

DOMESTIC VIOLENCE:  
FLORIDA LICENSED MENTAL HEALTH PROFESSIONALS'  
PERCEIVED LEVEL OF COMPETENCE

By

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This dissertation is dedicated to all mental health professionals who work with victims of domestic violence with the hopes of inspiring and promoting continued education and research.

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DOMESTIC VIOLENCE: FLORIDA LICENSED MENTAL HEALTH  
PROFESSIONALS' PERCEIVED LEVEL OF COMPETENCE

By

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There are three separate disciplines in which mental health professionals train in the state of Florida to work with clients facing domestic violence. These are clinical social work, marriage and family therapy, and mental health counseling. In addition, there are three separate accrediting bodies regulating the programs from which graduate training is taught, as well as three separate licenses in the state of Florida, under Chapter 491.004 for these mental health professionals to obtain: Licensed Clinical Social Workers (LCSW), Licensed Marriage and Family Therapists (LMFT), and Licensed Mental Health Counselors (LMHC). This research study surveyed Florida licensed mental health professionals to determine their perceived level of competency in assessing and treating domestic violence.

An E-mail survey was distributed to over 8,000 licensed professionals, under Chapter 491.004, in the state of Florida. Research findings failed to show a significant relationship between graduate coursework and practicum/internship training and level of perceived competency when assessing and treating domestic violence. However, research findings did show a significant relationship between postgraduate clinical

contact experience, as well as self-initiated learning and perceived level of competency when assessing and treating domestic violence. Furthermore, study results found no significant relationship between discipline (clinical social work, marriage and family therapy and mental health counseling) and perceived level competency when assessing and treating domestic violence, meaning one discipline over another did not report a higher level of perceived competency.

Given the findings of this research study, educational policy makers and accrediting bodies should consider evaluating current curriculum requirements for mental health professionals in training, in the area of domestic violence. In addition, licensure boards should consider evaluating licensure requirements as well as continuing education requirements in the area of domestic violence. Implications of this research study suggest improvements to graduate curriculum, as well as graduate clinical training are needed in order to increase levels of competency in assessing and treating domestic violence, among Florida licensed mental health professionals.

## CHAPTER 1 INTRODUCTION

Domestic violence is a social crisis that affects all cultural and socioeconomic backgrounds. This pervasive and significant issue threatens the safety and security of victims and their families across the United States. Current statistics show that one in four women will experience domestic violence in her lifetime (Tjaden & Thoennes, 2000). Each day at least three women in the United States die as a result of domestic violence (Bureau of Justice Statistics, 2005). Women are twice as likely to be killed by an intimate partner than men (Bureau of Justice Statistics, 2008). Moreover, in 2007, women comprised 70% of victims killed by an intimate partner, a statistic that has changed very little since 1993 (Bureau of Justice Statistics, 2008).

When domestic violence victims leave abusive relationships, finding a safe place to stay is critical. Leaving a violent relationship is one of the most dangerous times for a victim. McKenzie (1995) reports that “women who leave marriages and relationships plagued by domestic violence are seventy-five percent more likely to be injured or killed by their batterers than the ones who stay” (pp. 20-21). Safe shelter and housing are crucial. Without domestic violence shelters or transitional housing, many victims are faced with the choice of either becoming homeless or returning to their violent partner. In addition, “medical expenditures for domestic violence cost the U.S. \$3 to \$5 billion annually. American business debits another \$100 billion in lost wages, absenteeism, sick leave utilization, and non-productivity” according to the Colorado Domestic Violence Coalition, 1991 (McKenzie, 1995, p. 19). According to the Florida Department of Law Enforcement (2009) there were 113,123 domestic violence offences reported in

2008, just in the state of Florida. The reality is domestic violence affects a large population including our schools, our workplace, and our community as a whole.

Domestic violence does not discriminate. All races and socioeconomic groups are affected by the social problem of domestic violence. Domestic violence can be physical, psychological, sexual, and/or financial. According to Lenore Walker (2000) domestic violence is about power and control, about one person controlling another by using the various forms of violence mentioned above.

Mental health professionals are often the first responders in assessing and treating domestic violence. According to Jacobson and Gottman (1998), “the vast majority of psychiatrist, psychologists, and social workers in the United States have little or no training in the rehabilitation of batterers. Although batterers are treated every day and all too commonly by counselors without such training, batterers provide unique challenges” (p. 224). This research study examined how licensed mental health professionals in the state of Florida are prepared to undertake such a task and how competent these professionals feel in doing so.

According to curriculum requirements, little emphasis is seemingly placed on formal instruction and coursework in the area of domestic violence. Currently, under Chapter 491.004 of the Florida Statutes, Licensed Mental Health Counselors, Licensed Marriage and Family Therapists, and Licensed Clinical Social Workers are not required to take specific coursework or practicum/internship experiences in the area of domestic violence for licensure. Also, the state of Florida only requires these licensed professionals to obtain two hours of continuing education credit every six years in the area of domestic violence. Furthermore, the accrediting bodies such as the

Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE), the Council for Accreditation of Counseling and Related Education Programs (CACREP), and the Council on Social Work Education (CSWE), all of whom accredit degree programs for these mental health professionals, currently do not have requirements specifying coursework or experiences in the area of assessing and treating domestic violence.

The purpose of this study was to examine how the mental health profession is addressing this social problem of domestic violence. Specifically, this study examined how Florida licensed professionals in three different mental health disciplines, Marriage and Family Therapy, Mental Health Counseling, and Clinical Social Work, are educated and credentialed to assess and treat domestic violence and how they view their own level of competence.

### **Need for Study**

Domestic violence is a major societal problem. Millions of Americans are affected by domestic violence, yet the subject is often viewed as a private matter. According to the National Violence Against Women Survey (NVAWS), an estimated 5.3 million intimate partner violence victimizations occur on women living in the United States (Centers for Disease Control and Prevention, 2003). Research finds “violence in virtually all family relations-victims not only include children and women, but young and elderly parents, siblings, and dating partners” (Gelles, 1990, p. 17). Research also suggests that “violence and abuse can be found among truck drivers and physicians, laborers and lawyers, the employed and unemployed, the rich and the poor. The fact that violence can be found in all types of homes leads some people to conclude that social factors, especially income and employment, are not relevant in explaining family

violence” (Gelles, 1993, p. 33). The research conducted by Todahl, Linville, Chou, and Maher-Cosenza (2008), reported that domestic violence was quite prevalent in the United States and it was reasonable to assume that “many family therapy clients have endured mild, moderate, or severe violence at some point in their lives, including during the course of therapy” (pp. 28-29). These findings furthermore underscore the need for mental health professionals to be competent in assessing and treating domestic violence.

Even with more awareness and education about the issue, domestic violence continues to be a prevalent and pervasive problem that warrants further research. The news media often report on the daily occurrences of domestic violence. Domestic violence does not discriminate; lower socioeconomic classes are not the only ones affected by domestic violence, like some may think. Celebrities, politicians, and other prominent individuals in our society are all too often individuals affected by domestic violence, either as victim or perpetrator.

In the United States, law enforcement, court, social services, and healthcare systems are inundated with victims and perpetrators of domestic violence. The statistics on domestic violence clearly illustrate how significant a social problem this really is in our country: “An estimated 1.3 million women are victims of physical assault by an intimate partner each year” (Centers for Disease Control and Prevention, 2003, p. 14). According to Straus and Gelles (1986), young boys who witness domestic violence in the home are twice as likely to become perpetrators of violence as an adult toward their own family. In survey research conducted by Tjaden and Thoennes (2000) it was found that 4.8 million American women were victims of domestic violence. Based on

these findings, researchers concluded that domestic violence was not only a significant criminal justice problem facing America, but also a serious threat to our nation's public health (Tjaden & Thoennes, 2000).

