivational Interviewing (MI). Because the focus of the current research is on the choice to treat couples, rather than a particular type of couples treatment, a description of the two most widely researched systemic interventions for IPV (i.e., BCT, DVFTC) will follow.

BCT has been used by a research group led by O'Farrell and Fals-Stewart (2002) to treat substance abuse disorders among adult couples. Research indicates that BCT has helped alcoholic men to significantly reduce incidents of IPV, a common correlate of substance abuse (Fals-Stewart et al., 2005; O'Farrell, Murphy, Hoover, Fals-Stewart, & Murphy, 2004; O'Farrell, Van Hutton, & Murphy, 1999). In one study, for example, 60% of male alcoholic participants had been violent with their female partners in the year prior to assessment (O'Farrell et al., 2004). After treatment, the rate of IPV had reduced to 24% among the male alcoholic sample. Of the men who had stopped drinking, the rate of IPV had reduced to 12%, the same prevalence rate found in a matched nonalcoholic comparison sample. Overall, individual treatment of substance abuse does not have as large of an impact on IPV as systemic interventions (Stith et al., 2012), although BCT is typically used with couples in which only one partner is abusing substances (Fals-Stewart, O'Farrell, & Birchler, 2004).

DVFTC requires that clients be carefully screened before beginning couples treatment (Stith & McCollum, 2009; Stith, McCollum, & Rosen, 2011; Stith, McCollum, Rosen, Locke, & Goldberg, 2005; Stith, Rosen, McCollum, & Thomsen, 2004). It employs a number of safeguards in working with couples, first requiring that each partner to take part in six weeks of gender separate therapy sessions prior to conjoint treatment. During this phase of the program, therapists work with clients to develop a vision of a healthy relationship with their partner. In addition, clients are educated about IPV, develop safety plans, and learn about taking negotiated time-outs and using mindfulness meditation when conflict begins to escalate. Once conjoint sessions have begun, gender separate sessions are held both before and after each conjoint session in order to evaluate the appropriateness of a conjoint session as well as the appropriateness of sending the couple home together after a conjoint session. Research indicates that DVFTC leads to a significant reduction in IPV, as measured by both partners in the relationship (Stith et al., 2012).

It is possible that the limited efficacy of BIPs may be related to its universal application to the treatment of male perpetration of IPV regardless of IPV type. Unfortunately, research on BIPs does not investigate differences in efficacy for different types of IPV. Therefore, evidence on the inappropriateness of the treatment of situational couple violence with BIPs is not available. However, a conceptual analysis of the aims of BIPs (e.g., to decrease the use of power and control over one's partner), the fundamental difference between situational couple violence and intimate terrorism, and the available efficacy rates of different IPV treatment approaches

supports the argument that different interventions may be more appropriate for different IPV types (e.g., Babcock et al., 2007; Simpson et al., 2007). Although those engaging in intimate terrorism may be appropriately treated by BIPs, perpetrators who engage in situational couple violence may benefit from alternative forms of treatment (e.g., couples treatment) that specifically treat this particular type of violence (e.g., improving communication skills; Babcock et al., 2007).

Therapist Factors in Treatment of IPV

Therapists, however, do not make treatment decisions solely based on efficacy research. The decision to conduct couples therapy for the treatment of IPV is influenced by both client factors and therapist factors.

Schacht et al. (2009) found that MFTs widely vary in the criteria that they use to determine whether conjoint therapy is appropriate when IPV is detected among couples. Fifty-two percent of MFTs considered the overall prognosis of the relationship, 42% considered the level of fear experienced by the victim and the safety in the relationship, 40.5% considered the severity, frequency, and duration of the abuse, 30.2% considered psychopathology experienced by either the victim or the perpetrator, and 23.1% considered whether or not other therapy services were being used by either the victim or the perpetrator. Additionally, 5.6% considered the potential effect that couples therapy might have on current levels of IPV, 4.8% considered past injuries or lethality of past violence, 1.7% considered the use or presence of weapons, and 1.4% considered the perpetrator's history of violence in other relationships. These data, however, were collected in 2000, shortly after Johnson's (1995) aggressor types were identified and prior to much of the research supporting the efficacy of couples treatment for IPV with clients experiencing less severe forms of violence. It is likely that in the fourteen years since these data were collected, MFTs have altered the criteria that they use to determine whether conjoint therapy is appropriate when IPV is detected. In addition, this research did not investigate the impact of MFTs' ability to correctly identify differing IPV types or the influence of a therapist's own personal experience with IPV. Because the literature indicates that the appropriate selection of couples treatment for IPV is dependent on IPV type (e.g., Babcock et al., 2007; Simpson et al., 2007), this led to the second hypothesis, that MFTs who are accurately able to identify the type of violence portrayed in a given vignette (i.e., situational couple violence) will be more likely to endorse couples treatment as the preferred treatment modality for clients who have experienced

situational couple violence.

Therapists' correct recognition of appropriate therapeutic interventions is influenced both by their professional training (Dudley, McCloskey, & Kustron, 2008) and their own personal values and biases (Levey & Hershey, 2008). Especially in situations when it is unclear what decision would be most effective, therapists have a tendency to distort the facts of the current situation to suit their own values and beliefs (Levey & Hershey, 2008).

When therapists encounter family violence in their clinical work, this experience may trigger memories of exposure to violence (Benatar, 2000; Iliffe & Steed, 2000). Owen (2008) found that counselors are more likely to attempt confirming their own hypotheses rather than attempting to disconfirm them when conducting intake assessments. Likewise, Jacob (2012) speculated that clinicians with more exposure to battering may use a confirmatory bias when evaluating vague descriptions of IPV, leading them to assume that the violence may be more severe and to believe that individual treatment would be more appropriate than couples treatment. Thus, a therapist's past exposure to IPV has the potential to influence his or her decision regarding the preferred treatment modality for couples when they have experienced IPV. This led to the third hypothesis: that MFTs who have experienced less IPV in their own romantic relationships will be more likely to endorse couples treatment as the preferred treatment modality for clients who have experienced IPV. Bowen family system's theory provides a theoretical background that helps to explain why the relationship between personal experience with IPV and IPV treatment endorsement may exist and is therefore reviewed next.

Bowen Family Systems Theory

Bowen family systems theory is a transgenerational theory of human behavior that views the family as an emotional unit and describes complex interactions within that unit using systems thinking (Bowen, 1978). According to this theory, family members are affected by one another's thoughts, feelings, and actions in such a way that when one person's functioning changes, reciprocal changes in the functioning of other family members follow.

Differentiation of Self

At the cornerstone of Bowen's theory is the concept of differentiation (Bowen, 1978; Kerr & Bowen, 1988). Differentiation of self allows an individual to balance two opposing forces: the force toward separateness and the force toward togetherness. When an individual possesses high levels of differentiation, he or she is able to maintain a sense of self that is both

separate from and connected to another person or the entire family unit. Each family and, to some extent, the individuals within each family, differ in their ability to balance the force toward separateness and the force toward togetherness (Bowen, 1978; Kerr & Bowen, 1988). When the family is calm, individuals within that system are often allowed more room to express their unique qualities and unlikeness from the rest of the family. However, when emotional intensity rises, greater emotional pressure is exerted from the family onto individual members to fall in line with the rest of the system, thereby reducing the space for the individuality of each member. The levels of differentiation of each family member can be indicated by the extent to which they are able to face this pressure while continuing involvement with the family in a calm and thoughtful manner. When emotional pressure to conform to the family is high, individuals low in differentiation may either give into this pressure, fusing with the family and losing themselves in the process, or assert their right to individuality by cutting themselves off from the family emotionally and/or physically. Individuals with high levels of differentiation are better equipped to resolve relationship issues with their family without losing themselves or family connections.

In addition, individuals high in differentiation have the ability to distinguish between thoughts and feelings (Bowen, 1978). This ability allows them to consciously choose to be guided by either their intellect or their emotions. Those with higher levels of differentiation possess a greater ability to cope with stress because they can feel the strong emotions that may be tied to the situation but still base their actions on logical thought. Those with lower levels of differentiation, on the other hand, are highly reactive and base their actions on their emotions rather than logical thought. Therefore, high levels of differentiation allow people to remain in close emotional contact with others without having apparently automatic reactions from the emotional environment govern one's thoughts, emotions, and behaviors (Friedman, 1991).

Differentiation is linked to a number of intrapersonal and interpersonal benefits. Skowron, Stanley, and Shapiro (2009), for example, found that higher levels of differentiation are correlated with fewer psychological and interpersonal problems. In addition, higher levels of differentiation are associated with fewer life stressors, increased psychological well-being (Bartle-Haring, Rosen, & Stith, 2002), and a greater ability to cope with stress (Murdock & Gore, 2004).

Differentiation in Therapists

Bowen (1978) stressed that it is the professional responsibility of the MFT to explore and

understand the dynamics, patterns, and relationships in one's own family of origin in order to develop one's own sense of self and ultimately to maintain high levels of differentiation. Only by remaining differentiated is the therapist able to work with couples without becoming triangulated in emotional situations, while still maintaining intimate contact with the couple.

As one might imagine, couples who have experienced IPV are prime candidates for bringing emotional intensity to couples therapy. In addition, working with this presenting problem may in and of itself be accompanied by heightened levels of stress on therapists due to increased volatility. According to Bowen (1978), only highly differentiated therapists will be able to maintain both intimacy and emotional objectivity as an observer of a family system that is in emotional turmoil.

Accordingly, therapists low in differentiation may be less equipped to handle high conflict couples due to heightened levels of anxiety. With increased anxiety, less differentiated individuals are at an increased risk of making decisions based on emotions rather than logical thought (e.g., that evidence based practice indicates that couples treatment may be a better treatment option than individual treatment for couples experiencing less severe forms of IPV). Less differentiated therapists may be more likely to 'cutoff' by separating clients and treating them individually in an attempt to lessen anxiety. For those who have experienced IPV in their own romantic relationships, IPV experienced by clients may be particularly likely to trigger anxiety, potentially leading to an increased likelihood of working with clients individually rather than as a couple. This led to the fourth hypothesis, that levels of therapist differentiation will moderate the relationship between IPV experienced in MFTs' own romantic relationships and their endorsement of couples treatment for clients who have experienced IPV. Interestingly, lower levels of differentiation are correlated with an increased probability of experiencing IPV (Rosen, Bartle-Haring, & Stith, 2001), perhaps making this association even more likely.

Hypotheses

This study sought to investigate the factors that are associated with a MFT's decision to work with clients individually or as a couple when they present with IPV. Investigated factors included: (1) the type of IPV experienced by the clients, (2) the therapist's accuracy in identifying the type of violence experienced by clients, (3) the therapist's experience with IPV in their own romantic relationships, and (4) therapists' levels of differentiation. Specifically, I tested the following hypotheses:

1. Participants will be more likely to endorse couples treatment as the preferred treatment modality when given a vignette portraying situational couple violence (i.e., vignettes 1-3) than when given a vignette portraying intimate terrorism (i.e., vignettes 4-6).
2. Participants who are accurately able to identify the type of violence portrayed in the vignette (i.e., situational couple violence) will be more likely to endorse couples treatment as the preferred treatment modality for clients who have experienced situational couple violence.
3. Participants who have experienced less IPV in their own romantic relationships will be more likely to endorse couples treatment as the preferred treatment modality for clients who have experienced IPV.
4. Levels of differentiation will moderate the relationship between IPV experienced in participants' own romantic relationships and their endorsement of couples treatment for clients who have experienced IPV.

CHAPTER THREE

METHOD

Participants

Participants were current members of the American Association for Marriage and Family Therapy (AAMFT) who conduct couples therapy and are either licensed as a MFT or currently working under the supervision of an AAMFT approved MFT supervisor. Participants (n = 385) were obtained from three separate methods of data collection: (1) paper and pencil surveys mailed to clinical members of AAMFT in states without standards precluding couples treatment during the course of the primary domestic violence intervention, (2) Internet surveys completed by members of AAMFT and the National Council for Family Relations (NCFR) list serves, and (3) Internet surveys completed by students and faculty at MFT training programs across the United States.

Participants were disqualified and dropped from the study if they did not indicate that they were either licensed as a MFT or currently working under the supervision of an AAMFT approved MFT supervisor, if they did not indicate that they had worked with any couples over the past year, or if they answered any of the three quality-control questions inaccurately on the questionnaire. If any scale was missing data, that scale was not used in the analyses, however, participants were not dropped entirely from the study for missing data. After the disqualification of the aforementioned participants, the sample comprised 275 participants.

In order to identify differences between major demographic variables for participants from each of these sampling methods, the descriptive analyses will be reported separately for each method of data collection. This will be followed by a summary report on descriptive statistics for the total sample. In addition, the total sample will then be compared with general demographic variables for the entire membership of AAMFT. Completion rates for each method of data collection will then be discussed.

Detailed participant exclusion frequencies by criterion variables can be found in Table 1. A full list of general and clinical demographic variable frequencies can be found in Tables 2 and 3. Means, standard deviations, and the range of numeric demographic variables can be found in Table 4. These tables are organized by the method of data collection, allowing for a comparison between different subsets of the sample for each variable.

Paper and Pencil Surveys

Of the 1,000 paper and pencil surveys sent to clinical members of AAMFT, a total of 200 were completed and returned, yielding a response rate of 20%. Forty-one of these surveys, however, were excluded from the analyses because they did not meet inclusion criteria (see Table 1). Unfortunately, INFOCUS Marketing, the company from which the AAMFT mailing list was obtained, did not allow "AAMFT" to be printed anywhere on the mailing. Therefore the paper and pencil questionnaire could not ask if participants were currently working under the supervision of an AAMFT approved MFT supervisor. After the exclusion of surveys from participants who did not meet inclusion criteria, a total of 159 paper and pencil surveys were utilized in data analyses.

The majority of participants were female (70.4%), White (88.1%), and ranged between 50 and 69 years of age (60.4%). Most (76.7%) indicated that the highest level of education that they had obtained was a Master's degree.

All participants were clinical fellows of AAMFT and were currently licensed as a MFT. The average number of years of licensure was 16.08 (SD = 10.73), with a slightly higher average number of years practicing (M = 20.13, SD = 11.14). All participants were currently practicing in states without standards against couples treatment during the course of the primary domestic violence intervention. The majority indicated that they worked in private practice (84.9%) and saw between 1-19 couples in the past year (54.8%).

Surveys from List Serves

A total of 45 surveys were completed by members of AAMFT from links sent through AAMFT and NCFR list serves. Thirteen of these surveys, however, were excluded from the analyses because they did not meet inclusion criteria (see Table 1). After the exclusion of such surveys, a total of 32 surveys were utilized in data analyses.