For these reasons, it would seem important to evaluate how licensed mental health professionals in the state of Florida are being trained to work with domestic violence, in terms of formal education, licensure, and continuing education. According to Tjaden and Thoennes (2000), "the mental health community should receive comprehensive training on the appropriate treatment of stalking victims" (p. 14). Tjaden and Thoennes (2000) found that over 25% of stalking victims seek counseling. As a result, mental health professionals should be trained in the area of stalking and be educated about the specific needs of stalking victims, in order to better serve this population (Tjaden & Thoennes, 2000). In addition, Bograd and Mederos (1999) argue that "the clinical assessment of whether domestic violence exists requires specific skills and knowledge" (p. 292). Based on the literature presented, all Florida licensed mental health professionals should have the skills and knowledge to assess and treat domestic violence. For these reasons, this study examined how licensed professionals in each discipline licensed under Chapter 491.004 of the Florida Statutes (i.e. clinical social workers, mental health counselors, and marriage and family therapists), perceived their own competency in assessing and treating domestic violence. This study also examined if one discipline over another felt more prepared or competent in assessing and treating domestic violence.

### **Clinical Social Workers**

According to the Council on Social Work Education Standards (CSWE), (2001), "the purpose of the social work profession is to promote human and community well-

being. Guided by a person and environment construct, a global perspective, respect for human diversity, and knowledge based on scientific inquiry, social work's purpose is actualized through its quest for social and economic justice, the prevention of conditions that limit human rights, the elimination of poverty, and the enhancement of the quality of life for all persons" (p. 1). There are 10 core competencies the CSWE Standards (2001) establish that graduate students must achieve: "(a) Identify [yourself] as a professional social worker and conduct self accordingly, (b) Apply social work ethical principles to guide professional practice, (c) Apply critical thinking to inform and communicate professional judgments, (d) Engage diversity and difference in practice, (e) Advance human rights and social economic justice, (f) Engage in research-informed practice and practice informed research, (g) Apply knowledge of human behavior and the social environment, (h) Engage in policy practice to advance social and economic well-being and to deliver effective social work services, (i) Respond to contexts that shape practice, and (j) Engage, assess, intervene, and evaluate individuals, families, groups, organizations, and communities" (pp. 3-7). None of these competencies specifically address the need for training and education in the area of domestic violence.

### **Mental Health Counselors**

Training for mental health counselors is guided by the Council for Accreditation of Counseling and Related Educational Programs or CACREP. The mission of this council is "to provide leadership and to promote excellence in professional preparation through the accreditation of counseling and related education programs. As an accrediting body, CACREP is committed to the development of standards and procedures that reflect the needs of a dynamic, diverse, and complex society. The CACREP is dedicated to encouraging and promoting the continuing development and improvement

of preparation programs, and preparing counseling and related professionals to provide service consistent with the ideal of optimal human development”

([www.cacrep.org/mission](http://www.cacrep.org/mission), 05/28/2008) in addition to developing guidelines for professional counselor development.

Specific guidelines are established by this council in terms of developing curriculum for Mental Health Counselors. CACREP identifies eight common core curriculum areas which are required for mental health programs; Professional Orientation and Ethical Practice; Social and Cultural Diversity; Human and Growth Development; Career Development; Helping Relationships; Group Work; Assessment; and Research and Program Evaluation (CACREP Standards, 2009). In the core area of Human Growth and Development, CACREP requires mental health counselors in training to have an understanding of the “effects of crises, disasters, and other trauma-causing events on persons of all ages” (CACREP Standards, 2009). However, there is no core area that specifically addresses the study of domestic violence.

In addition to the eight core areas, CACREP identifies additional knowledge and skills needed for students preparing to work as Mental Health Counselors. There is specific mention of substance abuse, professional issues, management of services, and ethical and legal considerations in the practice of mental health, and not domestic violence (CACREP Standards, 2009).

Additionally, students are required to have a specific understanding of “the impact of crises, disasters, and other trauma-causing events on people” (CACREP Standards, 2009, p. 29) however, again there is no mention of students needing experience or knowledge in the area of domestic violence. Although CACREP also accredits Marriage

and Family Counseling programs in CACREP accredited programs, this study focused on the accrediting body that each of the three professions identify with most strongly from an organizational standpoint.

### **Marriage and Family Therapists**

Marriage and family therapy programs that are accredited by the American Association for Marriage and Family Therapy, Commission on Accreditation for Marriage and Family Therapy Education, or COAMFTE are guided by six core competencies. The six primary competencies are: “(a) Admission to treatment, (b) Clinical assessment and diagnosis, (c) Treatment planning and case management, (d) Therapeutic interventions, (e) Legal issues, ethics and standards and (f) Research and program evaluation” (AAMFT, 2004, p. 1). In addition, there are five secondary competencies which outline specific skills and knowledge a Marriage and Family Therapist must develop. These five competencies are Conceptual, Perceptual, Executive, Evaluative, and Professional. Under Clinical Assessment and Diagnosis, it is outlined that Marriage and Family Therapists will develop the skill and knowledge to “screen and develop adequate safety plans for substance abuse, child and elder maltreatment, domestic violence, physical violence, suicide potential, and dangerousness to self and other” (AAMFT, 2004, p. 3). Also under Legal Issues, Ethics and Standards, it is specified that therapists will “develop safety plans for clients who present with potential self-harm, suicide, abuse, or violence” (AAMFT, 2004, p.5). In addition, CACREP addresses Marriage and Family Therapists as needing additional knowledge and skills in the area of understanding “family development and the life cycle, sociology of the family, family phenomenology, contemporary families, family

wellness, families and culture, aging and family issues, family violence, and related family concerns” (CACREP Standards, 2009, p. 35).

The need for specialized training in the area of domestic violence is evident in the statistical data presented: “Considerable research on battered women has been conducted over the past two decades. Both the 1980 and 1985 National Family Violence Surveys revealed approximately 12% of women in the United States are physically abused by their husbands or partners annually” (Straus et al., 1980; Straus & Gelles, 1990, as cited in O’Keefe, 1997, pp.1-2). According to Stalans and Lurigio (1995), “about 1.8 million women experience at least one of the more serious forms of violence, such as being kicked, punched, choked, or attacked with a weapon” (p.387).

Victims are seeking out mental health professionals to assist them in coping with their trauma. It was reported in one study that 60% of domestic violence victims sought assistance from mental health professionals, whereas 20% sought assistance from law enforcement, clergy, physicians, and crisis centers (Campbell, Raja, & Grining, 1999). Also in this study conducted by Campbell, Raja, and Grining (1999), it was found that 14% of mental health professionals had no formal training in the area of domestic violence. Additionally, of those 14% of mental health professionals with no formal training, 48% had actually treated domestic violence survivors (Campbell et al., 1999).

Mental health professionals need to be knowledgeable about theories of violent relationships, risk factors, assessment, interventions, and treatment approaches when working with survivors of relationship violence. In 1994 Walker stated that research was beginning to show how many women had been sexually and physically abused: “Victims can be expected to appear in the average therapist’s practice” (p. 4). As a result,

“virtually any mental health practitioner who works with women needs to have some understanding of the different forms of violence against women and the assessment and treatment effects of such violence” (Walker, 1994, p. 4). Goldner (1998) states:

violent men and battered women can present a paradoxical and confusing picture of their relationship. Extreme polarities like love and hate, remorse and cynicism, blame and over responsibility, are characteristic of their interactional process, and, as a result, these men and women often send contradictory messages to outsiders about the status of their relationship, about their goals for therapy, and about the need for social control. Thus it should not be surprising that professionals working with these clients tend to react to them in extremes. (pp. 263-264)

Furthermore, Margolis and Rungta (1986) state “a recurring theme in the literature is that counselors working with populations different from themselves experience discomfort and consequently are less effective than they would ordinarily be” (p. 642).

In addressing dual diagnosis, counselors in training need to be particularly aware of the impact of violence in relationships, in terms of the treatment of substance abuse:

“Counselors who provide services to women need to first screen all women for potential domestic violence” (Training Initiative, 2005, p. 3). “For those women who do screen positive for domestic violence, their treatment plan must include issues of safety for themselves and their children and treatment for trauma” (Training Initiative, 2005, p. 3).

Most graduate level programs for mental health professionals only provide a general overview for working with clients involved in violent relationships and usually in one course. Yet most mental health professionals begin their counseling career working with families, couples, and individuals facing issues of domestic violence. Mental health professionals in training need formal instruction on relationship violence to provide them with the essential foundation for working with this specialized population. In addition, they need experience working with clients’ experiencing

relationship violence in a face-to-face, supervised capacity. Without this specialized training, mental health professionals are more likely to respond to victims in a blaming or insensitive manner, resulting in further traumatization, also known as ‘secondary victimization’. Campbell, Raja, and Grining (1999) state that secondary victimization could be avoided by training mental health counselors on issues of violence in relationships.

### **Purpose and Significance of Study**

The purpose of this study was to examine the perceived level of competency in assessing and treating domestic violence of mental health professionals who are licensed in the state of Florida as clinical social workers, mental health counselors, or marriage and family therapists.

The United States government recognizes that domestic violence is a social problem. On January 5, 2006, the Violence Against Women Act of 2005 was signed into law by then President Bush, reauthorizing original legislation passed in 1994. This bill allocated monies in the amount of \$3.9 million to be spent on programs supporting victims of domestic violence and sexual assault (Harris & Musso, 2006). Victims of domestic violence seek treatment from mental health professionals, such as social workers, mental health counselors, and marriage and family therapists: “Of the estimated 5.3 million rapes, physical assaults, or stalking incidents by intimate partners each year, nearly 1.5 million result in some type of mental health counseling” (Centers for Disease Control and Prevention, 2003, p. 18). It would seem plausible that mental health professionals would benefit from preparation and training to work with victims and perpetrators of domestic violence. According to research conducted by Lee and Nichols (2010), recent trends show mental health professionals are not just working in

clinic settings. More often, mental health professionals are working with business institutions, hospitals, schools, and within the court system. As a result, mental health professionals are increasingly required to assess, treat, teach, and provide consultation in areas such as domestic violence (Lee and Nichols, 2010).

Education and training in the area of domestic violence is important and needed. According to the literature, the financial strain that domestic violence places on our society is significant. Recognizing the economic costs of domestic violence can underscore the need for programs for victims and families of domestic violence. The CDC (2003) estimated domestic violence costs the United States \$5.8 billion annually. According to the CDC (2003), "U.S. women lose nearly 8.0 million days of paid work each year because of violence perpetrated against them by current or former husbands, cohabitants, dates, and boyfriends, which is equivalent of 32,114 full-time jobs each year" (p. 19). Most of the costs of domestic violence were related to health care, due to victims being physically abused (CDC, 2003). Researching costs associated with domestic violence illustrates the prevalence of this problem to policy makers who are ultimately responsible for funding programs that assist victims of domestic violence.

In a research study conducted by Todahl, Linville, Chou, and Maher-Cosenza (2008), 2<sup>nd</sup> year masters-level graduate students in a COAMFTE-accredited family therapy training program reported struggling with and having concerns with screening for domestic violence during clinical encounters. Specifically, this study reported that these graduate students had a lack of confidence in conducting the actual screening for violence, as well as having a lack of confidence in how to assist a client if in fact domestic violence was reported. Further findings of this study found that these

graduate student participants reported personal reactions of feeling “stunned, depressed, overwhelmed, or inadequate” when conducting assessments for domestic violence (Todahl et al., 2008, p.38): “One participant described her personal reaction as inhibiting her ability to be an effective clinician” (Todahl et al., 2008, p. 38). Mental health professionals have a duty and responsibility to be competent when assessing and treating domestic violence. By examining Florida licensed mental health professionals’ current level of competence in assessing and treating domestic violence, this study hopes to provide a better understanding of the specific educational and training needs in the area of domestic violence.

What are the experts saying is needed in the area of domestic violence education and training? According to research conducted by Greene and Bogo (2002) “the history of family therapy is tarnished by our inability to detect and adequately respond to women who were being brutalized by their partners” (p. 464). Bograd and Mederos (1999) suggests “therapists should assume risk for domestic violence in all couples or families that present for therapy until it is ruled out” (p. 294). Bograd (1999) also argues that the literature on domestic violence is changing. She reflects on her own work and concludes, “I privileged the dimension of gender over others because it seemed to offer a parsimonious explanatory power and clinical direction. I believed that gender-sensitive models of domestic violence were universal” (Bograd, 1999, p. 276). More recently, however, Bograd (1999) has argued that family therapists and other mental health practitioners should absolutely consider the impact of class, race, gender, and sexual orientation as they relate to domestic violence. Furthermore, Bograd (1999) initially assumed that theories of domestic violence “unintentionally forced those whose

experiences differed from the mainstream to the margins” (pp. 279-280). Now Bograd (1999) suggests that family therapy practitioners and other mental health professionals must be free from “socially constructed stereotypes” of domestic violence (1999, p. 280). She contends that domestic violence is very complex and that mental health practitioners must consider the notion of intersectionality or the idea that factors affecting domestic violence are multidimensional. Race, class, gender, and sexual orientation influence how domestic violence is experienced by the individual (Bograd, 1999). “Intersectionalities color the meaning and nature of domestic violence” (Bograd, 1999, p. 276).

## **Theoretical Framework**

### **Critical Theory**

From a Critical Theory approach, the role of researcher is not neutral; the researcher’s values are known. The researcher’s goal is a call to action, motivating others to act. It is the belief of this researcher that one cannot remain neutral when conducting research. Our values influence how we make sense of the world around us. We construct our understanding of meaning and reason for why things happen: “Social values, struggles, and interests influence the questions, concepts, and strategies of education science” (Popkewitz, 1990, p. 50). As stated by Comstock (1982) “the function of critical social science is to increase the awareness of social actors of the contradictory conditions of action which are distorted or hidden by everyday understandings” (p. 371). “All men and women are potentially active agents in the construction of their social world and their personal lives: that they can be the subjects, rather than the objects of socio-historical processes” (Comstock, 1982, p. 371).

For these reasons, critical theory is the underlying theoretical framework guiding the research in this dissertation. From a critical theory approach, it is assumed that having active interaction with one's values and not remaining neutral, will ultimately promote change: "Rather than look for the universal and necessary features of social scientific knowledge, Critical theory has instead focused on the social relationships between inquirers and other actors in the social sciences" (Stanford Encyclopedia of Philosophy, 2005, p. 20). As stated by Popkewitz (1990), "Human possibility, it is believed, occurs through understanding how the boundaries and structures are formed through struggle rather than as given as an inevitable and unaltered present" (p. 49).

Values influence research: "Because humans are constructions, paradigms inevitably reflect the values of their human constructors. They enter into inquiry at choice points such as the problem selected for study, the paradigm within which to study it, the instruments and the analytic modes used, and the interpretations, conclusions, and recommendations made" (Guba, 1990, p. 23). Once individuals gain awareness, change can then occur: "The task of inquiry is, by definition, to raise people (the oppressed) to a level of true consciousness. Once they appreciate how oppressed they are, they can act to transform the world" (Guba, 1990, p. 24).

### **Jurgen Habermas**

Jurgen Habermas is considered to be one of the most significant philosophers of Critical Theory. He is thought to have bridged the gap between theory and practice, when applying a critical theory approach (Rediger, 1996). According to Rediger (1996), Habermas' "basic tenet is that human beings are unnecessarily oppressed by the hidden values of ideologies and can be freed from this oppression through self-reflection and action based on the realization of alternatives" (p. 128). An important

competence for mental health professionals to have is an awareness of his or her own values and also, an awareness of how those values play a part in the therapy services they provide. Mental health professionals must be conscious of how their approach or philosophy of helping others is influenced greatly by their own views and how they make sense of the world.