The majority of participants were female (68.8%), White (75.0%), and ranged between 20 and 39 years of age (68.8%). Most indicated that the highest level of education that they had obtained was either a Master's degree (40.6%) or a Ph.D. (53.1%).

The majority of participants were either clinical fellows (40.6%) or student members (31.3%) of AAMFT. The majority (65.6%) were currently licensed as a MFT. The average number of years of licensure was 9.02 (SD = 8.65), with a slightly higher average number of years practicing (M = 9.48, SD = 8.83). Only 25% of participants were currently practicing in

states without standards against couples treatment during the course of the primary domestic violence intervention. The majority indicated that they either worked in private practice (43.8%) or a school or university setting (34.4%) and saw between 1-9 couples in the past year (43.8%).

Surveys from MFT Programs

Of the survey links sent to the 133 representative faculty members of MFT graduate training programs in the United States, responses were collected from 33 of the links. The total number of links shared with faculty and students in those programs is uncertain.

A total of 140 surveys were completed by AAMFT members from this method of data collection. Fifty-six of these surveys, however, were excluded from the analyses because they did not meet inclusion criteria (see Table 1). After the exclusion of such surveys, a total of 84 surveys were utilized in data analyses.

The majority of participants were female (77.4%), White (76.2%), and ranged between 20 and 29 years of age (71.4%). Most indicated that the highest level of education that they had obtained was either a Bachelor's degree (44.0%) or a Master's degree (44.0%).

The majority of participants were student members of AAMFT (75%). The majority (77.4%) were not currently licensed as a MFT. For those who were licensed, the average number of years of licensure was 4.88 (SD = 4.97). For all participants in this category, the average number of years practicing was 3.62 (SD = 5.42). Only 32.1% of participants were currently practicing in states without standards against couples treatment during the course of the primary domestic violence intervention. The majority indicated that they worked in a school or university setting (57.1%) and saw between 1-9 couples in the past year (56.0%).

Summary Demographic Variables

In sum, a total of 385 participants completed the study. Of the completed surveys, 110 were excluded from the analyses because they did not meet inclusion criteria (see Table 1), yielding 275 surveys for data analyses. Participants from MFT programs were more likely to be excluded from the study than participants recruited by the AAMFT mailing list and AAMFT and NCFR list serves. This exclusion was mostly due to lack of clinical experience, and was related to educational attainment and the age of participants. A series of chi-square tests, however, indicated that those who were excluded from the analyses did not differ significantly from the final sample in terms of gender or race.

The majority of participants were female (72.4%) and White (82.9%). Participants ranged

between 23 and 86 years of age, with an average age of 45.92 (*SD* = 16.9). While each subset of the sample tended to have a majority of participants within a particular age range, the total sample's age range was more evenly distributed. Most indicated that the highest level of education that they had obtained was a Master's degree (62.5%).

The majority of participants (59.3%) were clinical fellows of AAMFT, with a smaller proportion (26.5%) indicating that they were student members of AAMFT. The majority (72.4%) were currently licensed as a MFT. For those who were licensed, the average number of years of licensure was 14.27 (*SD* = 10.75). For all participants, the average number of years practicing was 13.96 (*SD* = 12.11). The majority (69.8%) of participants were currently practicing in states without standards against couples treatment during the course of the primary domestic violence intervention. The majority indicated that they worked in a private practice (63.3%), followed by those working in a school or university setting (25.1%). Most participants (66.5%) saw between 1-19 couples in the past year.

Comparison with AAMFT Membership

At the time that the survey was distributed, INFOCUS Marketing reported that there were 22,195 active members of AAMFT. The majority of members were female (66.7%) and had clinical fellow membership status (43.9%), followed by student membership status (32.1%). The majority had a Master's degree (37.9%). The total sample obtained for this study roughly matches the distribution of demographic variables of all AAMFT members, as reported by INFOCUS at the time that the survey was distributed. A more detailed description of demographic variables by AAMFT membership and total sample can be found in Table 5.

At the time that the survey was distributed, INFOCUS also reported the number of clinical fellows of AAMFT that were living in each of the states without standards against working with couples who have experienced IPV. Membership numbers by state are listed in Table 6, along with a comparison of sample sizes obtained from paper and pencil surveys for each of these states. Response rates of participants from paper and pencil surveys who met inclusion criteria roughly match the distribution of clinical members in each of these states.

Procedure

The present study was a randomized experiment approved by Florida State University's Institutional Review Board (IRB; see Appendix A). As noted previously, participants were recruited three ways: (1) paper and pencil surveys (n = 1,000) were mailed to randomly selected

clinical members from the AAMFT mailing list obtained by INFOCUS Marketing. In order to increase the likelihood of participants choosing their preferred treatment modality rather than the one required by state standards, surveys were only mailed to members in states without standards prohibiting couples treatment during the course of the primary domestic violence intervention (i.e., California, Colorado, Illinois, Kansas, Nevada, Rhode Island, Washington, West Virginia; Maiuro & Eberle, 2008). (2) Links to the questionnaire were sent via list serves for AAMFT and NCFR. (3) Links to the questionnaire were emailed to Marriage and Family Therapy graduate programs across the United States, with a request that the links be shared with the faculty members and students of those programs.

Potential respondents were told that if they choose to participate, they would be asked to complete a questionnaire about a hypothetical counseling scenario, in addition to questions about their own personal relationships (see Appendix B for Recruitment Script). Those who agreed to participate signed an informed consent form (see Appendix C) or clicked their consent on a web page, depending on whether they participated via a paper and pencil questionnaire or over the Internet. Participants were then provided with a questionnaire (see Appendix D). Those receiving a paper and pencil survey also received a preaddressed, stamped envelope for the purpose of returning the survey. In addition, all participants were given an address to a website that will direct them to a feedback form (see Appendix E) that will reveal the results of the study.

Some participants may have had a vested interest in the outcome of the study, encouraging some participants to take the survey more than once in order to influence the results. Therefore, in the recruitment script, participants were asked to only complete the questionnaire one time.

Measures

The study survey assessed general demographic information such as sex, age, ethnicity, education level, and location of occupation (see Appendix D). In addition, it assessed how many years the participant had been practicing as a MFT, whether or not the participant was licensed as a MFT, and approximately how many couples they worked with over the past year. Additional scales assessed the participant's experience with IPV in their own romantic relationships and their personal levels of differentiation. Participants were also presented with one of six randomly selected vignettes and asked a series of questions pertaining to the information presented in the vignette.

Independent Variables

Personal experience with IPV. A shortened version of the Revised Conflict Tactics Scales (CTS2; Straus et al., 1996) was used to assess participants' experience of abuse in past and current romantic relationships. The full version of the assessment consists of 39 items, each containing two questions, for a total of 78 questions. It is divided into five major types of conflict-resolution tactics: negotiation, psychological aggression, physical assault, sexual coercion, and injury experienced between partners. For the purposes of this study, only the psychological aggression and physical assault scales were utilized. Both of these scales contain minor and severe subscales. The psychological aggression scale contains 8 items such as "Insulted or swore at partner." The physical assault scale contains 12 items such as "Kicked, bit, or punched partner."

Participants are traditionally asked to report the number of times in the past year that they performed or experienced each of the behaviors listed on the assessment. Participants are also asked to report the number of times in the past year that their partner performed or experienced each of those behaviors, with responses made on a scale from 0 to 7, with 0 indicating that "this has never happened," 6 indicating "more than 20 times in the past year," and 7 indicating "not in the past year, but it did happen before." This scale was altered for the purposes of this study to assess the behaviors that have occurred over the life course of the participant, whether it be in current or past romantic relationships. Accordingly, responses were made on a scale from 0 to 6, with 0 indicating that "this has never happened" and 6 indicating "more than 20 times."

According to the suggestion made by Straus et al. (1996), the CTS2 was scored by adding together the midpoints of the response category chosen by the participant for each item. For Categories 0, 1, and 2, the midpoints are 0, 1, and 2, respectively. The midpoint for Category 3 (3-5 times) is 4. The midpoint for Category 4 (6-10 times) is 8. The midpoint for Category 5 (11-20 times) is 15. The recommended midpoint for Category 6 (More than 20 times) is 25. Higher scores indicate more IPV experienced in one's romantic relationships, with lower scores indicating less IPV experienced in one's romantic relationships.

Scale and subscale reliabilities were examined using Chronbach's Alpha (α). Composite reliability for the CTS was good (α = .88), with scale and subscale reliabilities ranging between .66 and .92 (see Table 7).

Differentiation. The Revised Differentiation of Self Inventory (DSI-R) is 46-item self-

report measure of differentiation. The Differentiation of Self Inventory - Short Form (DSI-SF; Drake, 2011) has been shown to be more efficient than the DSI-R and was used for the purposes of this study. The DSI-SF consists of 20 items derived from the DSI-R. As regards concurrent criterion validity, the DSI-SF is positively related to self-esteem and negatively related to depression, state anxiety, trait anxiety, and perceived stress (Drake, 2011). Convergent validity of the DSI-SF is supported by a positive relationship between the subscales of the DSI-SF and the Level of Differentiation of Self Scale (Drake, 2011).

Drake (2011) reports that the DSI-SF retains 98% of the internal consistency of the full version of the Emotional Control subscale, 95% of the internal consistency of the full version of the Emotional Reactivity subscale, 92% of the internal consistency of the full version of the Fusion of Others subscale, and 97% of the internal consistency of the full version of the I-Position subscale. Overall, the full scale score of the DSI-SF retains 99% of the internal consistency of the full version of the full scale. In addition, test-retest reliability of the DSI-SF is .85 (Full Scale).

To score the DSI-SF, items 2, 4, 5, 6, 7, 8, 9, 11, 13, 14, 15, 16, 17, 18, and 19 were first reverse scored (i.e., 6 = 1, 5 = 2, 4 = 3, 3 = 4, 2 = 5, 1 = 6). The scores for all items were then averaged to create a total score for the full scale. Higher scores indicate greater levels of differentiation, with lower scores indicating lower levels of differentiation. Chronbach's Alpha for the DSI-SF was good ($\alpha = .87$; see Table 7).

Vignettes. Participants were presented with one of six randomly assigned vignettes illustrating a clinical scenario that the therapist would potentially encounter in their work as a couples therapist (see Appendix F). Each vignette illustrates a particular form of IPV (i.e., situational couple violence, intimate terrorism), with either a male or female perpetrator or a mutually aggressive couple. Vignettes 1-3 illustrate situational couple violence, with Vignette 1 illustrating mutual aggression, Vignette 2 illustrating male perpetrated violence, and Vignette 3 illustrating female perpetrated violence. Vignettes 4-6 illustrate intimate terrorism, with Vignette 4 illustrating mutual violent control, Vignette 5 illustrating male perpetrated violence, and Vignette 6 illustrating female perpetrated violence.

Vignettes were pilot tested with a group of MFT doctoral students and practicing clinicians ($n = 6$) to ensure appropriateness and believability (see Appendix G). Feedback was solicited in an informal meeting regarding their content and wording. Following these

discussions, alterations were made to the final draft as needed, and the vignette was administered to a sample of undergraduate students (n = 137) taking classes in the college of Human Sciences at a southeastern university. The intention of piloting these vignettes was to ensure that the last three vignettes represented a significantly more severe and controlling form of violence than that which was presented in the first three vignettes. The descriptive statistics were examined for responses on each of the six vignettes (see Table 8). A series of independent samples *t*-tests were then conducted to compare the responses (see Table 9) between the vignettes intended to represent situational couple violence and intimate terrorism for mutual violence (i.e., 1 and 4), male perpetrated violence (i.e., 2 and 5), and female perpetrated violence (i.e., 3 and 6). As predicted, there were significant differences in the comparisons between the vignettes, with Vignettes 4-6 eliciting responses indicating that the abuse and control represented was more severe than that presented in Vignettes 1-3.

For the purposes of the current study, Vignettes 4-6 were slightly altered by deleting the part about "recently suspect[ing] that [the other partner] had been talking on the phone with an old friend" (see Appendix G). This was done to ensure that Vignettes 4-6 were as consistent with Vignettes 1-3 as possible and that participant responses would be based on the violence itself rather than the nature of the argument.

Descriptive statistics were examined for responses on each of the six vignettes in the current study (see Table 10). A series of independent sample *t*-tests were then conducted to compare the responses (see Table 11) between the vignettes intended to represent situational couple violence and intimate terrorism for mutual violence (i.e., 1 and 4), male perpetrated violence (i.e., 2 and 5), and female perpetrated violence (i.e., 3 and 6). As predicted, there were significant differences in the comparisons between the vignettes, with Vignettes 4-6 eliciting responses indicating that the abuse and control represented was more severe than that presented in Vignettes 1-3. The only comparison that did not yield significant results was for the comparison between Vignettes 3 and 6 for the item regarding how controlling the male partner was. Because the female partner was the sole perpetrator of abuse in these two vignettes, a significant difference was not expected for this item.

In the current study, participants were asked to rate the severity of harm and extent of control presented in the vignette. Severity of harm was rated on a scale of 0 to 6, with 0 indicating "not at all harmful" and 6 indicating "extremely harmful." Extent of control was

measured with two items. The first item asked participants to rate how controlling the male partner was in the vignette. The second item asked participants to rate how controlling the female partner was in the vignette. Both items were rated on a scale of 0 to 6, with 0 indicating "not at all controlling" and 6 indicating "extremely controlling." Participants were also asked to identify the type(s) of violence presented in the vignette. Response options included "intimate terrorism / patriarchal terrorism," "violent resistance," "mutual violent control," and "situational couple violence / common couple violence." In addition, participants were allowed to select another option that stated, "I cannot answer this question because I'm uncertain of the definitions of these terms." Participants were instructed to "select all that apply."

Dependent Variable

Treatment type. After reading the vignette, participants were also asked to identify the type of treatment that seemed most appropriate for this particular couple. Available options were limited to *Couples Treatment* and *Individual Treatment*. No additional description of the course of treatment was provided. Participants, however, were reminded in the instructions that they were to select a specific treatment option rather than making the choice that would provide them with additional assessment information.

Research indicates that when the information provided is less clear, the likelihood of accessing personal biases in the decision-making process increases (Hsieh & Kirk, 2003). When situations lack the clarity necessary to determine the most effective option, people tend to distort facts in order to suit their personal values and beliefs (Levey & Hershey, 2008). Following the rationale provided by Jacob (2012) in his assessment of therapist decision-making with clients experiencing IPV, the vague nature of the vignettes helps to better understand the role that a therapist's past experiences play in the decision-making process by increasing the likelihood that they would access their own personal biases in the process.