According to Rediger (1996), mental health professionals engaged in family therapy have similar goals as critical theorists, that is, therapy is about change: “One way to conceptualize change is as a movement from constricting individual and relational life experience to an experience that is free from oppressive constraints. The change family therapy seeks is emancipatory” (p. 127). As with working with domestic violence, mental health professionals are working with victims to free them from their batterer’s control. Habermas’ notion of emancipation clearly speaks to the social issue of domestic violence and how the mental health professional may work with a victim toward reaching emancipation. In empowering the victim of domestic violence to recognize patterns of abusive behavior, “Habermas holds that the method of self-reflection is the key to the healing of the social sciences and the way to progress out of the regression that has followed positivism” (Rediger, 1996, p. 130). Habermas believes “it is only through methodology’s own self-reflective process that the rational project of human beings can be furthered” (Rediger, 1996, p. 129).

### **Donald E. Comstock**

According to Comstock (1982), “The function of a critical social science is to increase the awareness of social actors of the contradictory conditions of action which are distorted or hidden by everyday understandings” (p. 371). From a critical approach, it is believed that all individuals construct their social realities (Comstock, 1982).

Individuals in society act as subjects in the construction of their realities and not as objects (Comstock, 1982). From a critical approach, society is viewed as “a human construction which is altered through people’s progressive understanding of historically specific processes and structures” (Comstock, 1982, p. 372). Critical theorists look at human action: “Since humans are self-defining agents who reflect on and interpret their actions, and since all fundamental social change is the product of innovation in both meanings and social practices, future conditions and regularities are not predetermined” (Comstock, 1982, p. 375). Comstock also states “Critical social science sees society as humanly constructed and, in turn, human nature as a collective self-construction” (p. 375). According to Comstock (1982), the purpose of critical research is to promote action by “providing adequate knowledge of the historical development of social conditions and meanings and a vision of a desirable and possible future” (p. 386). With that focus in mind, this study can serve as a starting point in the assessment of practitioners’ own views of personal preparedness and competence in assessing and treating clients dealing with domestic violence. In other words, findings should point to suggestions for future planning in the training and supervision of clinical social workers, marriage and family therapists, and mental health counselors (in the state of Florida).

## **Domestic Violence**

### **Michele Bograd**

Bograd (1988) refers to domestic violence as wife abuse, in which a man uses physical force against a woman. As in critical research, Bograd (1988) defines wife abuse “as a pattern that becomes understandable only through examination of the social context” (p. 14). Bograd also states, “As feminists, we believe that the social institutions of marriage and family are special contexts that may promote, maintain, and

even support men's use of physical force against women" (p. 12). Bograd (1988) argues that feminists seek to find answers to wife abuse more so on a global level and not individual. They are not so much interested in why a particular man physically abused his wife, but rather why men, in general, in our society use physical force and power to control women: "Wife abuse is not a private matter, but a social one" (Bograd, 1988, pg. 15).

However, Bograd's more recent work illustrates a change in perspective. Bograd (1999) recognizes that domestic violence cannot be viewed only from a feminist lens; there are other factors like race, class, sexual orientation, as well as gender, that influence how we understand domestic violence. She recommends that "therapists should assume risk for domestic violence in all couples or families that present for therapy until it is ruled out" (Bograd & Mederos, 1999, pp. 293-294). She considers couples treatment as a viable approach for treating domestic violence. There are certain criteria that must be met in order for couples therapy to be considered an appropriate treatment modality for domestic violence such as spouses must freely agree to therapy; the man's violence must be considered minor, not resulting in injury and be infrequent; the man's psychological abuse of the woman must also be infrequent and not severe; there must not be a risk of escalated violence from the man; the woman cannot be afraid of escalated violence; and lastly, the man must take responsibility for his abusive behaviors (Bograd & Mederos, 1999).

### **Virginia Goldner**

Goldner, along with her colleagues at the Ackerman Institute, argue that it is helpful to "understand male violence as simultaneously an instrumental and expressive act. Its instrumentality rests on the fact that it is a powerful method of social control, a

strategy that a man consciously chooses. At another level of violence can be understood as an impulsive, expressive act. Male violence represents a conscious strategy of control and a frightening disorienting loss of control” (Goldner, Penn, Sheinberg & Walker, 1990, p. 346).

Goldner’s approach to domestic violence is to treat the couple together: “We do believe that couples therapy, grounded in feminist concerns for justice and safety, should be a credible treatment option when violence is the presenting problem” (Goldner, 1998, pp. 264-265). Goldner (1998) argues that “the currently dominant approach, gender-specific group treatment for offenders has not been shown empirically to be safe or more effective than other methods, including couples treatment that focuses on violence-reduction” (p. 265). Goldner (1998) also supports the idea of the therapist both maintaining a neutral stance in couples therapy, as well as acting as an advocate for the victim of domestic violence. She suggests maintaining this neutral stance by allowing the victim to speak truthfully about the violence relationship. At the same time, the therapist should also recognize the perpetrator as the offender and possibly a past victim in which has yet been disclosed. The role of the therapist is to make the couple client feel comfortable to talk about the abuse, past and present.

### **Richard Gelles and Murray Straus**

As a point of contrast, Richard Gelles and Murray Straus are discussed in this chapter. The research of Gelles and Straus is considered classic and landmark in terms of their contributions in the area of domestic violence research. For these reasons, discussion of their research findings are presented in this dissertation. Gelles and Straus are sociologists that believe social structural factors lead to domestic violence (Bograd, 1988). They stated, “We believe that violence in the family is more a

social problem than a psychological problem” (Straus, Gelles & Steinmetz, 1980, p. 202). Gender-neutral terms are used to describe domestic violence. Straus et al. (1980) refer to domestic violence as “abusive violence”, that is, “an act which has the high potential for injuring the person being hit” (p. 22). They too believe that domestic violence does not discriminate, that abuse is found at every socioeconomic level (Straus, Gelles, & Steinmetz, 1980). As sociologists, Straus and Gelles believe that violence is a learned behavior, that “the majority of today’s violent couples are those who were brought up by parents violent towards each other” (Straus et al., 1980, p. 100). As a result of their many studies, Straus et al. (1980) concluded that violence is used as a means of control.

### **Neil Jacobson and John Gottman**

Another point of contrast is the work conducted by Neil Jacobson and John Gottman. Jacobson and Gottman (1998) reported on their study of 201 couples involved in violent marriages. They found unexpected results regarding how batterers responded to the violence in their marriage. From their study, batterers were categorized as either ‘Type I’ or ‘Type II’. Type I batterers were described as being antisocial, sadistic, manipulative and emotionally independent (Jacobson & Gottman, 1998). Type II batterers were described as being insecure, jealous, emotionally dependent and fearful of being alone or abandoned by their partner (Jacobson & Gottman, 1998). Their research looked to develop a typology for perpetrators of domestic violence (Jacobson & Gottman, 1998). Jacobson and Gottman argue that “until marital interactions of batterers and their partners are better understood, one can only speculate about how violence unfolds in these relationships, the function that violence serves, or the communication patterns associated with violence” (Jacobson,

Gottman, Walkz, Rushe, Babcock, and Holtzworth-Munroe, 1994, p. 982).

Implications of their study findings suggest that mental health professionals should take into account these typologies when treating perpetrators of domestic violence (Jacobson & Gottman, 1998).

### **Research Question**

How do licensed Clinical Social Workers, Mental Health Counselors, and Marriage and Family Therapists in the state of Florida perceive their level of competence in assessing and treating domestic violence?

### **Quantitative Methodology and Critical Research**

Quantitative methodology has its place in critical research. Even those who often criticize quantitative methods, also recognize their value. Feminist researcher Kersti Yllo discusses the value of quantitative research, specifically work conducted by social science researchers: "Statistical data generated by the Conflict Tactics Scale, developed by Murray Straus and his colleagues, and now widely used, are taken most seriously" (Yllo & Bograd, 1988, p. 40).

Survey methodology was chosen for this research study because survey results can gather a significant amount of information in a relatively short period of time. This research study provided information on mental health professionals' perceived level of competency in assessing and treating domestic violence. The findings of this research study can provide a foundation for additional qualitative research. Further qualitative research may provide a more fruitful response in terms of what is needed in the area of assessing and treating domestic violence.

Survey methodology remains a viable way to conduct research from a critical theory approach. Survey methods allow the researcher to collect data in a sound and

efficient manner in which results can be applied to larger populations. For these reasons, survey methodology was utilized in an E-mail delivery format: "Email has become the standard method for communicating in most work organizations and for many individuals" (Dillman, Smyth, & Christain, 2009, p. 9). According to Dillman et al., most people prefer to respond via E-mail, and for the most part E-mail has replaced standard mail. Even when telephone messages are left for individuals, most respond back with an E-mail. Internet surveys are cost effective, that is, no postage has to be paid, no copies made or paper supplies or ink cartridges refilled and lastly, responses to survey require less field time (Dillman et al., 2009). However, researchers using E-mail survey methods should keep in mind that "in order for web surveys to be scientifically sound as a basis for generalizing results to a larger population, all members of a carefully defined population need to be given a known chance of being selected to participate" (Dillman, Tortora, Conradt, & Bowker, 1998). In sum, "the characteristics of millions of people can be estimated with confidence by collecting information from only a few hundred or thousand respondents" (Dillman, et al., 2009, p. 1).

### **Definition of Terms**

To even attempt to define domestic violence is complicated. Just referring to the act of violence as 'domestic violence' carries with it bias that others may criticize.

There are a variety of terms used to describe how one person can hurt another. For the purpose of this research study the term 'domestic violence' will be used. On the surface this term may seem to describe the same thing; however there are variations in meaning worthy of identifying. For clarification purposes, variations of meaning will be discussed in this study. It should be noted that theorists, researchers, and practitioners do not agree on how domestic violence is defined. Some believe a particular definition

is too broad, others, too narrow. Some may define certain experiences of violence differently. The following is an attempt to discuss how the legal system in the state of Florida as well as theorists, researchers, and practitioners define domestic violence.

**Domestic Violence:** According to the 2009 Florida state statute, Chapter 741.28, domestic violence is defined as “any assault, aggravated assault, battery, aggravated battery, sexual assault, sexual battery, stalking, aggravated stalking, kidnapping, false imprisonment, or any criminal offense resulting in physical injury or death of one family or household member by another family or household member”

(<http://www.leg.state.fl.us>, retrieved 12/13/2009).

McKenzie (1995) defines domestic violence encompassing “emotional abuse and physical attacks within the family context. Thus, domestic violence affects the entire family constellation including children, parents, grandparents, extended kin of all ages groups, and other persons anchored within the family network, who may not be related by blood or marriage” (p. 8). McKenzie also states, “Spousal battery is a choice men exercise intentionally and purposefully to resolve conflict and achieve their goals of dominance, and coercive control of women” (p. 8).

According to Lenore Walker (1979), “the slow emotional torture which produces invisible scars is as abusive as the quick, sharp physical blows” (p. 72). Domestic violence is physical assaults, sexual assaults, social isolation, humiliation, economic deprivation, and controlling behavior (Walker, 1979). Walker (1979) also describes domestic violence as occurring in cycles. These cycles of violence “explain how battered women become victimized, how they fall into learned helplessness behavior, and why they do not attempt to escape” (Walker, 1979, p. 55).

From a feminist perspective, Bograd (1988) defines domestic violence, or what is referred to as 'wife abuse' as "the use of physical force by a man against his intimate cohabiting partner"(p. 12). Bograd states, "This force can range from pushes and slaps to coerced sex to assaults with deadly weapons. Although many women suffer psychological abuse from their partners, we focus primarily on physical abuse" (Bograd, 1988, p. 12).

Straus, Gelles, and Steinmetz (1980) describe domestic violence as 'abusive violence': "Abusive violence is an act which has the high potential for injuring the person being hit, acts where people punched, kicked, or bit a family member, hit the person with a hard object, "beat up" another person, or shot, or tried to shoot, stabbed, or tried to stab, another family member" (Straus, Gelles, & Steinmetz, 1980, p. 22).

For the purposes of this study, the following definition of domestic violence will be used. Domestic violence is the physical, psychological, or sexual abuse of one family or household member by another family or household member. Physical abuse includes, but is not limited to, hitting, slapping, kicking, punching, with or without a weapon, which causes pain or injury. Psychological abuse includes, but is not limited to, stalking, humiliation, verbal abuse, false imprisonment, social isolation, economic deprivation, or any other controlling type behavior. Sexual abuse includes, but is not limited to, any unwanted, coerced, forced, or threat of forced sexual acts or attempted sexual acts.

### **Accrediting Bodies**

#### **Council on Social Work Education (CSWE)**

This organization, the Council on Social Work Education, is a nonprofit national organization which regulates graduate and undergraduate level programs of social work. The CSWE uses the Educational Policy and the Accreditation Standards (EPAS)

for the accreditation of social work programs and was founded in 1952. Currently there are 470 accredited bachelor level programs and 195 accredited master's level programs (<http://www.CSWE.org/CSWE>, retrieved 05/28/2008).

### **Council for Accreditation of Counseling and Related Education Programs (CACREP)**

CACREP, which refers to the Council for Accreditation of Counseling and Related Educational Programs, was established in 1981 (Adams, 2005). CACREP is the accrediting body which develops procedures and guidelines for educational programs in the counseling field for both master's, as well as doctoral level, studies. CACREP's mission is to "promote the professional competence of counseling and related practitioners through the development of preparation standards, the encouragement of excellence in program development and the accreditation of professional preparation programs" ([www.cacrep.org/misison.html](http://www.cacrep.org/misison.html), 3rd paragraph, retrieved 05/28/2008).

Currently, there are 62 accredited master's level programs in mental health counseling.

### **Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE)**

COAMFTE, which refers to the Commission on Accreditation for Marriage and Family Therapy Education, was established in 1978. This accrediting body regulates master's level, doctoral level, and postgraduate level programs in the area of marriage and family therapy. According to COAMFTE, "specialized accreditation of marriage and family therapy programs is a public service that aims to encourage programs to continue their own self-study and development and indicate that programs are meeting established standards and their own stated objectives" ([www.aamft.org/about/comafte](http://www.aamft.org/about/comafte), 3<sup>rd</sup> paragraph, retrieved 05/28/2008).

## **Licensing Board**

In the state of Florida, one board regulates licensing for mental health professionals under Chapter 491.004 of the Florida Statutes and under Rule 64B4 of the Florida Administrative Code. The Board of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling regulate these three disciplines in Florida.

### **Licensed Clinical Social Worker**

According to 2009 Florida Statute, Chapter 491.004, the practice of clinical work is defined as:

The use of scientific and applied knowledge, theories, and methods for the purpose of describing, preventing, evaluating, and treating individual, couple, marital, family, or group behavior, based on the person-in-situation perspective of psychosocial development, normal and abnormal behavior, psychopathology, unconscious motivation, interpersonal relationships, environmental stress, differential assessment, differential planning, and data gathering. The purpose of such services is the prevention and treatment of undesired behavior and enhancement of mental health. The practice of clinical social work includes methods of a psychological nature used to evaluate, assess, diagnose, treat, and prevent emotional and mental disorders and dysfunctions (whether cognitive, affective, or behavioral), sexual dysfunction, behavioral disorders, alcoholism, and substance abuse. The practice of clinical social work includes, but is not limited to, psychotherapy, hypnotherapy, and sex therapy. The practice of clinical social work also includes counseling, behavior modification, consultation, client-centered advocacy, crisis intervention, and the provision of needed information and education to clients, when using methods of a psychological nature to evaluate, assess,

diagnose, treat, and prevent emotional and mental disorders and dysfunctions (whether cognitive, affective, or behavioral), sexual dysfunction, behavioral disorders, alcoholism, or substance abuse. The practice of clinical social work may also include clinical research into more effective psychotherapeutic modalities for the treatment and prevention of such conditions ([www.leg.state.fl.us](http://www.leg.state.fl.us), retrieved 11/03/2009).