It was expected that, given the less severe patterns of abuse described in Vignettes 1-3, this hypothetical couple would be appropriate for couples treatment, as there is no evidence of control or intimate terrorism, and it is in keeping with the framework of the conjoint couples model (Stith et al., 2004). The individual treatment option would be a valid treatment option for any of these vignettes, but less so for Vignette 1, as the presenting problem appears to be related to less severe mutual aggression. Vignettes 4-6 demonstrate more severe forms of violence that are characterized by control, indicating intimate terrorism and mutual violent control. Clients in

these vignettes would not be appropriate for couples treatment (Stith et al., 2004). Given the patterns of violence for Vignettes 4-6, it was expected that clinicians would be more likely to choose individual therapy as the appropriate form of treatment.

Quality-Control Questions

Three quality-control questions were placed within the CTS and DSI-SF scales in the questionnaire. The two items placed in the CTS requested that participants, "Please select the number three" and "Please select the number six." The item placed in the DSI-SF requested that participants, "Please select the number two." It was assumed that if participants did not accurately answer these three questions, these responses were either indicative of waywardness throughout the entire survey or at least on these key measures. Accordingly, participants who inaccurately answered any of these three questions were dropped from the study.

Analytic Strategy

Missing Data

According to the recommendation made by Straus (2001), when a respondent omitted one or more item in a CTS scale, both the item and scale or subscale that that item belonged to were coded as missing values. This same method was employed for items on the DSI. If any scale was missing data, that scale was not used in the analyses, however, participants were not dropped entirely from the study for missing data.

Certain survey items received a higher completion rate than others. Completion rates did not appear to differ between general demographic characteristics. The following will describe the completion rates for survey items, highlighting differences between methods of data collection.

The CTS received a 97.4% completion rate. Four participants (1.5%) did not respond to any items on the scale. Another 3 (1.1%) were missing at least one item response. Noncompletion rates for the CTS were higher for participants who received paper and pencil surveys. This scale was located in the middle of the survey, or pages 2-3 of the paper and pencil survey. It is possible that those who completed the paper and pencil surveys did not complete this scale because the pages of the questionnaire stuck together and they did not see it.

The vignette and accompanying questions received a 97.1% completion rate. Eight participants (2.9%) did not respond to any items about the vignette. Another 2 (0.7%) were excluded from the analyses because they checked both 'separate treatment' and 'couples treatment.' Noncompletion rates for the vignette were higher for participants who received paper

and pencil surveys. These questions were located after the CTS, or pages 4-5 of the paper and pencil survey. It is possible that those who completed the paper and pencil surveys did not complete these items because the pages of the questionnaire stuck together and they did not see them. In addition, online participants only had the option of choosing 'separate treatment' or 'couples treatment,' making it impossible for both options to be selected.

The DSI-SF received the lowest completion rate (95.2%). Eight participants (3%) did not respond to any items on this scale. Another 5 (1.8%) were missing at least one item response. Noncompletion rates for the DSI-SF were higher for participants who completed the survey over the Internet. It was located at the end of the survey, or the last page of the paper and pencil survey. It is possible that those who completed the online surveys did not complete this scale because they could not see that they were almost finished with the survey and stopped completing it.

Data Screening

The data were first screened for violations to assumptions of normality by assessing skewness and kurtosis. Violations to the assumption of normality occur when values are greater than 3.0 for skewness and kurtosis (Kline, 2011). The CTS was skewed (1.97) and kurtotic (5.46). Unfortunately, this is a common problem among IPV measures (e.g., Straus et al., 1996). Two cases of extreme univariate outliers on the CTS were Winsorised, resulting in the reduction of both skewness (1.47) and kurtosis (1.62).

Sample Size and Statistical Power

A series of a priori power analyses were conducted to compute the required sample size to test each hypothesis using G Power (Buchner, Erdfelder, Faul, & Lang, 2009) and Demidenko's (2007) test procedure with variance correction. For statistical power of .8, at an alpha level of .05, the sample size needed to detect an effect size of an odds ratio of 2.47 (equivalent to $r = .30$, or a moderate effect size; Chinn, 2000) for Hypothesis 1 was 88 (Cohen, 1992). Using the same procedure and the same criteria, the sample size needed for Hypothesis 2 was also 88. Because only Vignettes 1-3 were used in this analysis, however, at least 30 participants were required per vignette. Using the same procedure and the same criteria, 72 participants were required for Hypothesis 3, and 100 were required for Hypothesis 4.

The largest sample size required for any of the 4 hypotheses was 100 (Hypothesis 4). Divided evenly among the 6 vignettes, 17 participants were required per vignette. However, the

second hypothesis required that 30 participants complete each of Vignettes 1-3. Therefore, if 30 participants were required to complete each of the 6 total vignettes, a total sample size of 180 was required. The total sample size exceeded this number, allowing adequate power to detect effects.

CHAPTER FOUR
STUDY RESULTS

The results from hypotheses testing will first be reported, followed by the results from additional analyses.

Hypothesis Tests

Endorsement of Treatment Modality by IPV Type

Hypothesis 1, that participants would be more likely to endorse couples treatment as the preferred treatment modality when given a vignette portraying situational couple violence than when given a vignette portraying intimate terrorism, was supported by the data, $\chi^2(1, N = 265) = 17.88$, $p < .001$. Cramer's V was .26, indicating a moderate effect size (Cohen, 1988). Endorsement of couples treatment frequencies by vignette and method of data collection are shown in Table 12.

Endorsement of Treatment Modality by Accurate Identification of IPV Type

Hypothesis 2, that participants who are accurately able to identify the type of violence portrayed in the vignette would be more likely to endorse couples treatment as the preferred treatment modality for clients who have experienced situational couple violence, was supported by the data, $\chi^2(1, N = 134) = 4.88$, $p = .027$, Cramer's $V = .19$. As predicted, the accuracy of identification of violence type was not related to the endorsement of couples treatment for participants who received vignettes portraying intimate terrorism, $\chi^2(1, N = 127) = 2.29$, $p = .13$, Cramer's $V = .13$ (Cohen, 1988). Treatment response frequencies by identification of IPV type are shown in Table 13 and detailed analyses concerning accurate identification of violence type are reported in the section "Additional Findings."

Endorsement of Treatment Modality by Therapists' Personal Experience with IPV

Hypothesis 3, that participants who have experienced less IPV in their own romantic relationships would be more likely to endorse couples treatment as the preferred treatment modality for clients who have experienced IPV, was not supported by the data. Scales were "mean centered" to help remove nonessential multicolinearity and two independent binary logistic regressions were then run to examine the effects of the CTS on treatment choice. The CTS did not predict treatment choice among participants who received vignettes portraying situational couple violence or among participants who received vignettes portraying intimate terrorism (see Table 14).

Therapists' Levels of Differentiation as a Moderating Factor

Hypothesis 4, that levels of differentiation would moderate the relationship between IPV experienced in participants' own romantic relationships and their endorsement of couples treatment for clients who have experienced IPV, was not supported by the data. Scales were "mean centered" and interaction terms were computed. Two independent binary logistic regressions were then run to examine the interaction between IPV and differentiation on treatment choice. There was a nonsignificant interaction between the DSI-SF and CTS, and nonsignificant main effects for the DSI-SF and the CTS among participants who received vignettes portraying situational couple violence and among participants who received vignettes portraying intimate terrorism (see Table 15).

Additional Findings

Severity of Harm

To determine whether participants' perceptions of the severity of harm functioned as a mediator between the type of violence presented in the vignette (i.e., situational couple violence or intimate terrorism) and their endorsement of couples treatment as the preferred treatment modality, a bootstrapping analysis was conducted according to the recommendations of Preacher and Hayes (2008). Results indicate that perceptions of the severity of harm in the vignette mediated the effects of type of violence presented in the vignette on treatment choice, with a 95% bias-corrected and accelerated CI [0.30, 0.95]. The presence of a significant mediation effect suggests that the relationship between violence type and treatment choice is partly explained through the perception of the severity of harm presented in the vignette (see Figure 1).

Severity of Control

Although severity of control correlated with severity of harm, $r(253) = .52$, $p < .01$, the two variables shared only 27% of their variance. Consequently it was reasonable to conduct similar analyses to those reported above to examine whether severity of control functioned as a mediator between the type of violence and endorsement of couples treatment. Severity of control mediated the effects of type of violence on treatment choice, with a 95% bias-corrected and accelerated CI [0.23, 0.71]. The presence of a significant mediation effect suggests that the relationship between violence type and treatment choice is partly explained through the perception of the severity of control presented in the vignette (see Figure 2).

IPV Type and Gender of Perpetrator

To determine whether there was an interaction between the type of violence presented in the vignette and the gender of the perpetrator of violence, an interaction term was first created for gender and violence type. Only vignettes portraying either male or female perpetrated violence (i.e., Vignettes 2, 3, 5, and 6) were included in the analyses. A logistic regression indicated that there was not a significant interaction between type of violence and the gender of the perpetrator (see Table 16). Significant main effects, however, were found for both type of violence and the gender of the perpetrator.

Upon further investigation, among those who received vignettes displaying situational couple violence, gender was not a significant predictor of treatment type, $\chi^2(2, N = 134) = 4.70$, $p = .095$, Cramer's V = .187. However, among those who received vignettes displaying intimate terrorism, gender was a significant predictor of treatment type, $\chi^2(2, N = 131) = 7.83$, $p = .02$, Cramer's V = .24, with separate treatment being chosen more often with male perpetrators of violence and couples treatment chosen more often with female perpetration of violence.

Accuracy of Identification of IPV Type

Accuracy of identifying IPV type was examined for each of the six randomly assigned vignettes (see Table 17). Those who received vignettes portraying mutual perpetration of situational couple violence (Vignette 1) were more likely to accurately identify violence type than those who received vignettes portraying mutual violent control (Vignette 4), $\chi^2(1, N = 90) = 5.34$, $p = .021$, Cramer's $V = .244$. Those who received vignettes portraying female perpetrated situational couple violence (Vignette 3) were more likely to accurately identify violence type than those who received vignettes portraying female perpetrated intimate terrorism (Vignette 6), $\chi^2(1, N = 79) = 18.18$, $p < .001$, Cramer's $V = .480$. The comparison of male perpetrated situational couple violence (Vignette 2) and male perpetrated intimate terrorism (Vignette 5) did not significantly differ, $\chi^2(1, N = 94) = 0.42$, $p = .519$, Cramer's $V = .066$.

Two additional chi-square tests were conducted to compare the accuracy of identification of IPV type for situational couple violence (i.e., 2 and 3) and intimate terrorism (i.e., 5 and 6) perpetrated by males and females. Those who received vignettes portraying female perpetrated situational couple violence (Vignette 3) were more likely to accurately identify violence type than those who received vignettes portraying male perpetrated situational couple violence (Vignette 2), $\chi^2(1, N = 92) = 3.86$, $p = .049$, Cramer's $V = .205$. However, those who received

vignettes portraying female perpetrated intimate terrorism (Vignette 6) were less likely to accurately identify violence type than those who received vignettes portraying male perpetrated intimate terrorism (Vignette 5), $\chi^2(1, N = 81) = 4.14$, $p = .042$, Cramer's $V = .226$.

No significant differences were found when comparing groups who received vignettes portraying mutually perpetrated situational couple violence (Vignette 1) with those who received vignettes portraying male perpetrated situational couple violence (Vignette 2), $\chi^2(1, N = 92) = 0.73$, $p = .393$, Cramer's $V = .089$, or female perpetrated situational couple violence (Vignette 3), $\chi^2(1, N = 88) = 1.21$, $p = .271$, Cramer's $V = .117$. In addition, no significant differences were found when comparing groups who received vignettes portraying mutual violent control (Vignette 4) with those who received vignettes portraying male perpetrated intimate terrorism (Vignette 5), $\chi^2(1, N = 92) = 0.75$, $p = .388$, Cramer's $V = .090$, or female perpetrated intimate terrorism (Vignette 6), $\chi^2(1, N = 81) = 1.60$, $p = .206$, Cramer's $V = .140$.

State Standards

A chi-square test was used to determine whether there was a difference between the endorsed treatment modality of participants from states with standards prohibiting couples treatment during the course of the primary domestic violence intervention and states without such laws. Using the presence or absence of state law as a dichotomous predictor variable, and the endorsed treatment modality as the dichotomous criterion variable, no significant difference was detected between groups among the subset of participants who received vignettes portraying situational couple violence (Vignettes 1-3), $\chi^2(1, N = 134) = 0.143$, $p = .705$, Cramer's $V = .033$ or among the subset of participants who received vignettes portraying intimate terrorism (Vignettes 4-6), $\chi^2(1, N = 131) = 1.25$, $p = .236$, Cramer's $V = .098$ (Cohen, 1988). Endorsement of couples treatment frequencies by vignette and domestic violence intervention state standards are shown in Table 18.

Importance of Predictor Variables

Logistic regression was used to examine the predictor variables in a multivariate context in order to identify the most important predictors of endorsed treatment modality. This analysis was conducted for participants who received vignettes in which violence was perpetrated by one partner (Vignettes 2, 3, 5, and 6). Cases of mutual aggression were not included to allow for the inclusion of the gender of the perpetrator of abuse as a predictor variable. The factors that significantly influenced treatment choice were violence type and the gender of the perpetrator,

with violence type being the strongest predictor. The accurate identification of IPV type, IPV experienced in one's own relationships, and levels of differentiation did not contribute significantly to the model (see Table 19).

CHAPTER FIVE
DISCUSSION

Using a sample of members of AAMFT, I examined factors potentially associated with a MFT's decision to work with clients individually or as a couple when they present with IPV. Investigated factors included: (1) the type of IPV experienced by the clients, (2) the therapist's accuracy in identifying the type of violence experienced by clients, and (3) the therapist's experience with IPV in their own romantic relationships, as moderated by levels of differentiation. Overall, there was some evidence in support of the proposed hypotheses.

In support of the first hypothesis, participants were more likely to endorse couples treatment as the preferred treatment modality when given a vignette portraying situational couple violence than when given a vignette portraying intimate terrorism. Blasko, Winek, and Bieschke (2007) speak of the unique position that MFTs are in of having to differentiate between situational couple violence and intimate terrorism. They explain that the necessity of this distinction is directly related to the need to tailor effective interventions to victims, perpetrators, or both. Likewise, many have suggested that conjoint treatment is more effective for situationally violent couples, but that it is not appropriate for cases of intimate terrorism in which more severe forms of violence and patterns of coercive control are of concern (e.g., Stith et al., 2012). The findings of the current study suggest that MFTs are likely to make treatment decisions that are aligned with the suggestions made by these IPV researchers.

The second hypothesis was also supported in that participants who accurately identified the type of violence portrayed in the vignette were more likely to endorse couples treatment as the preferred treatment modality for clients who experienced situational couple violence. As predicted, this finding was not significant for participants who received vignettes portraying intimate terrorism.

Upon further investigation of the accuracy of identification of IPV types, those who received the vignette portraying mutual perpetration of situational couple violence were more likely to accurately identify the type of violence than those who received the vignette portraying mutual violent control. Those who received the vignette portraying female perpetrated situational couple violence were more likely to accurately identify the type of violence than those who received the vignette portraying female perpetrated intimate terrorism. The comparison of groups who received vignettes portraying male perpetration of situational couple violence and those who

received vignettes portraying male perpetrated intimate terrorism, however, was not significant.

It appears that MFTs were more accurate at identifying situational couple violence than intimate terrorism, except when the violence was solely male perpetrated. This may be due to the fact that situational couple violence is more likely to be seen than intimate terrorism in general populations that would present in therapy on their own free will. Interestingly, those who received vignettes portraying female perpetrated situational couple violence were more likely to accurately identify the type of violence than those who received vignettes portraying male perpetrated situational couple violence. Historically, men have been more readily identified as the perpetrators of abuse (Stith et al., 2012). This finding, however, suggests that MFTs may have made a shift in their understanding of IPV to more readily identify female perpetrators of situational couple violence. However, it appears as though male perpetrated violence may be seen as having more harmful outcomes; possibly explaining why male perpetrated situational couple violence is less accurately identified.

Alternatively, those who received vignettes portraying female perpetrated intimate terrorism were less likely to accurately identify the type of violence than those who received vignettes portraying male perpetrated intimate terrorism. Participants who received vignettes portraying female perpetrated intimate terrorism were, in fact, the least likely to correctly identify violence type. This may be because the term "patriarchal terrorism" was also included next to the term "intimate terrorism" in the IPV type options provided in the questionnaire. This term was included in case participants were familiar with the original terminology proposed by Johnson. Its language (i.e., patriarchal), however, is indicative of male perpetrated violence, which is part of Johnson's reasoning for changing the terminology. Regardless, the word "patriarchal" may have confused participants by making them think that it was referring to only male perpetrated abuse. Those participants who may have been confused by this language, however, were likely basing their response on Johnson's old terminology, and were likely unaware of the most up to date terminology and research on these types (e.g., that intimate terrorism can be female perpetrated, even if it is unlikely). Alternatively, the lower likelihood of correctly identifying female perpetrated intimate terrorism may have been due to the fact that intimate terrorism is not often perpetrated by women and is therefore unlikely to be seen in a clinical setting (Johnson, 2006). It is also possible that participants are less likely to think that female perpetrated violence is as harmful as male perpetrated violence; possibly explaining why

female perpetrated intimate terrorism is less accurately identified. This is concerning because women are capable of perpetrating intimate terrorism, and it is important that practitioners be cognizant of this possibility and take necessary precautions when it does occur. Although treatment choice does appear to be related to the accurate identification of IPV type, it does not, however, appear to be influenced by personal experience with IPV.

The third hypothesis was that participants who have experienced less IPV in their own romantic relationships would be more likely to endorse couples treatment as the preferred treatment modality for clients who have experienced IPV. However, this hypothesis was not supported by the data for participants who received vignettes portraying situational couple violence or for participants who received vignettes portraying intimate terrorism. This finding suggests that MFTs are not likely to let their own personal experiences with IPV influence their treatment choice for clients who have experienced IPV. Ideally, MFTs make decisions based on the best evidence based treatment available, and do not base treatment options on their own personal bias. The current findings suggest that MFTs are likely following these guidelines.

Additionally, it was hypothesized that levels of differentiation would moderate the relationship between IPV experienced in participants' own romantic relationship and their endorsement of couples treatment for clients who have experienced IPV. The data, however, did not support this hypothesis for participants who received vignettes portraying situational couple violence or for participants who received vignettes portraying intimate terrorism. Participants from the current study had an average total DSI-SF score of 4.48 (SD = 0.63). Skowron and Friedlander (1998) obtained a total DSI score of 3.74 (SD = 0.60) for a sample of adults. Similarly, Skowron and Schmitt (2003) obtained a total DSI-R score of 3.86 (SD = 0.72). More recently, Drake (2011) obtained a total DSI-SF score of 4.15 (SD = 0.77) with a sample of college students. It appears as though the participants in the current study have higher levels of differentiation than that found in other studies. It is possible that the current study did not capture a wide enough range of differentiation in participants to be able to accurately assess differentiation as a moderating factor. Bowen (1978), however, proposed that high levels of differentiation among therapists are necessary in order to maintain both intimacy and emotional objectivity as an observer of a family system that is in emotional turmoil. Therefore, the high levels of differentiation found in the current study are actually ideal for the MFT community.

Additional Findings

In addition to the hypotheses explicitly tested, several important supplementary findings emerged.

Mediation

Perceived severity of harm mediated the relationship between violence type and treatment choice. Similarly, perceptions of the severity of control mediated the relationship violence type and treatment choice. The presence of these significant mediation effects suggest that the relationship between violence type and treatment choice is partly explained through the perception of the severity of control and partly explained through the perception of the severity of harm presented in the vignettes. The correlation between severity of harm and control suggests that both are likely to occur together. However, harm and control are two separate constructs that may occur independently of one another. Situational couple violence, for example, is not characterized by control. It is, however, harmful. Alternatively, intimate terrorism is characterized by both harm and control. These findings are consistent with Johnson's theoretical perspective on aggressor types and the aims of the creation of the vignettes.

Endorsement of Couples Treatment

Overall, 61.5% of participants endorsed couples treatment as the preferred treatment modality (see Table 12). Upon further investigation, 76.12% of participants who were presented with a vignette depicting situational couple violence endorsed couples treatment. Given the nature of the type of violence depicted in these vignettes, couples treatment would be an appropriate choice. Unexpectedly, 51.15% of participants who were presented with a vignette depicting intimate terrorism also endorsed couples treatment. This finding was surprising because couples experiencing IPV that is characterized by more severe forms of violence and issues of power and control are more appropriately placed in individual treatment. Stith and colleagues' (2014) model of conjoint treatment, for example, excludes participants who are experiencing severe violence during the initial screening process. Unfortunately, prior research has indicated that many clinicians do not consider the potential safety implications of conducting couples therapy when IPV has occurred (Schacht et al., 2009). Therefore, it is possible that the MFTs in this sample did not carefully consider the safety implications of conducting conjoint treatment with the clients presented in the vignettes.

It is also possible that participants did not think that the violence presented in the vignette

was severe enough to exclude the clients from participation in conjoint treatment. However, analyses in the current study did indicate a significant difference in the perceptions of severity of harm and control between vignettes depicting situational couple violence and vignettes depicting intimate terrorism. In addition, perceptions of severity of harm and control did mediate the relationship between IPV type and the endorsement of couples treatment. However, these differences may not have been large enough to elicit a response that would be more supportive of separate treatment.

When investigating differences between mutual, male, and female perpetration of intimate terrorism, the endorsement of couples treatment drastically differed. Among participants who received vignettes depicting male perpetration of intimate terrorism, only 34.7% endorsed couples treatment. Among participants who received vignettes depicting female perpetration of intimate terrorism, 55.3% endorsed couples treatment. The endorsement of couples treatment increased to 61.7% for participants who received vignettes depicting mutual violent control. Ultimately, participants were much more likely to endorse couples treatment for instances of mutual violence control and female perpetrated intimate terrorism than male perpetrated intimate terrorism.

The difference in the endorsement of couples treatment for male versus female perpetrated intimate terrorism may be related to the common misconception that only men can be the perpetrators of abuse in relationships, or that when abuse does occur, it is not as harmful when it is perpetrated by women. It is both perplexing and concerning, however, that mutual violent control was the form of intimate terrorism that received the highest endorsement of couples treatment, because it included both male and female perpetrated intimate terrorism, arguably the most severe IPV type. In this instance, it is possible that participants acknowledged the fact that both partners in the relationship needed treatment and selected couples treatment as the preferred treatment modality as a way of ensuring that both received care for the perpetration of IPV. Alternatively, it is possible that because participants were forced to select a treatment option, had it been provided, they may have preferred an alternative option that allowed individual treatment prior to any sort of couples treatment. Even models of conjoint treatment (e.g., Stith et al., 2014) often include a component of gender-specific treatment prior to participation in conjoint treatment. It is possible that participants familiar with these models anticipated that couples treatment would first include a component of individual therapy.

Importance of Predictor Variables

When participants who received vignettes portraying violence perpetrated by only one partner were analyzed (allowing for the inclusion of the gender of the perpetrator in the analysis), the factors that significantly predicted treatment choice were violence type and the gender of the perpetrator, with violence type being the strongest predictor. This finding suggests, that even though violence type is the strongest predictor of treatment choice, the gender of the perpetrator of abuse also plays a significant role in treatment choice, with cases of female perpetrated violence more likely being selected for couples treatment than cases of male perpetrated violence. The significance of this main effect, however, was only present among those who received vignettes displaying intimate terrorism, and not among those who received vignettes portraying situational couple violence. Again, this finding may be related to the common misconception that only men can be the perpetrators of abuse in relationships, or that when abuse does occur, it is not as harmful when it is perpetrated by a woman. Although research does indicate that physical abuse perpetrated by men is likely to be more harmful than physical abuse perpetrated by women, IPV perpetrated by women is also harmful and should be taken seriously.

Limitations and Future Research

This study contains a number of limitations related to the sample, respondent error, and survey measures. These limitations will be described and, where relevant, potential remedies and implications for future research will be discussed.

Sample

The sample included current members of AAMFT who conduct couples therapy. Paper and pencil surveys were sent to a random probability sampling of 1,000 clinical members of AAMFT living in states without standards prohibiting couples treatment during the course of the primary domestic violence intervention. In addition, an online sample of AAMFT members was derived from sending an Internet questionnaire through list serves for AAMFT and NCFR and to students and faculty members in MFT graduate programs across the United States.

Although it was specifically requested in the recruitment script that participants only complete the survey once, it is possible that people may have completed the survey more than once. Qualtrics allows the option of providing a unique link for each participant that can only be completed once, however, the way in which the links were distributed to list serves and representatives within graduate training programs necessitated that the links be used for multiple

respondents. And although Qualtrics also allows the option of only allowing one survey to be submitted for each IP address, it was recognized that many participants may share computers, and therefore IP addresses, with other potential respondents. If only clinical members of AAMFT completed surveys via the Internet, it would be possible to compare responses between the paper and pencil surveys and the Internet surveys to investigate whether or not there were significant differences between surveys unlikely to be submitted multiple times by the same respondent (i.e., paper and pencil surveys) and surveys with an increased likelihood of this possibility (i.e., Internet surveys). However, due to the fact that a large portion of Internet respondents were composed of student members of AAMFT, differences derived from this comparison may be more likely due to fundamental differences between these two populations (e.g., age, education level, experience practicing as a therapist). Future research could mitigate the possibility of participants responding more than once by only sending paper and pencil surveys to participants rather than allowing Web-based responses.

It is also important to recognize that the sampling for the study only includes members of AAMFT and is not necessarily representative of other MFTs who are not members of AAMFT. Additionally, this sampling was of an American association, and is not necessarily representative of therapists practicing in other countries. Future research should seek to determine whether there is a difference between members and nonmembers of AAMFT in the identification of IPV types and endorsement of treatment type for IPV. Future research should also investigate these research questions among MFTs in countries other than the United States.

Respondent Error

Respondent error may have limited the current research by way of (1) underreporting of violence, (2) inaccurate responses on Likert-scale items, and (3) response distortion with regards to the referent period of the CTS.

Underreporting of violence is a common concern particularly for respondents who have perpetrated or been victimized by IPV. Among a population of practicing MFTs, participants may have been less likely to report IPV out of fear of the ramifications that it may hold for their professional career if this information were to become known among the MFT community or among clients.

In addition, in a series of similarly formatted Likert-scale items, such as those in the CTS, participants often read a few items on the scale and answer with the same response on all items

without actually reading them all. Alternatively, participants may not read questions at all and may arbitrarily select responses. In order to mitigate the potential effects of respondent error due to carelessness, three items were randomly placed throughout the survey to ensure that participants were actually reading the items. Two of these items were placed within the CTS and one was placed within the DSI. Only 14 respondents who met the other inclusion criteria for the study failed to answer all three of these items correctly, and these participants were excluded from data analyses.

Other researchers have raised concern about response distortion when utilizing the CTS (Straus, 1990). Of particular concern is the referent period of the measure. In this study, participants were asked to report the number of times that each behavior occurred over a nonspecified period of time with both current and previous partners. The reasoning behind this was to take into consideration the sum total of lifetime experiences with IPV experienced by therapists that may influence their work with clients who have also experienced IPV. However, by asking participants to report the frequency of events over a long period of time, the probability of inaccurate recall was likely increased. Future research could seek to investigate the ways in which study results may differ if participants are only asked to report incidents that have occurred over the past 12 months.

Measures

CTS. Despite the fact that the CTS is the best known and most commonly used measure of IPV (Straus, 2007), a number of concerns have been raised regarding its use. In addition to the aforementioned concerns regarding underreporting and response distortion, particular items would be more informative if they gathered more specific information with regards to contextual factors (e.g., whether or not the violence was perpetrated in self-defense). By assessing for additional information, future researchers may distinguish between different types of IPV experienced by respondents. It is possible that therapists who have experienced different types of IPV (e.g., intimate terrorism, violent resistance, situational couple violence) may differ in levels of differentiation and in their preferred treatment type for clients who have experienced IPV. Future research should seek to identify any potential differences by employing the use of a scale that could identify different IPV types by identifying the context of the violence.

Despite these limitations, the CTS is undoubtedly the most well known and most frequently used measure of IPV (Straus, 2007). It has adequate reliability and captures an array

of conflict tactics. As such, the CTS was the most appropriate measure of IPV for the current study.

Vignettes. The vignettes were purposely designed to be vague in order to assess any participant bias regarding IPV; however, participants may have been frustrated with the requested forced response for separate treatment or couples treatment based on limited information. MFTs are ideally trained to gather more information prior to making treatment choices in order to provide the best treatment possible (Schacht et al., 2009). Some participants did not answer particular questions regarding the vignettes, especially those who received pencil and paper surveys. Despite the fact that the treatment choice question acknowledged that it would be difficult to make a treatment decision with the limited amount of information presented in the vignette, many respondents wrote notes indicating that they were unable to answer these questions due to a lack of available information.