### **Licensed Mental Health Counselor**

According to 2009 Florida Statute, Chapter 491.004, the practice of mental health counseling is defined as:

The use of scientific and applied behavioral science theories, methods, and techniques for the purpose of describing, preventing, and treating undesired behavior and enhancing mental health and human development and is based on the person-in-situation perspectives derived from research and theory in personality, family, group, and organizational dynamics and development, career planning, cultural diversity, human growth and development, human sexuality, normal and abnormal behavior, psychopathology, psychotherapy, and rehabilitation. The practice of mental health counseling includes methods of a psychological nature used to evaluate, assess, diagnose, and treat emotional and mental dysfunctions or disorders (whether cognitive, affective, or behavioral), behavioral disorders, interpersonal relationships, sexual dysfunction, alcoholism, and substance abuse. The practice of mental health counseling includes, but is not limited to, psychotherapy, hypnotherapy, and sex therapy. The practice of mental health counseling also includes counseling, behavior modification, consultation, client-centered advocacy, crisis intervention, and the provision of needed information and education to clients, when using methods of a psychological nature to evaluate, assess, diagnose, treat, and prevent emotional and mental disorders and

dysfunctions (whether cognitive, affective, or behavioral), behavioral disorders, sexual dysfunction, alcoholism, or substance abuse. The practice of mental health counseling may also include clinical research into more effective psychotherapeutic modalities for the treatment and prevention of such conditions ([www.leg.state.fl.us](http://www.leg.state.fl.us), retrieved 11/03/2009).

### **Licensed Marriage and Family Therapist**

According to 2009 Florida Statute, Chapter 491.004, the practice of marriage and family therapy is defined as:

The use of scientific and applied marriage and family theories, methods, and procedures for the purpose of describing, evaluating, and modifying marital, family, and individual behavior, within the context of marital and family systems, including the context of marital formation and dissolution, and is based on marriage and family systems theory, marriage and family development, human development, normal and abnormal behavior, psychopathology, human sexuality, psychotherapeutic and marriage and family therapy theories and techniques. The practice of marriage and family therapy includes methods of a psychological nature used to evaluate, assess, diagnose, treat, and prevent emotional and mental disorders or dysfunctions (whether cognitive, affective, or behavioral), sexual dysfunction, behavioral disorders, alcoholism, and substance abuse. The practice of marriage and family therapy includes, but is not limited to, marriage and family therapy, psychotherapy, including behavioral family therapy, hypnotherapy, and sex therapy. The practice of marriage and family therapy also includes counseling, behavior modification, consultation, client-centered advocacy, crisis intervention, and the provision of needed information and education to clients, when using methods of a psychological nature to evaluate, assess, diagnose, treat, and

prevent emotional and mental disorders and dysfunctions (whether cognitive, affective, or behavioral), sexual dysfunction, behavioral disorders, alcoholism, or substance abuse. The practice of marriage and family therapy may also include clinical research into more effective psychotherapeutic modalities for the treatment and prevention of such conditions ([www.leg.state.fl.us](http://www.leg.state.fl.us), retrieved 11/03/2009).

### **Graduate Training-Clinical Hours**

#### **Clinical Social Work**

According to the Council of Social Work Education (2001), “the purpose of the social work profession is to promote human and community well-being” (p. 1). Social workers take a global approach to their work of social and economic justice, seeking equality for all. Educational requirements for a degree in social work are a minimum of 400 hours of education for bachelors degree and 900 hours of education for master’s (Council on Social Work Education, 2001, Education Policy and Accreditation Standards).

#### **Mental Health Counseling**

Current education requirements for a master’s degree in clinical mental health counseling are a minimum of 54 semester hours in the program. Students are required to have practicum experiences, with a minimum of 100 clock hours, and an internship experience, with a minimum of 600 clock hours. Also, mental health counselors are required to obtain two years postmaster’s supervised clinical experience. Education requirements for doctoral degrees require a minimum of 96 semester hours in the program and a minimum of 600 clock hours of doctoral level counseling internships (Council for Accreditation of Counseling and Related Educational Programs, 2009, Standards).

## **Marriage and Family Therapy**

Marriage and family therapists are “mental health professionals trained in psychotherapy and family systems, and licensed to diagnose and treat mental and emotional disorders within the context of marriage, couples and family systems ([www.aamft.org/faqs](http://www.aamft.org/faqs), retrieved 05/28/2008). Education requirements for a master’s degree in marriage and family therapy require:

A minimum of 72 semester hours in the program which also requires a minimum of 500 clock hours of internship, of which 250 hours must be with couples or families present in the therapy room. They must also have 100 hours of face-to-face supervision. Also, required for licensure are two years of post-master’s supervised clinical experience. On the doctoral level, students must complete a minimum of 1,000 hours of direct client contact.

### **Organization of Study**

In the following chapters, this research study is discussed in detail. Chapter one provides an overview of what will be studied and its purpose. Significant terms are defined. Theoretical frameworks are discussed and overall argument of why this researcher should evaluate Florida licensed mental health professionals’ perceived level of competence in assessing and treating domestic violence. Chapter Two contains a review of relevant literature related to the social issue of domestic violence. The prevalence of domestic violence is discussed. Also in this chapter, experts in the field of assessing and treating domestic violence are presented in terms of current training and what is needed for future training. Chapter Three presents the methodology used in this research study, to include relevant variables, population, instrumentation, data collection, data analysis, and argument for using quantitative methodology with a critical

approach to research. Chapter Four examines the results of data collected. And finally, Chapter Five includes discussion of the results of this research study as well as conclusions. Methodological limitations are presented in Chapter Five, as well as implications and recommendations for future research.

## CHAPTER 2 REVIEW OF LITERATURE

### **Overview**

Violent relationships are unique in terms of the dynamics, power inequities, and the role of gender. Because of the prevalence of relationship violence in United States, most mental health professionals will have contact with survivors of domestic violence at some point in time in their career (Campbell, Raja, & Grining, 1999, p.1010). How are mental health graduate programs preparing professionals to work with this special population? In a study conducted by Campbell, Raja, and Grining (1999) results found that mental health professionals did not receive training on domestic violence in graduate school but rather postgraduate, in which they sought elective training on their own. Campbell et al. (1999) question whether therapists are receiving adequate training to address the needs of victims of domestic violence.

What defines domestic violence? There are many definitions which constitute violence and are at times, conflicting. According to Gordon (2000), “many advocates and scholars conceptualize domestic violence as an array of physical, and verbal acts used to achieve domination and control over an intimate partner and argue that the proper referent for domestic violence directed at women should not be episodes of specific acts of physical, psychological, and sexual violence but, rather, a pattern of behavior and experiences of violence and abuse within a relationship” (p. 747). The criminal justice system tends to define relationship violence in terms of physical acts, like hitting, kicking and pushing. Research has broadened this definition to include psychological, sociological, as well as economic perspectives, when defining violence. As cited in Gordon (2000), landmark studies conducted by Murray Straus, Richard

Gelles, and Lenore Walker “have paid careful attention to measurement and sampling issues to obtain generalizable results on domestic violence” (p. 748). Researchers now recognize that domestic violence is not one dimensional: “A growing number of researchers and government agencies contend that violence against women is multidimensional in nature and that definitions and research should recognize that many women’s lives rest on a continuum of unsafety” (Stanko, 1990 as cited in Dekeseredy, 2000, p. 729). This continuum involves not just the physical aspects of violence, but the psychological or emotional aspects as well, which can be just as painful (Dekeseredy, 2000). Consequently, “there is no consensus among researchers or practitioners as to how broad or narrow the definition of violence should be or as to how to define the specific components of any definition (e.g., violence, neglect, rape, or psychological abuse)” (Gelles, 2000, p. 786).