Measures not included in study. It is important to acknowledge that many factors must be taken into consideration when making decisions regarding the treatment of IPV (Schacht et al., 2009), and many of these factors were beyond the scope of this study. For example, it is important to acknowledge that the question assessing the certainty of participants' treatment decision does not assess the reason for their uncertainty. Some participants may have been uncertain because of the lack of information provided in the vignette, while others may have been uncertain due to a lack of knowledge of common IPV treatment protocols. Future research could ask participants *why* they are uncertain of their decision.

There are a number of other factors that may influence therapists' IPV treatment decisions that were not measured in this study. These factors include other experiences with violence, such as child abuse, or experiences witnessing interparental violence. Future research should investigate the potential influence of these factors.

Implications

The current study indicates that MFTs are likely to make IPV treatment choices primarily based on the type of violence experienced by the couple. It appears that IPV treatment choice is not influenced by personal experience with IPV, but rather by the therapist's accurate identification of IPV type and the gender of the perpetrator of abuse. This study suggests that perceptions of IPV have the ability to impact appropriate treatment choices made by MFTs when working with clients who have experienced IPV. However, the high level of endorsement of

couples treatment for instances of intimate terrorism is concerning. These findings highlight the need for continued education on IPV, IPV types, gender biases with regards to IPV, and the importance of taking safety into consideration when making treatment decisions.

It is imperative that MFTs continuously educate themselves on IPV and the most current and effective treatments for IPV in order to provide the best treatment possible for clients. The current findings suggest that while MFTs are likely to recognize women as perpetrators of abuse, more serious instances of female perpetrated intimate terrorism may continue to be unrecognized. MFTs need to continue to be educated on IPV and the possibility that all types of IPV may be male or female perpetrated. It is possible that in instances of more severe types of abuse, people are unwilling to see men as victims. Alternatively, women may not be considered capable of perpetrating more severe types of abuse, even when performing the same acts. Despite the fact that male perpetrated violence is most often more harmful than female perpetrated violence, female perpetrated violence must be taken seriously within the MFT community and we must make greater efforts to educate MFTs about this problem. In addition, in an effort to encourage the best treatment of IPV possible, we must continue to educate MFTs about the accurate identification of IPV types, the most effective evidence based treatments for each type of IPV, and the gravity of taking client safety into consideration when making IPV treatment choices.

In particular, the high endorsement of couples treatment for female perpetrated intimate terrorism and mutual violent control is especially of concern because it is likely to put both the clients and the therapist at risk of harm. Safety must be the primary consideration for any type of IPV intervention (Stith et al., 2012). Clients who have experienced intimate terrorism would likely benefit more from individual treatment on issues regarding power and control prior to any sort of couples treatment. MFT training programs play an important role in the process of IPV education and training. Not only is it important to educate new therapists on the most up to date information regarding IPV (e.g., Johnson's aggressor types and the likelihood and seriousness of female perpetration of IPV) and its treatment (e.g., the efficacy of different treatment options and the importance of considering client safety in making treatment choices), but it is also important to encourage clinicians to continue keeping up to date on this research once they have finished their formal schooling.

This study also holds important implications for future research. Future research could

investigate differences in the support of couples treatment with multiple vignettes that are designed to depict a spectrum of severity of harm and control. It would be interesting to see at what point on the scale of severity of harm and control participants would be most likely to endorse individual treatment for IPV. In addition, it would be interesting to investigate the impact that biological differences, or differences in size, might have on the endorsement of couples treatment for different IPV types. Future research could include photos of both male and female perpetrators of differing size to determine whether size mediates the relationship between the gender of the perpetrator of abuse and treatment choice. Future research might also conduct a similar study in which additional treatment options are included (e.g., individual treatment followed by couples treatment) to determine whether this would alter the likelihood of the endorsement of couples treatment, especially for instances of intimate terrorism.

Conclusion

This study sought to investigate factors associated with a MFT's decision to work with clients individually or as a couple when they present with IPV. Investigated factors included: (1) the type of IPV experienced by the clients, (2) the therapist's accuracy in identifying the type of violence experienced by clients, and (3) the therapist's experience with IPV in their own romantic relationships, as moderated by levels of differentiation.

Although findings did not provide support for the hypotheses regarding differentiation and MFTs' own personal experience with IPV, participants were more likely to endorse couples treatment as the preferred treatment modality when given a vignette portraying situational couple violence than when given a vignette portraying intimate terrorism. In addition, it was found that participants who were accurately able to identify the type of violence portrayed in the vignette were more likely to endorse couples treatment as the preferred treatment modality for clients who experienced situational couple violence. As predicted, this finding was not significant for participants who received vignettes portraying intimate terrorism.

These findings suggest that MFTs make treatment decisions based on the type of violence that clients are experiencing. Additional analyses, however, indicate that accurate identification and appropriate treatment choice may be more difficult in situations in which intimate terrorism is taking place, especially when women are the perpetrators of this abuse.

This study holds practical value and has important implications for all therapists working with couples who have experienced IPV and for the field of MFT. In particular, it speaks to the

need for continued education within the MFT field on IPV types, the possibility and serious nature of both male and female perpetrated violence, and the efficacy of conjoint treatment for clients who have experienced less severe forms of violence.

APPENDIX A
IRB APPROVAL LETTER

The Florida State University
Office of the Vice President For Research
Human Subjects Committee
Tallahassee, Florida 32306-2742
(850) 644-8673 · FAX (850) 644-4392

APPROVAL MEMORANDUM

Date: 11/25/2013

To: Rebecca Cobb

Address: _____
Dept.: FAMILY & CHILD SCIENCE

From: Thomas L. Jacobson, Chair

Re: Use of Human Subjects in Research
Marriage and Family Therapists' Treatment of Intimate Partner Violence

The application that you submitted to this office in regard to the use of human subjects in the research proposal referenced above has been reviewed by the Human Subjects Committee at its meeting on 11/13/2013. Your project was approved by the Committee.

The Human Subjects Committee has not evaluated your proposal for scientific merit, except to weigh the risk to the human participants and the aspects of the proposal related to potential risk and benefit. This approval does not replace any departmental or other approvals, which may be required.

If you submitted a proposed consent form with your application, the approved stamped consent form is attached to this approval notice. Only the stamped version of the consent form may be used in recruiting research subjects.

If the project has not been completed by 11/12/2014 you must request a renewal of approval for continuation of the project. As a courtesy, a renewal notice will be sent to you prior to your expiration date; however, it is your responsibility as the Principal Investigator to timely request renewal of your approval from the Committee.

You are advised that any change in protocol for this project must be reviewed and approved by the Committee prior to implementation of the proposed change in the protocol. A protocol change/amendment form is required to be submitted for approval by the Committee. In addition, federal regulations require that the Principal Investigator promptly report, in writing any unanticipated problems or adverse events involving risks to research subjects or others.

By copy of this memorandum, the Chair of your department and/or your major professor is reminded that he/she is responsible for being informed concerning research projects involving human subjects in the department, and should review protocols as often as needed to insure that the project is being conducted in compliance with our institution and with DHHS regulations.

This institution has an Assurance on file with the Office for Human Research Protection. The Assurance Number is FWA00000168/IRB number IRB00000446.

Cc: Frank Fincham, Advisor
HSC No. 2013.11533

APPENDIX B

RECRUITMENT SCRIPT

You are being asked to participate in a research study designed by Rebecca Cobb of Florida State University; your participation is voluntary. If you choose to participate, you will be asked to complete a questionnaire about a hypothetical counseling scenario, in addition to questions about your own personal relationships. After you complete the questionnaire you will be provided with a web site address that will disclose information about the study. Information at this web site will provide you with a statement of feedback summarizing the study's method, rationale, hypotheses, and results. This information will be made available after the completion of the study. You will also be given contact information to obtain further details of the study. In order to participate in this study you must: 1) be a member of the American Association for Marriage and Family Therapy (AAMFT), 2) be a licensed Marriage and Family Therapist or currently be working under the supervision of an AAMFT approved supervisor, and 3) conduct couples therapy. Please do not complete this questionnaire more than once.

It should take less than 20 minutes to complete the study questions. All responses will remain anonymous, so do not put your name on the questionnaire. If you choose to participate you may choose not to answer particular questions. If you agree to participate, you can withdraw your participation at any time without penalty.

APPENDIX C

CONSENT FORM

Study of Marriage and Family Therapists and Family Relationships

Rebecca A. Cobb, M.S.

Purpose of Research: You are asked to participate in a study designed by Rebecca Cobb of Florida State University so that we may develop a better understanding of Marriage and Family Therapists and their own personal relationships.

Specific Procedures: If you choose to participate in this study, you will be asked to answer a number of questions on a questionnaire. Some of the questions may make you feel uncomfortable.

Duration of Participation: It should take less than 20 minutes for you to complete this entire survey.

Risks: You may be made uncomfortable about the sensitive nature of the questions. However, you should experience no more risk than that which is found in everyday life.

Benefits: You will not receive any direct benefits from participation in this study. You will have a chance to take part in a survey and contribute to the scientific understanding of the factors that are associated with Marriage and Family Therapists and their own personal relationships.

Compensation: You will not receive compensation for taking part in this research.

Confidentiality: There is no personally identifying information on this questionnaire. All responses will remain anonymous, and will be used only in combination with the responses of other participants in this and related studies. The name recorded on this form will not be linked to your questionnaire or any study results. You may choose not to answer particular questions, or to withdraw your participation at any time. The data will be kept for a period of five years after publication of any articles related to this study, and accessed only by members of the research team. The project's research records may be reviewed by departments at Florida State University responsible for regulatory and research oversight.

Voluntary Nature of Participation: You do not have to participate in this research project. If you agree to participate you can withdraw your participation at any time without penalty.

Contact Information: If you have any questions about this research project, you can contact Rebecca A. Cobb, M.S. at _____ or Dr. Frank Fincham at _____. If you have concerns about the treatment of research participants, you can contact the Institutional

Review Board at Florida State University at _____.

Documentation of Informed Consent: I have had the opportunity to read this consent form and have the research study explained. I have had the opportunity to ask questions about the research project and my questions have been answered. I am prepared to participate in the research project described above.

_____	_____	_____
Participant's Name	Participant's Signature	Date
	_____	_____
	Researcher's Signature	Date

APPENDIX D

QUESTIONNAIRE

Thank you for taking the time to participate in this study. All of your responses will be kept strictly confidential. Please answer all questions as honestly as you can; there are no right or wrong answers.

1. What is your gender? ☐ Male ☐ Female ☐ Transgender

2. How old are you? _____ Years

3. What is your ethnicity? (Check one)
   ☐ African-American ☐ Caucasian (White) ☐ Native American
   ☐ Asian-American ☐ Hispanic ☐ Multiracial
   ☐ Other (please specify: _____)

4. What is the highest level of education you have completed? (Check one)
   ☐ Bachelor's Degree ☐ Master's Degree ☐ Ph.D. ☐ PsyD

5. Are you currently a licensed Marriage and Family Therapist?
   ☐ Yes ☐ No

   If 'yes', in which state(s) are you currently licensed?

   _____

   How many years have you been licensed? _____ Years

6. If you are not licensed as a Marriage and Family Therapist, are you currently working under the supervision of an AAMFT approved supervisor?
   ☐ Yes ☐ No

7. Are you currently a member of the American Association for Marriage and Family Therapy (AAMFT)?
   ☐ Yes ☐ No

   If 'yes', what is your current membership status?
   ☐ Student Member ☐ Associate Member ☐ Pre-Clinical Fellow
   ☐ Affiliate Member ☐ Member ☐ Clinical Fellow

8. How many years of experience do you have practicing as a therapist? _____ Years

9. In which state(s) are you currently conducting therapy? _____

10. In which of the following settings do you currently conduct therapy? (select all that apply)
    ☐ Private practice ☐ School or university
    ☐ Public mental health clinic ☐ Medical hospital or clinic
    ☐ Private mental health clinic ☐ Other (please specify: _____)

11. Approximately how many couples have you worked with in the past year? _____

No matter how well a couple gets along, there are times when they disagree, get annoyed with the other person, want different things from each other, or just have spats or fights because they are in a bad mood, are tired, or for some other reason. Couples also have many different ways of trying to settle their differences. This is a list of things that might happen when you have differences. Please mark how many times you remember doing each of these things to a partner, and how many times you remember a partner (your current and previous partners) doing them to you.

How often did this happen?

1 = Once 2 = Twice 3 = 3-5 4 = 6-10 5 = 11-20 6 = More than 20 times

0 = This has never happened

1. I insulted or swore at my partner.	**1**	**2**	**3**	**4**	**5**	**6**	**0**
2. My partner did this to me.	**1**	**2**	**3**	**4**	**5**	**6**	**0**
3. I threw something at my partner that could hurt.	1	2	3	4	5	6	0
4. My partner did this to me.	1	2	3	4	5	6	0
5. I called my partner fat or ugly.	**1**	**2**	**3**	**4**	**5**	**6**	**0**
6. My partner called me fat or ugly.	**1**	**2**	**3**	**4**	**5**	**6**	**0**
7. I destroyed something that belonged to my partner.	1	2	3	4	5	6	0
8. My partner did this to me.	1	2	3	4	5	6	0
9. I twisted my partner's arm or hair.	**1**	**2**	**3**	**4**	**5**	**6**	**0**
10. My partner did this to me.	**1**	**2**	**3**	**4**	**5**	**6**	**0**
11. I shouted or yelled at my partner.	1	2	3	4	5	6	0
12. My partner did this to me.	1	2	3	4	5	6	0
13. I pushed or shoved my partner.	**1**	**2**	**3**	**4**	**5**	**6**	**0**
14. My partner did this to me.	**1**	**2**	**3**	**4**	**5**	**6**	**0**
15. I stomped out of the room or house or yard during a disagreement.	1	2	3	4	5	6	0
16. My partner did this to me.	1	2	3	4	5	6	0
17. I accused my partner of being a lousy lover.	**1**	**2**	**3**	**4**	**5**	**6**	**0**
18. My partner accused me of this.	**1**	**2**	**3**	**4**	**5**	**6**	**0**
19. I said something to spite my partner.	1	2	3	4	5	6	0
20. My partner did this to me.	1	2	3	4	5	6	0
21. I grabbed my partner.	**1**	**2**	**3**	**4**	**5**	**6**	**0**
22. My partner did this to me.	**1**	**2**	**3**	**4**	**5**	**6**	**0**

How often did this happen?

1 = Once 2 = Twice 3 = 3-5 4 = 6-10 5 = 11-20 6 = More than 20 times

0 = This has never happened

23. I threatened to hit or throw something at my partner.	1	2	3	4	5	6	0
24. My partner did this to me.	1	2	3	4	5	6	0
25. I slapped my partner.	**1**	**2**	**3**	**4**	**5**	**6**	**0**
26. **My partner did this to me.**	**1**	**2**	**3**	**4**	**5**	**6**	**0**
27. Please select the number three.	1	2	3	4	5	6	0
28. Please select the number six.	1	2	3	4	5	6	0
29. I used a knife or gun on my partner.	**1**	**2**	**3**	**4**	**5**	**6**	**0**
30. My partner did this to me.	**1**	**2**	**3**	**4**	**5**	**6**	**0**
31. I punched or hit my partner with something that could hurt.	1	2	3	4	5	6	0
32. My partner did this to me.	1	2	3	4	5	6	0
33. I slammed my partner against a wall.	**1**	**2**	**3**	**4**	**5**	**6**	**0**
34. My partner did this to me.	**1**	**2**	**3**	**4**	**5**	**6**	**0**
35. I beat up my partner.	1	2	3	4	5	6	0
36. My partner did this to me.	1	2	3	4	5	6	0
37. I burned or scalded my partner on purpose.	**1**	**2**	**3**	**4**	**5**	**6**	**0**
38. My partner did this to me.	**1**	**2**	**3**	**4**	**5**	**6**	**0**
39. I kicked my partner.	1	2	3	4	5	6	0
40. My partner did this to me.	1	2	3	4	5	6	0
41. I choked my partner.	**1**	**2**	**3**	**4**	**5**	**6**	**0**
42. My partner did this to me.	**1**	**2**	**3**	**4**	**5**	**6**	**0**

Answer the following questions based on the vignette. Indicate how strongly you agree or disagree with each statement by choosing the appropriate <u>number</u> on the accompanying scale.

Insert randomly selected vignette here (see Appendix F).

1. Read the following two treatment options and select which seems the most appropriate for this couple. While it will be difficult to make a treatment decision with the limited amount of information presented here, do your best to select which option you believe would be most appropriate in this situation.
   ☐ Separate treatment ☐ Couples treatment

2. How certain are you about your decision for question #1?
   Not certain at all 0 1 2 3 4 5 6 **Completely certain**

3. This example illustrates domestic violence / intimate partner violence.
   Strongly disagree 0 1 2 3 4 5 6 **Strongly agree**

4. How severe is the harm in this situation?
   Not at all harmful 0 1 2 3 4 5 6 **Extremely harmful**

5. Based on what you know about Michael and Jessica, how controlling do you think Michael is in this situation?
   Not at all controlling 0 1 2 3 4 5 6 **Extremely controlling**

6. Based on what you know about Michael and Jessica, how controlling do you think Jessica is in this situation?
   Not at all controlling 0 1 2 3 4 5 6 **Extremely controlling**

7. Which of the following types of violence is this example most likely illustrating? (select all that apply)
   ☐ Intimate terrorism / patriarchal terrorism
   ☐ Violent resistance
   ☐ Mutual violent control
   ☐ Situational couple violence / common couple violence
   ☐ I cannot answer this question because I'm uncertain of the definitions of these terms.

8. Intimate partner violence is frequently bidirectional. ☐ True ☐ False

9. Gender-specific treatment is the most effective intervention for male perpetrators of intimate partner violence. ☐ True ☐ False

10. Couples therapy is always contraindicated. ☐ True ☐ False

11. Intimate partner violence cannot be treated. ☐ True ☐ False

12. Which of the following are effective in couples therapy? (select all that apply)

☐ A no violence contract
☐ Anger management strategies
☐ Communication skills training
☐ Acceptance of responsibility for violence
☐ Encouragement of expression of anger

These are questions concerning your thoughts and feelings about yourself and relationships with others. Please read each statement carefully and decide how much the statement is generally true of you on a 1 (not at all) to 6 (very) scale. If you believe that an item does not pertain to you (e.g., you are not currently married or in a committed relationship, or one or both of your parents are deceased), please answer the item according to your best guess about what your thoughts and feelings would be in that situation. Be sure to answer every item and try to be as honest and accurate as possible in your responses.

	Not at all true of me					**Very true of me**
1. I tend to remain pretty calm even under stress.	**1**	**2**	**3**	**4**	**5**	**6**
2. I usually need a lot of encouragement from others when starting a big job or task.	1	2	3	4	5	6
3. No matter what happens in my life, I know that I'll never lose my sense of who I am.	**1**	**2**	**3**	**4**	**5**	**6**
4. I tend to distance myself when people get too close to me.	1	2	3	4	5	6
5. When my spouse/partner criticizes me, it bothers me for days.	**1**	**2**	**3**	**4**	**5**	**6**
6. At times my feelings get the best of me and I have trouble thinking clearly.	1	2	3	4	5	6
7. I'm often uncomfortable when people get too close to me.	**1**	**2**	**3**	**4**	**5**	**6**
8. I feel a need for approval from virtually everyone in my life.	1	2	3	4	5	6
9. At times I feel as if I'm riding an emotional roller-coaster.	**1**	**2**	**3**	**4**	**5**	**6**
10. Please select the number two.	1	2	3	4	5	6
11. There's no point in getting upset about things I cannot change.	**1**	**2**	**3**	**4**	**5**	**6**
12. I'm overly sensitive to criticism.	1	2	3	4	5	6
13. I'm fairly self-accepting.	**1**	**2**	**3**	**4**	**5**	**6**
14. I often agree with others just to appease them.	1	2	3	4	5	6
15. If I have had an argument with my spouse/partner, I tend to think about it all day.	**1**	**2**	**3**	**4**	**5**	**6**
16. When one of my relationships becomes very intense, I feel the urge to run away from it.	1	2	3	4	5	6
17. If someone is upset with me, I can't seem to let it go easily.	**1**	**2**	**3**	**4**	**5**	**6**
18. I often feel unsure when others are not around to help me make a decision.	1	2	3	4	5	6
19. I'm very sensitive to being hurt by others.	**1**	**2**	**3**	**4**	**5**	**6**
20. My self-esteem really depends on how others think of me.	1	2	3	4	5	6
21. I tend to feel pretty stable under stress.	**1**	**2**	**3**	**4**	**5**	**6**

APPENDIX E

STATEMENT OF FEEDBACK

Thank you for participating in this study! If you would like more information about this study you may contact Rebecca Cobb at _____. Information about the study's method, rationale, hypotheses, and results will be made available after the completion of the study at https://fsu.qualtrics.com/WRReport/?RPID=RP2_0OfcbEQErf2Fih7& P=CP.

APPENDIX F

VIGNETTES

1. Imagine that you are a counselor working in private practice. Michael and Jessica are in a committed romantic relationship and come to see you for counseling of their own free will. According to both, they recently had an argument, during which both Michael and Jessica became extremely frustrated with one another. The argument ended with both Michael and Jessica shoving one another, each throwing a paperback book at the other person, and each storming out of the house.
2. Imagine that you are a counselor working in private practice. Michael and Jessica are in a committed romantic relationship and come to see you for counseling of their own free will. According to both, they recently had an argument, during which both Michael and Jessica became extremely frustrated with one another. The argument ended with Michael shoving Jessica, throwing a paperback book at her, and storming out of the house.
3. Imagine that you are a counselor working in private practice. Michael and Jessica are in a committed romantic relationship and come to see you for counseling of their own free will. According to both, they recently had an argument, during which both Michael and Jessica became extremely frustrated with one another. The argument ended with Jessica shoving Michael, throwing a paperback book at him, and storming out of the house.
4. Imagine that you are a counselor working in private practice. Michael and Jessica are in a committed romantic relationship and come to see you for counseling of their own free will. According to both, both Michael and Jessica recently punched each other, leaving bruises, and threatened to take the other person's cell phone away if they talked with people they didn't want them talking to.
5. Imagine that you are a counselor working in private practice. Michael and Jessica are in a committed romantic relationship and come to see you for counseling of their own free will. According to both, Michael recently punched Jessica, leaving a bruise, and threatened that he would take Jessica's cell phone away if she talked with people he didn't want her talking to.
6. Imagine that you are a counselor working in private practice. Michael and Jessica are in a committed romantic relationship and come to see you for counseling of their own free will. According to both, Jessica recently punched Michael, leaving a bruise, and threatened that

she would take Michael's cell phone away if he talked with people she didn't want him talking to.

APPENDIX G

PILOTED VIGNETTES

1. Michael and Jessica are in a committed romantic relationship. According to both, they recently had an argument, during which both Michael and Jessica became extremely frustrated with one another. The argument ended with both Michael and Jessica shoving one another, each throwing a paperback book at the other person, and each storming out of the house.
2. Michael and Jessica are in a committed romantic relationship. According to both, they recently had an argument, during which both Michael and Jessica became extremely frustrated with one another. The argument ended with Michael shoving Jessica, throwing a paperback book at her, and storming out of the house.
3. Michael and Jessica are in a committed romantic relationship. According to both, they recently had an argument, during which both Michael and Jessica became extremely frustrated with one another. The argument ended with Jessica shoving Michael, throwing a paperback book at him, and storming out of the house.
4. Michael and Jessica are in a committed romantic relationship. According to both, each partner recently suspected that the other had been talking on the phone with an old friend. Both Michael and Jessica punched each other, leaving bruises, and threatened to take the other person's cell phone away if they talked with people they didn't want them talking to.
5. Michael and Jessica are in a committed romantic relationship. According to both, Michael recently suspected that Jessica had been talking on the phone with an old friend. Michael punched Jessica, leaving a bruise, and threatened that he would take Jessica's cell phone away if she talked with people he didn't want her talking to.
6. Michael and Jessica are in a committed romantic relationship. According to both, Jessica recently suspected that Michael had been talking on the phone with an old friend. Jessica punched Michael, leaving a bruise, and threatened that she would take Michael's cell phone away if he talked with people she didn't want him talking to.

APPENDIX H

TABLES

Table 1
Inclusion Criteria by Method of Data Collection

Variable	Paper & Pencil (N = 200)	List Serves (N = 45)	Schools (N = 140)	Total (N = 385)
Licensure / Supervision				
None	6.5% (13)	2.2% (1)	15.0% (21)	9.1% (35)
Missing	0.5% (1)	0.0% (0)	0.0% (0)	0.3% (1)
Couples				
None	10.5% (21)	20.0% (9)	20.0% (28)	14.3% (55)
Missing	1.0% (2)	0.0% (0)	2.1% (3)	1.3% (5)
Inaccurate Response(s)	2.0% (4)	6.7% (3)	5.0% (7)	3.6% (14)
Total	20.5% (41)	28.9% (13)	40.0% (56)	28.6% (110)

Table 2

General Demographic Variable Frequencies by Method of Data Collection

Variable	Paper & Pencil	List Serves	Schools	Total
Gender				
Female	70.4% (112)	68.8% (22)	77.4% (65)	72.4% (199)
Male	29.6% (47)	31.3% (10)	21.4% (18)	27.3% (75)
Transgender	0.0% (0)	0.0% (0)	1.2% (1)	0.4% (1)
Race				
White	88.1% (140)	75.0% (24)	76.2% (64)	82.9% (228)
African American	2.5% (4)	12.5% (4)	6.0% (5)	4.7% (13)
Hispanic	2.5% (4)	0.0% (0)	13.1% (11)	5.5% (15)
Asian-American	1.3% (2)	3.1% (1)	0.0% (0)	1.2% (3)
Multiracial	4.4% (7)	6.3% (2)	1.2% (1)	3.6% (10)
Other	0.0% (0)	3.1% (1)	3.6% (3)	1.5% (4)
Age				
20-29	1.3% (2)	34.4% (11)	71.4% (60)	15.6% (73)
30-39	15.1% (24)	34.4% (11)	11.9% (10)	16.7% (45)
40-49	11.3% (18)	3.1% (1)	9.5% (8)	9.8% (27)
50-59	27.6% (44)	18.8% (6)	6.0% (5)	20.0% (55)
60-69	32.8% (52)	6.3% (2)	1.2% (1)	20.0% (55)
70-79	11.3% (18)	3.1% (1)	0.0% (0)	6.9% (19)
80-89	0.6% (1)	0.0% (0)	0.0% (0)	0.4% (1)
Education				
Bachelor's Degree	0.0% (0)	6.3% (2)	44.0% (37)	14.2% (39)
Master's Degree	76.7% (122)	40.6% (13)	44.0% (37)	62.5% (172)
Ph.D.	17.6% (28)	53.1% (17)	10.7% (9)	19.6% (54)
Psy.D.	5.7% (9)	0.0% (0)	1.2% (1)	3.3% (9)
Total (N)	159	32	84	275

Table 3

Clinical Demographic Variable Frequencies by Method of Data Collection

Variable	Paper & Pencil	List Serves	Schools	Total
AAMFT Membership				
Student Member	0.0% (0)	31.3% (10)	75.0% (63)	26.5% (73)
Affiliate Member	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)
Associate Member	0.0% (0)	3.1% (1)	1.2% (1)	0.7% (2)
Preclinical Fellow	0.0% (0)	9.4% (3)	4.8% (4)	2.5% (7)
Clinical Fellow	100% (159)	40.6% (13)	11.9% (10)	59.3% (163)
Supervisor Designation	0.0% (0)	18.8% (6)	6.0% (5)	4.0% (11)
Licensed				
Yes	100% (159)	65.6% (21)	22.6% (19)	72.4% (199)
No	0.0% (0)	34.4% (11)	77.4% (65)	27.6% (76)
Years Licensed				
0-9	35.2% (56)	43.8% (14)	19.0% (16)	31.3% (86)
10-19	26.4% (42)	6.3% (2)	3.6% (3)	17.1% (47)
20-29	22.6% (36)	12.5% (4)	0.0% (0)	14.5% (40)
30-39	14.5% (23)	3.1% (1)	0.0% (0)	8.7% (24)
40-49	1.3% (2)	0.0% (0)	0.0% (0)	0.7% (2)
Years Practicing				
0-9	35.2% (56)	62.5% (20)	89.3% (75)	54.9% (151)
10-19	26.4% (42)	21.9% (7)	7.1% (6)	20.0% (55)
20-29	22.6% (36)	9.4% (3)	3.6% (3)	15.3% (42)
30-39	14.5% (23)	6.3% (2)	0.0% (0)	9.1% (25)
40-49	1.3% (2)	0.0% (0)	0.0% (0)	0.7% (2)
50-59	0.6% (1)	0.0% (0)	0.0% (0)	0.4% (1)
State Practicing				
With IPV Standards	0.0% (0)	75.0% (24)	67.9% (57)	29.5% (81)
Without IPV Standards	100% (159)	25.0% (8)	32.1% (27)	69.8% (192)
Setting of Practice				
Private Practice	84.9% (135)	43.8% (14)	29.8% (25)	63.3% (174)
Public Mental Health Clinic	7.5% (12)	18.8% (6)	21.4% (18)	13.1% (36)
Private Mental Health Clinic	6.3% (10)	6.3% (2)	8.3% (7)	6.9% (19)
School or University	6.3% (10)	34.4% (11)	57.1% (48)	25.1% (69)
Medical Hospital or Clinic	7.5% (12)	12.5% (4)	9.5% (8)	8.7% (24)
Other	5.7% (9)	15.6% (5)	10.7% (9)	8.4% (23)
Couples in Past Year				
1-9	25.2% (40)	43.8% (14)	56.0% (47)	36.7% (101)
10-19	29.6% (47)	25.0% (8)	32.1% (27)	29.8% (82)
20-29	17.6% (28)	21.9% (7)	7.1% (6)	14.9% (41)
30-39	10.1% (16)	3.1% (1)	2.4% (2)	6.9% (19)
40-69	6.9% (11)	3.1% (1)	2.4% (2)	5.1% (14)
70-99	1.3% (2)	0.0% (0)	0.0% (0)	0.7% (2)
100+	15.7% (15)	3.1% (1)	0.0% (0)	5.8% (16)
Total (N)	159	32	84	275