### **Prevalence of Domestic Violence**

People in all walks of life can be victims of domestic violence or harassment, abuse, or life endangering situations. It occurs in all socioeconomic groups and across all cultural groups. In a study conducted by Silverman, Raj, Mucci, and Hathaway (2001), “approximately 1 in 5 adolescent girls (18%-20%) reported being physically and/or sexually hurt by a dating partner” (pp. 576-577). In another study, researchers found violence to be “the leading cause of injury to women ages 15 through 44 years” (Novello, Rosenberg, Saltzman & Shosky, 1992, p. 3132). Furthermore, married women were found to be at great risk for being victims of domestic violence: “Each year 1.6 million wives in the United States are severely assaulted by their husbands and about 13% of all murders are husband killing their wives (Straus & Gelles, 1986; Ohrenstien, 1977, as cited in Gottman, Jacobson, Rushe, Shortt, Babcock, La Taillade & Waltz,

1995, p. 227). According to the Bureau of Justice Statistics (2005), “about seven in ten female rape or sexual assault victims stated the offender was an intimate, other relative, a friend or an acquaintance”.

Mental health professionals seek continuing education and post graduate training to improve their knowledge and skills in the area of domestic violence. Wingfield and Blocker (1998) state, “Academician awareness needs to be heightened for adding domestic violence interventions course work into existing curriculums” (p. 92). Through workshops, externships, certificate programs, and institutes specializing in educating professionals in the area of domestic violence, mental health professionals seem to be seeking knowledge and practice outside of traditional academic graduate schools.

### **Conceptualization of Domestic Violence**

#### **Michele Bograd**

Saunders (1988) states, “A key element of feminist theories of woman abuse is that men use physical violence to maintain male dominance in the family” (p, 90). From a feminist perspective, domestic violence is referred to as wife abuse and defined as “the use of physical force by a man against his intimate cohabitating partner” (Bograd, 1988, p. 12). The focus is primarily on the physical abuse and not as much on the psychological abuse. Reasons for referring to domestic violence as ‘wife abuse’ is because feminists feel “generic terms ignore the context of the violence, its nature, and consequences, the role obligations of each family member and the different mechanisms or transactional sequences that lead to various forms of abuse” (Bograd, 1988, p. 13). Feminist theorists tend to focus more broadly in terms of answering the question, why did that man beat his wife? Feminist are more concerned with “why do men in general use physical force against their partners and what functions this serves

for a given society in a specific historical context”(Bograd, 1988, p. 13). From a feminist perspective, men in the United States oppress women in many social positions, however, the use of physical violence to control women is the most overt means in doing so.

Like critical theorists, feminist theorists argue that one cannot be value free when conducting research. From a feminist perspective, “there is no such thing as true neutrality in social science, since we can never function completely independently of dominant ideologies and belief systems” (Bograd, 1988, pp. 20-21). Actually, feminists encourage women researchers to examine their values and speak out about their experiences from their own perspective. Bograd (1988) states, “Feminists suggest that it is crucial that researchers make explicit the values that guide their work” (p. 21).

Earlier work by Bograd (1999) focused on informing others of the prevalence of domestic violence. Bograd examined domestic violence through a feminist lens in which she believed that battered women were being implicated by the concepts, practices and interventions used by mental health professionals. Her later work discovered that there are other factors like race, socioeconomic status, and sexual orientation that play a part in conceptualizing domestic violence (Bograd, 1999). She stated, “We exist in social contexts created by the intersections of systems (e.g. race, class, gender, and sexual orientation) and oppression. Intersectionalities color the meaning and nature of domestic violence, how it is experienced by self and responded to by others, how personal and social consequences are represented, and how and whether escape and safety can be obtained” (p. 276). Therefore, according to Bograd (1999) theoretical conceptualizations and interventions of domestic violence must not

remain universal, a one-size-fits-all approach does not work. Not everyone experiences domestic violence in the same manner and as a result, theories and interventions should be sensitive to the social contexts that influence domestic violence (Bograd, 1999).

Bograd (1999) suggests that “domestic violence does not have a singular impact on families” (p. 283) and mental health professionals need to recognize that social contexts shape how people experience domestic violence. Bograd (1999) argues it is the responsibility of the mental health professional to incorporate the notion of intersectionalities into theory and practice: “It is incumbent upon those of us in the field who already have power and prestige to shoulder the responsibility of expanding our models, examining our practices, and giving voice to those who are silences among us” (p. 286).

Bograd (1999) identifies preconditions that need to be met in order to conduct an assessment of domestic violence, as well as treatment of domestic violence. Those preconditions are that “the man’s participation is voluntary, special agreements about confidentiality must be established, and an optimal therapeutic stance must be achieved” (Bograd, 1999, p. 294). During couples therapy, which is the mode in which Bograd suggests treatment of domestic violence, the therapist must be “frank and clear about the allocation of responsibility and the inappropriateness of abusive behavior regardless of circumstances” (p. 296). In couples therapy Bograd (1999) suggests the therapist maintain an “attitude of supportive skepticism that constantly questions the depth of the batterer’s resolve and realism” (p. 296). Both individual sessions, as well as couples sessions, should be employed when treating domestic violence, with the first

session being a couples interview (Bograd, 1999). In addition, Bograd recommends to treat the disclosure to domestic violence with care, as it may not be disclosed in the initial couples session. According to Bograd, the therapist will have a better understanding and be more informed after the initial individual session regarding the potential existence of domestic violence. Furthermore, in order for couples therapy to be an effective mode of treatment for domestic violence, it is essential that both spouses “freely agree to couples counseling” (Bograd, 1999, p. 303).

### **Rhea Almeida**

Rhea Almeida examines domestic violence by utilizing a Cultural Context Model (Almeida & Durkin, 1999). Almeida defines culture as “the accumulation of social traditions and practices, as well as rich anthologies of art, music, dance, food, and language that are passed down through the generations to bind the interior of family life with different societies. Within the interior walls of all culture exist many oppressive practices that may appear to be necessary and fundamental to maintaining that particular culture” (Almeida & Durkin, 1999, p. 314). She argues that “culturally expanded definitions of both battered woman and batterer are necessary for ethical intervention” when treating domestic violence (Almeida & Durkin, 1999, p. 315).

The basic tenets of the Cultural Context Model include that “credibility begins in the therapeutic process with the victim’s personal narrative. This does not mean that the batterer provides his narrative in a similar fashion to ‘level the playing field’—his work is based on the victim’s experience of violence” (Almedia & Durkin, 1999, p. 316). In this model, a tenet is “for batterers, identifying and dismantling the structures of power and control that promote violence is a lifelong process—passing nonviolence on to the next generation through internalization” (Almeida & Durkin, 1999, p. 316).

Almeida agrees that assessment for domestic violence should be an “integral part of the screening process” in couples therapy (Almeida & Durkin, 1999, p. 318). In addition, similar to Bograd, Almeida suggests that the initial session should be conducted with the couple, followed by initial individual sessions: “This sequence offers the therapist the opportunity to obtain specific information regarding power and control dimensions and to screen for domestic violence without compromising the safety of the woman and/or entering into a power struggle with the man” (p. 317).