Table 4

General & Clinical Demographic Variables by Method of Data Collection

Variable	Paper & Pencil	List Serves	Schools	Total
Age				
Mean (SD)	55.88 (13.17)	37.78 (13.34)	30.15 (8.98)	45.92 (16.90)
Range	28-86	24-70	23-61	23-86
Years Licensed				
Mean (SD)	16.08 (10.73)	9.02 (8.65)	4.88 (4.97)	14.27 (10.75)
Range	1-45	1-30	0-19	0-45
Years Practicing				
Mean (SD)	20.13 (11.14)	9.48 (8.83)	3.62 (5.42)	13.96 (12.11)
Range	2-50	1-35	0-29	0-50
Couples in Past Year				
Mean (SD)	39.03 (99.49)	15.41 (21.41)	9.67 (9.62)	27.31 (77.33)
Range	1-1,000	1-120	1-60	1-1,000

Table 5

Demographic Variables of Active AAMFT Members & Total Sample

Variable	AAMFT Membership	Total Sample
Gender		
Female	66.7% (14,815)	72.4% (199)
Male	27.1% (6,008)	27.3% (75)
Transgender	--	0.4% (1)
AAMFT Membership		
Student Member	32.1% (7,128)	26.5% (73)
Affiliate Member	2.5% (551)	0.0% (0)
Associate Member	12.8% (2,847)	0.7% (2)
Preclinical Fellow	--	2.5% (7)
Clinical Fellow	43.9% (9,734)	59.3% (163)
Supervisor Designation	8.7% (1,935)	4.0% (11)
Education		
Bachelor's Degree	--	14.2% (39)
Master's Degree	37.9% (8,406)	62.5% (172)
Ph.D.	9.2% (2,031)	19.6% (54)
Psy.D.	--	3.3% (9)
D.Min.	1.3% (299)	0.0% (0)
Ed.D.	1.1% (244)	0.0% (0)
Total (N)	22,195	275

Table 6

AAMFT Clinical Membership and Paper and Pencil Sample by States without IPV Standards

Variable	AAMFT Clinical Membership	Paper & Pencil Sample
California	47.7% (1,339)	40.3% (64)
Colorado	9.2% (257)	10.1% (16)
Illinois	10.4% (293)	12.5% (20)
Kansas	4.5% (125)	4.4% (7)
Nevada	8.3% (232)	5.7% (9)
Rhode Island	1.9% (53)	2.5% (4)
Washington	17.7% (498)	24.5% (39)
West Virginia	0.4% (11)	0.0% (0)
Total (N)	2,808	159

Table 7

Descriptive Statistics for CTS and DSI-SF

Scale & Subscale	Mean (SD)	Range	Alpha
CTS			
Psychological	46.31 (52.55)	0-268	.88
Minor	44.03 (48.26)	0-200	.92
Severe	2.40 (8.30)	0-68	.66
Physical	3.21 (10.33)	0-127	.86
Minor	2.66 (8.52)	0-103	.78
Severe	0.38 (1.92)	0-24	.79
Total	49.50 (58.37)	0-395	.88
DSI-SF			
Emotional Reactivity	4.03 (0.95)	1.17-6.00	.83
"I" Position	4.66 (0.67)	1.83-6.00	.69
Emotional Cutoff	4.80 (1.00)	1.67-6.00	.77
Fusion with Others	4.62 (0.74)	2.40-6.00	.61
Total	4.48 (0.63)	2.30-5.85	.87

Table 8

Descriptive Statistics on Questions from Piloted Vignettes

	Vignette 1 (N = 29)	Vignette 2 (N = 17)	Vignette 3 (N = 22)	Vignette 4 (N = 20)	Vignette 5 (N = 25)	Vignette 6 (N = 24)
Illustrates domestic violence[a]						
Mean	5.03	5.65	5.27	6.75	6.92	6.21
SD	1.59	1.87	1.61	0.91	0.28	1.53
Range	2 – 7	1 – 7	2 – 7	3 – 7	6 – 7	1 – 7
Severity of harm						
Mean	4.34	5.18	4.36	6.1	6.44	4.83
SD	1.26	1.63	1.22	1.07	0.71	1.55
Range	2 – 7	2 – 7	1 – 6	4 – 7	5 – 7	1 – 7
How controlling Michael is						
Mean	4.24	5.71	2.86	6.25	6.83	1.58
SD	1.46	1.45	1.42	0.91	0.38	1.32
Range	1 – 7	1 – 7	1 – 7	4 – 7	6 – 7	1 – 7
How controlling Jessica is						
Mean	4.03	2.06	4.86	6.25	1.84	6.71
SD	1.24	0.97	1.46	0.91	1.21	0.86
Range	1 – 7	1 – 4	1 – 7	4 – 7	1 – 5	3 – 7

[a]Domestic violence: 1 = *Strongly disagree*, 7 = *Strongly agree*.

Table 9

Comparison of Piloted Vignettes

Variables	*t*	df	95% CI
Illustration of IPV			
Vignettes 1 & 4	-4.35*	47	-2.51, -0.99
Vignettes 2 & 5	-3.37**	40	-2.04, -0.51
Vignettes 3 & 6	-2.02***	44	-1.87, 0.00
Severity of Harm			
Vignettes 1 & 4	-5.08*	47	-2.45, -1.06
Vignettes 2 & 5	-3.44**	40	-2.01, -0.52
Vignettes 3 & 6	-1.14	44	-1.30, 0.36
How Controlling Michael is			
Vignettes 1 & 4	-5.47*	47	-2.75, -1.27
Vignettes 2 & 5	-3.66**	39	-1.75, -0.50
Vignettes 3 & 6	3.17**	44	0.47, 2.09
How Controlling Jessica is			
Vignettes 1 & 4	-6.82*	47	-2.87, -1.56
Vignettes 2 & 5	.62	40	-0.49, 0.93
Vignettes 3 & 6	-5.28*	44	-2.55, -1.14

* $p < .001$, ** $p < .01$, *** $p < .05$

Table 10

Vignette Descriptive Statistics

Survey Item	Mean (SD)	Range
Illustration of IPV[a]		
Situational Couple Violence		
Vignette 1: Mutual Perpetration	4.77 (1.57)	2-7
Vignette 2: Male Perpetrated	5.56 (1.62)	2-7
Vignette 3: Female Perpetrated	4.64 (1.75)	1-7
Intimate Terrorism		
Vignette 4: Mutual Violent Control	6.24 (1.18)	1-7
Vignette 5: Male Perpetrated	6.40 (0.79)	4-7
Vignette 6: Female Perpetrated	5.96 (1.23)	2-7
Severity of Harm		
Situational Couple Violence		
Vignette 1: Mutual Perpetration	4.32 (0.94)	3-6
Vignette 2: Male Perpetrated	4.88 (1.39)	2-7
Vignette 3: Female Perpetrated	4.21 (1.34)	2-7
Intimate Terrorism		
Vignette 4: Mutual Violent Control	5.67 (1.14)	1-7
Vignette 5: Male Perpetrated	5.55 (0.97)	3-7
Vignette 6: Female Perpetrated	5.26 (1.20)	2-7
How Controlling Michael is		
Situational Couple Violence		
Vignette 1: Mutual Perpetration	4.01 (1.10)	2-6
Vignette 2: Male Perpetrated	4.62 (1.41)	2-7
Vignette 3: Female Perpetrated	3.37 (1.14)	1-5
Intimate Terrorism		
Vignette 4: Mutual Violent Control	5.20 (1.26)	2-7
Vignette 5: Male Perpetrated	5.77 (0.98)	4-7
Vignette 6: Female Perpetrated	3.10 (1.36)	1-6
How Controlling Jessica is		
Situational Couple Violence		
Vignette 1: Mutual Perpetration	4.01 (1.10)	2-6
Vignette 2: Male Perpetrated	3.63 (1.31)	1-7
Vignette 3: Female Perpetrated	4.27 (1.14)	1-7
Intimate Terrorism		
Vignette 4: Mutual Violent Control	5.11 (1.39)	1-7
Vignette 5: Male Perpetrated	2.89 (1.32)	1-6
Vignette 6: Female Perpetrated	5.79 (0.95)	3-7

[a]Domestic violence: 0 = *Strongly disagree*, 6 = *Strongly agree*.

Table 11

Comparison of Vignettes

Variables	*t*	df	95% CI
Illustration of IPV			
Vignettes 1 & 4	-5.03*	88	-2.05, -0.89
Vignettes 2 & 5	-3.20**	94	-1.35, -0.32
Vignettes 3 & 6	-3.86*	79	-2.01, -0.64
Severity of Harm			
Vignettes 1 & 4	-6.15*	88	-1.79, -0.92
Vignettes 2 & 5	-2.75**	93	-1.17, -0.19
Vignettes 3 & 6	-3.65*	77	-1.63, -0.48
How Controlling Michael is			
Vignettes 1 & 4	-4.69*	86	-1.69, -0.68
Vignettes 2 & 5	-4.65*	93	-1.65, -0.66
Vignettes 3 & 6	0.93	74	-0.30, 0.84
How Controlling Jessica is			
Vignettes 1 & 4	-4.09*	86	-1.63, -0.56
Vignettes 2 & 5	2.70**	91	0.19, 1.28
Vignettes 3 & 6	-6.31*	75	-2.00, -1.04

* $p < .001$, ** $p < .01$, *** $p < .05$

Table 12

Endorsement of Couples Treatment by Method of Data Collection

	Paper & Pencil	List Serves	Schools	Total (N)
Situational Couple Violence				
Vignette 1: Mutual Perpetration	88.9% (24)	80.0% (4)	81.8% (9)	80.4% (37)
Vignette 2: Male Perpetrated	66.7% (18)	75.0% (6)	61.5% (8)	65.3% (32)
Vignette 3: Female Perpetrated	73.9% (17)	100.0% (4)	75.0% (12)	73.3% (33)
Intimate Terrorism				
Vignette 4: Mutual Violent Control	48.0% (12)	83.3% (5)	80.0% (12)	61.7% (29)
Vignette 5: Male Perpetrated	32.1% (9)	60.0% (3)	33.3% (5)	34.7% (17)
Vignette 6: Female Perpetrated	61.9% (13)	50.0% (2)	50.0% (6)	55.3% (21)
Total (N)	61.6% (93)	75.0% (24)	63.4% (52)	63.8% (169)

Table 13

Endorsement of Treatment Modality by Accuracy of Identification of IPV Type

Identification of IPV Type	Individual	Couples	Total (N)
Vignettes 1-3: Situational Couple Violence			
Accurate	16.88% (13)	83.12% (64)	77
Inaccurate or Unsure	33.33% (19)	66.67% (38)	57
Vignettes 4-6: Intimate Terrorism			
Accurate	58.54% (24)	41.46% (17)	41
Inaccurate or Unsure	44.19% (38)	55.81% (48)	86
Total (N)	36.02% (94)	63.98% (167)	261

Table 14

Logistic Regression Analysis of CTS and Treatment Choice

Vignette Violence Type	*B* (SE)	Wald	Exp(B)	95% CI	Model χ^2	Pseudo R^2
Situational Couple Violence	-0.00 (.00)	0.47	1.00	0.99-1.00	(8, *N* = 131) = 5.66	.003
Intimate Terrorism	-0.00 (.00)	0.03	1.00	0.99-1.01	(8, *N* = 127) = 2.00	.000

* $p < .05$, ** $p < .01$, ***$p < .001$ (2-tailed)

Table 15

Logistic Regression Analysis of Differentiation as a Moderating Factor between IPV and Treatment Choice

Variable	*B* (SE)	Wald	Exp(B)	95% CI	Model χ^2	Pseudo R^2
Situational Couple Violence					(8, *N* = 125) = 11.75	.042
CTS	-0.00 (.00)	0.06	1.00	0.99-1.01		
DSI	-0.45 (.38)	1.38	0.64	0.30-1.35		
DSI x CTS	0.01 (.01)	3.41	1.01	1.00-1.02		
Intimate Terrorism					(8, *N* = 123) = 8.26	.020
CTS	-0.00 (.00)	0.33	1.00	0.99-1.00		
DSI	0.40 (.30)	1.74	1.49	0.82-2.69		
DSI x CTS	-0.00 (.01)	0.90	1.00	0.99-1.01		

* $p < .05$, ** $p < .01$, ***$p < .001$ (2-tailed)

Table 16

Logistic Regression Analysis of Interaction between IPV Type and Gender of Perpetrator on Treatment Choice

Variable	*B* (SE)	Wald	Exp(B)	95% CI
IPV Type	-0.92 (.49)	3.54	0.40	0.15-1.04
Gender	0.87 (.45)	3.79	2.39	0.99-5.77
IPV Type x Gender	-0.37 (.65)	0.33	0.69	0.19-2.48
Model χ^2 (2, N = 176) =	0.00			
Pseudo R^2 =	.098			

* $p < .05$, ** $p < .01$, ***$p < .001$ (2-tailed)

Table 17

Accuracy Identifying IPV Type

	Accurate	Inaccurate	Uncertain	Total (N)
Situational Couple Violence				
Vignette 1: Mutual Perpetration	54.3% (25)	15.2% (7)	26.1% (12)	44
Vignette 2: Male Perpetrated	47.0% (23)	22.4% (11)	28.6% (14)	48
Vignette 3: Female Perpetrated	66.7% (30)	6.7% (3)	24.4% (11)	44
Intimate Terrorism				
Vignette 4: Mutual Violent Control	31.9% (15)	23.4% (11)	42.6% (20)	46
Vignette 5: Male Perpetrated	38.8% (19)	34.7% (17)	20.4% (10)	46
Vignette 6: Female Perpetrated	18.4% (7)	34.2% (13)	39.5% (15)	35
Total (N)	43.3% (119)	22.5% (62)	29.8% (82)	263

Table 18

Endorsement of Couples Treatment by State Standards Against Couples Treatment of IPV

	Standard Present	Standard Absent	Total (N)
Situational Couple Violence			
Vignette 1: Mutual Perpetration	90.0% (9)	77.8% (28)	43
Vignette 2: Male Perpetrated	63.6% (7)	65.8% (25)	48
Vignette 3: Female Perpetrated	81.3% (13)	69.0% (20)	43
Intimate Terrorism			
Vignette 4: Mutual Violent Control	81.3% (13)	51.6% (16)	46
Vignette 5: Male Perpetrated	41.7% (5)	32.4% (12)	48
Vignette 6: Female Perpetrated	46.7% (7)	60.9% (14)	37
Total (N)	67.5% (54)	62.16% (115)	265

Table 19

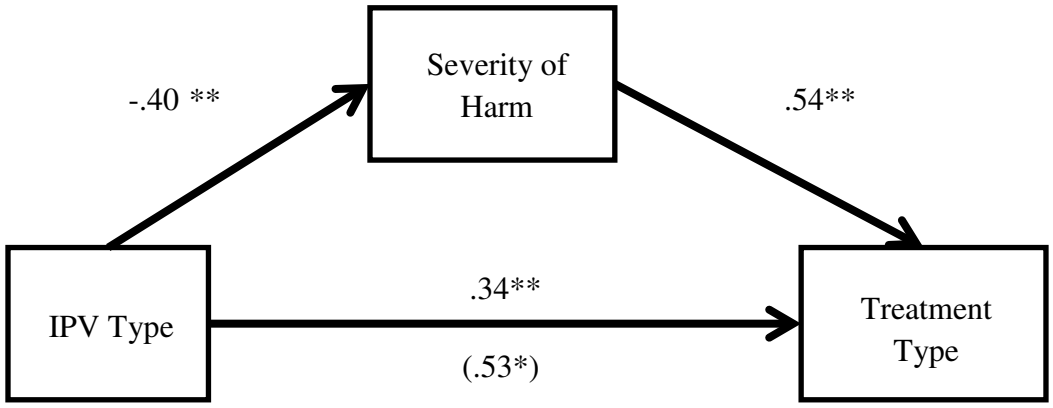
Logistic Regression of Predictor Variables on Treatment Choice for Vignettes 2, 3, 5, and 6

Variable	*B* (SE)	Wald	Exp(B)	95% CI
Gender of Perpetrator	-0.76 (.35)*	4.74	0.47	0.23-0.93
Violence Type	1.10 (.36)**	10.07	2.99	1.52-5.88
Accuracy of Identification	0.34 (.21)	2.73	1.41	0.94-2.12
IPV	-0.00 (.00)	0.19	1.00	0.99-1.00
Differentiation	0.08 (.27)	0.08	1.08	0.64-1.82
Model χ^2 (5, N = 159) =	19.85***			
Pseudo R^2 =	.117			

* $p < .05$, ** $p < .01$, ***$p < .001$ (2-tailed)

APPENDIX I

FIGURES

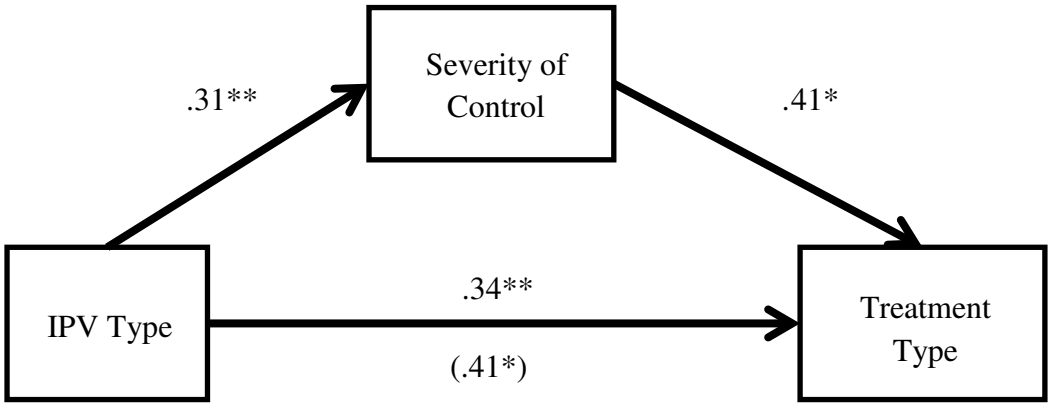


* $p < .05$

** $p < .01$

Note: Reported as Exp(*B*)

Figure 1. Mediation of IPV type and treatment type by severity of harm.



* $p < .05$

** $p < .01$

Note: Reported as Exp(*B*)

Figure 2. Mediation of IPV type and treatment type by severity of control.

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Cobb. R. A. (2011). A review of "Not 'Just Friends': Rebuilding Trust and Recovering Your Sanity After Infidelity." *Journal of Couple and Relationship Therapy, 10,* 279-280.

Cobb, R. A., & Negash, S. (2010). Altered book making as a form of art therapy: A narrative approach. *Journal of Family Psychotherapy, 21,* 54-69.

Cobb, R. A., Walsh, C. E., & Priest, J. B. (2009). The Cognitive-Active Gender Role Identification Continuum. *Journal of Feminist Family Therapy, 21,* 77-97.

Priest, J. B., **Cobb, R. A.,** Vasquez, A. M., Lopez, G. P., Morris, C., Sutherland, T., & Cavazos, R. (2009). *Consumption and consequences of cocaine and other drugs in East Chicago, Indiana: A local epidemiological profile.* Merrillville, IN: Geminus Corporation.

PROFESSIONAL PRESENTATIONS

Cobb, R. A., Okafor, E. S., Schwab, E. T., & Scott, J. C. (2014, March). *The ethical use of social media in #MarriageandFamilyTherapy: Suggested guidelines.* Paper presented at the annual meeting of the International Family Therapy Association, Panama City, Panama.

Baker, L. R., **Cobb, R. A.,** Lambert, N. M., Fincham, F. D., & McNulty, J. K. (2014, February). *Relationship self-efficacy prevents intimates from ending abusive relationships.* Poster presented at the annual meeting of the Society for Social and Personality Psychology, Austin, TX.

Cobb, R. A., DeWall, C. N., Lambert, N. M., & Fincham, F. D. (2012, March). *Does believing your relationship can grow relate to lower perpetration of violence?* Poster presented at the annual meeting of the International Family Therapy Association, Vancouver, BC, Canada.

Cobb, R. A., Lambert, N. M., Baker, L. R., Fincham, F. D., & McNulty, J. K. (2011, November). *When believing in your relationship hurts: Relationship efficacy and IPV.* Paper presented at the annual meeting of the National Council on Family Relations, Orlando, FL.

Priest, J. B., Edwards, A. B., Wetchler, J. L., Gillotti, C. M., **Cobb., R. A.,** & Walsh, C. E. (2011, March). *Gender roles in couples therapy: Evaluating the CAGRIC model.* Paper presented at the annual meeting of the International Family Therapy Association, Noordwijkerhout, the Netherlands.

Cobb, R. A., Nalbone, D. P., Hecker, L. L., & Casanova, G. M. (2011, March). *Impact of interparental violence and gender role identification on adult IPV.* Poster presented at the annual meeting of the International Family Therapy Association, Noordwijkerhout, the Netherlands.

Cobb, R. A., Nalbone, D. P., Hecker, L. L., & Casanova, G. M. (2010, November). *Influence of interparental violence on gender identity and intimate partner violence.* Paper presented at the annual meeting of the National Council on Family Relations, Minneapolis, MN.

Fortner, L., Olmstead, S., **Cobb, R. A.,** Pilkington, S., & Pasley, K. (2010, November). *College students and contraception: Deciding, using, and discussing.* Poster presented at the annual meeting of the National Council on Family Relations, Minneapolis, MN.

Cobb, R. A., DeWall, C. N., Lambert, N. M., & Fincham, F. D. (2010, October). *Does believing your relationship can grow relate to lower perpetration of violence?* Poster presented at the annual meeting of the Society of Southeastern Social Psychologists, Charleston, SC.

Cobb, R. A., Nalbone, D. P., & Hecker, L. L. (2010, September). *Parental IPV, gender identity, and personal IPV.* Poster presented at the annual meeting of the American Association for Marriage and Family Therapy, Atlanta, GA.

Priest, J. B., **Cobb, R. A.,** & Roberts, K. D. M. (2009, November). *The influence of gender role identification on intrapersonal and interpersonal sexual satisfaction: Implications for therapy.* Poster presented at the annual meeting of the National Council on Family Relations, San Francisco, CA.

Roberson, P. N. E., & **Cobb, R. A.** (2009, November). *Guidelines for providing expert witness testimony as a marriage and family therapist.* Poster presented at the annual meeting of the National Council on Family Relations, San Francisco, CA.

Cobb, R. A., & Negash, S. (2009, April). *Altered book making in family therapy.* Poster presented at the semi-annual meeting of the Indiana Association for Marriage and Family Therapy, Indianapolis, IN.

Priest, J. B., **Cobb, R. A.,** & McNally, C. E. (2008, November). *The Cognitive-Active Gender Role Identification Continuum.* Poster presented at the annual meeting of the National Council on Family Relations, Little Rock, AR.

Cobb, R. A., McNally, C. E., Priest, J. B., & Wetchler, J. L (2008, October). *The Cognitive Active Gender Role Identification Continuum.* Poster presented at the annual meeting of the American Association for Marriage and Family Therapy, Memphis, TN.

PROFESSIONAL EXPERIENCE

2009-Present **Graduate Teaching Assistant,** Family and Child Sciences, FSU
Supervisor: Kay Pasley, Ed.D.

- Taught 10 discussion sections accompanying FAD2230 with a manualized psychoeducation program as part of a 5-year federally funded program to develop a national model for relationship education.
- Instructor of record and responsible for all aspects of teaching 10 sections total of the following undergraduate courses:
    - FAD 2230 Family Relationships: A Lifespan Development
    - FAD 3271 Ecological Contexts for Individual and Family Development
    - FAD 4601 Foundations of Counseling

2006-2009 **Graduate Teaching Assistant,** Behavioral Sciences, PUC
Supervisor: Michael Flanery, Ph.D.

- Instructor of record and responsible for all aspects of teaching 8 sections total of the following undergraduate courses:
    - PSY 120 Elementary Psychology
      (*also developed and taught as a distance learning course)*
    - PSY 349 Psychology of Women
    - PSY 350 Abnormal Psychology
    - PSY 362 Human Development II: Adolescence

2008-2010 **Project Manager,** Geminus Corporation, Merrillville, IN
Supervisor: Ann Vasquez

- Conducted research to assess drug use, mental health, and family dynamics of East Chicago residents for a project funded by a Strategic Prevention Framework State Initiative grant (funded through SAMHSA).
- Wrote annual epidemiological report and presented findings to local agencies.

2007 **Project Manager**, PUC
Supervisor: Dave Nalbone, Ph.D.

- Conducted countywide research and survey to identify strengths and weaknesses in provision of domestic violence victim services.
- Made recommendations to Lake County Sheriff's Department for improvement of services.

2005-2006 **Editorial Assistant,** *The International Journal for the Psychology of Religion* (IJPR), Santa Barbara, CA
Supervisor: Raymond Paloutzian, Ph.D.

- Assisted the editor with journal publications, maintained contact with authors and reviewers, and performed administrative duties as needed.

2005-2006 **Office Administrator,** Psychology Department, Westmont College
Supervisor: Thomas Fikes, Ph.D.

- Record and file data (e.g., documentation for program review, budget requests)
- Maintain the department's website and calendars
- Plan and organize student workshops and other events
- Supervise student employees and assistant secretary

2004-2006 **Personal Care Staff,** Devereux Foundation, Goleta, CA
Supervisor: Amy West

- Provided support and assistance in a residential setting to adults diagnosed with developmental disabilities and psychological disorders.

COUNSELING EXPERIENCE

2012-Present **Therapist,** Family Counseling Services, DISC Village, Tallahassee, FL
Supervisors: Daniel Lettenberger-Klein, M.S., Larry Barlow, Ph.D., & Wayne Denton, M.D., Ph.D.

- Perform individual, couple, and family therapy.

2009-2013 **Therapist Intern,** FSU Center for Couple and Family Therapy, Tallahassee, FL
Supervisors: Lenore McWey, Ph.D., & Larry Barlow, Ph.D.

- Performed individual, couple, and family therapy.

2011 **Therapist Intern,** Lee's Place, Tallahassee, FL
Supervisors: Brenda Rabalais, Ph.D., Lenore McWey, Ph.D., & Larry Barlow, Ph.D.

- Performed individual and family therapy with adults and children coping with grief, loss, and trauma.

2008-2009 **Therapist Intern,** Samaritan Counseling Center, Munster, IN
Supervisors: Lorna Hecker, Ph.D., Joseph Wetchler, Ph.D., Mark Killmer, Psy.D., Jennifer McComb, Ph.D.

- Performed individual, couple, and family therapy at Christian Community Action's Spring Valley Homeless Shelter.

2007 **Therapist Intern,** PUC's Couple and Family Therapy Center, Hammond, IN
Supervisors: Lorna Hecker, Ph.D., Joseph Wetchler, Ph.D., & Jerome Berick, M.S.W.

- Performed individual, couple, and family therapy.
- Performed substance abuse and anger management group therapy.

HONORS & AWARDS

2014	Dissertation Award Program Grant, College of Human Sciences, FSU
2011	Norejane Hendrickson Scholarship, FSU
2010	Dean's Doctoral Scholarship, FSU
2009	James Walters Scholarship, FSU
2005	Eugene Walker Award, Outstanding Achievement in Psychology, Westmont College
2004	Eugene Walker Award, Outstanding Achievement in Psychology, Westmont College
2001-2005	Provost's Academic Merit Scholarship, Westmont College

ASSOCIATION MEMBERSHIPS

Golden Key International Honor Society (member since 2011)
International Family Therapy Association (member since 2010)
Florida Association for Marriage and Family Therapy (member since 2009)
National Council on Family Relations (member since 2009)
American Association for Marriage and Family Therapy (member since 2008)
Kappa Omicron Nu: National Honor Society in Human Sciences (member since 2008)
Psi Chi: National Honor Society in Psychology (member since 2004)