Almeida suggests that if domestic violence exists, prior to couples therapy, the batterer should participate in group therapy that emphasizes “accountability, socioeducation, and sponsorship” (Almeida & Durkin, 1999, p. 316). Almeida & Durkin (1999) suggest therapists should incorporate into the group therapy process, cultural accountability, intersectionality of gender, race, class, culture, and sexual orientation, as well as partnering batterers with men who support nonviolence in relationships. Batterers should participate in group therapy as well as victims, in a separate group therapy (Almeida & Durkin, 1999). In these group therapies, batterers are separated into socioeducational groups called “cultural circles” to “heighten their consciousness regarding sexism and other forms of privilege and oppression” (Almeida & Durkin, 1999, p. 319). As batterers gain awareness, they are filtered into the larger group, with multiple cultures and with continued support from their sponsor (Almeida & Durkin, 1999).

According to Almeida & Durkin (1999), once the batterer has successfully completed group therapy, couples therapy can then begin: “Couples treatment should

only occur with men who have been educated about, and made substantive changes in, their destructive forms of power and control over partners and children” (p. 32).

### **Virginia Goldner**

Like Bograd and Almeida, Goldner also employs couples therapy as a mode of treatment for domestic violence. According to Goldner (1998), there are conditions that must be present and met, most importantly, that the violence has stopped and that the man take full responsibility for the abuse in order for couples therapy to be utilized. Goldner (1998) merges both feminist and systemic approaches in treating the violence, which may seem contradictory and has received some criticism in the past. Goldner states, “Clearly, placing a violent man and his victim in close quarters and inviting them to address contentious issues in their relationship has the potential to revictimize the woman physically and psychologically and to provide the offender with a platform for self-justification. However, we do believe that couples therapy grounded in feminist concerns for justice and safety, should be a credible treatment option when violence is the presenting problem” (pp. 264-265). Goldner (1998) also argues that gender-specific group therapy has not proved to be any safer or more effective than couples therapy, in the treatment of domestic violence.

Goldner (1998) suggests that intense attachment keeps the violent couple together: “Both partners in these relationships know that the violence is a terrible thing, and that no one should stay in a relationship if they are harming another person or being harmed by them, however, this intense attachment compels them to stay engaged despite the risks, the shame and the destructiveness” (p. 265). Furthermore, Goldner (1998) argues that there is overwhelming evidence to show women who leave violent relationships are at greater risk of further violence than women who stay. She

supports her argument with a U.S. Justice Department Report (1994) that found women were six times more likely to be victims of violence if they left a violent relationship, than those that stayed in a violent relationship (Goldner, 1998).

Goldner (1998) employs couples therapy with multiple perspectives: intellectual, political and psychological. The goal of therapy according to Goldner (1998) is to “develop the most comprehensive understanding of abuse and victimization, without compromising a clear moral vision regarding issues of accountability, that is, without blaming the victim, shaming the victim, or allowing the perpetrator to misuse psychological insight to avoid taking responsibility for his actions” (p. 268). Goldner (1998) suggest the role of the therapist in couples therapy is both neutral and advocate, when treating domestic violence: “The art of multiplicity rests on the belief that it is not only possible, but also necessary, to carry both positions into the treatment situation so that their truths can play in counterpoint, each an implicit commentary on the other” (p. 269). According to Goldner (1998), violence is the presenting problem and primary focus of treatment, not other issues, in order to keep focus of responsibility on the perpetrator. However, Goldner’s approach to couples therapy does emphasize responsibility and accountability for both partners: “Women in these relationships must take some responsibility for protecting themselves” (p. 279).

One of Goldner’s colleagues from the Ackerman Institute for the Family, Gillian Walker, also takes a feminist perspective when conceptualizing domestic violence. She refers to domestic violence as ‘wife beating’ and identifies wife abuse as “an assault, not interaction gone wrong” (Walker, 1990, p. 48). Furthermore, she proposes that the violence is against the woman and not the family, that violence is a crime and men

should take full responsibility: “Men beat their wives because they are permitted to do so” (p. 48). Walker (1990) suggests that wife beating is a social issue and we are all responsible for making changes in the way society conceptualizes women: “The lack of protection given to an assaulted woman is an important part of that social permission: violent husbands quickly learn that they can get away with assaulting their wives” (p. 48). Wife beating is not a private matter, but rather a community matter, in which the community should join efforts to eliminate the violence (Walker, 1990).

Walker strongly supports the notion of referring to the violence as ‘wife beating’ and not ‘family violence’. She argues that referring to the violence as family violence or domestic violence takes the responsibility off the man and shifts the focus, “it’s a matter of how men treat women” (Walker, 1990, p. 65). Walker (1990) further argues that the violent acts of men, as well as the suffering of the women, are minimized when referring to the violence as family violence.

Walker made great efforts with the Canadian government to examine violence against women, with the support of the United Way (Walker, 1990). Results of her research found that attitudes of social service professionals toward wife beating, as well as those of the medical professionals, often times resulted in secondary victimization: “Traditional attitudes towards the privacy of the family and lack of formal training on the issue to family violence are named as the basis of the inadequacy of professional response from the medical, mental health, and social service systems” (p. 186).

### **Lenore Walker**

Lenore Walker (1979) defines domestic violence as physical abuse, sexual abuse, economic deprivation, social isolation, and humiliation. Walker presents the theory of learned helplessness as a way to explain domestic violence (Walker, 1979; Walker,

2000). She refers to learned helplessness as a psychological rationale that provides an explanation of “why the battered woman becomes a victim in the first place and how the process of victimization is perpetuated to the point of psychological paralysis” (Walker, 1979, p. 43). According to Walker (1979), the theory of learned helplessness has three components: what actually happens in a given situation, the thoughts or beliefs about what will happen, and the reaction to what really does happen. Walker states, “Once we believe we cannot control what happens to us, it is difficult to believe we can ever influence it, even [if] later we experience a favorable outcome” (p. 47). She continues to provide further explanation as to why women stay in violent relationships: “Once the women are operating from a belief of helplessness, the perception becomes reality and they become passive, submissive, helpless” (p. 47).

Walker (1979) proposes battering does not occur constantly but rather occurs in phases. She identifies three phases, (a) tension building stage, (b) the acute battering incident, and (c) kindness and contrite loving behavior. In phase one, there may be a few incidents of battering, in which the victim will do whatever necessary to prevent the batterer’s anger from escalating (Walker, 1979; Walker 2000). Walker stated, “During the initial stages of this first phase, they indeed do have some limited control” (Walker, 1979, p. 57). However there are often times external factors that “upset this delicate balance” result in increased and escalated tension (p. 58). Walker continues, “Once the point of inevitability is reached, the acute battering will take place” (p. 59). This is the shortest of the three phases and could last between two to twenty four hours, typically (Walker, 1979). The batterer’s anger is out of control as he beats his victim. According to Walker (1979), batterers do not accept responsibility for their abusive behavior and

typically blame excessive drinking or being overly stressed as reasons for the abusive behavior. Most women do not seek help during this phase, “they feel no one can protect them from their men’s violence” (Walker, 1979, p. 64). The last phase is characterized by the batterer being loving and caring toward the victim, according to Walker (1979). Usually the batterer feels sorry for his abusive behavior (Walker, 1979): “The batterer truly believes he will never hurt the woman he loves, he believes he can control himself from now on. He also believes he has taught her such a lesson that she will never again behave in such a manner, and so he will not be tempted to beat her” (pp. 65-66).

Walker argues that helping battered women should be a collaborative community effort. According to Walker (1979), it involves educating the public through a collaborative effort among law enforcement agencies, the court system, the correctional system, domestic violence shelters, mental health agencies and professionals, medical professionals, and hospitals.

### **Alan Jenkins**

Jenkins (1990) argues that most models for assessing and treating domestic violence strive to find a causal explanation for why the violence occurs, which he proposes, “promotes an avoidance of responsibility by the perpetrator and an acceptance of responsibility by the victim” (p. 13). Jenkins states, “Responsibility for the abuse may be attributed to external events and stresses, the actions of others or medical/psychological conditions, over which the perpetrator feels he has little influence or control” (Jenkins, 1990, p. 13). As a result, victims of domestic violence often feel responsible for the violence. By focusing on an explanation for the violence, it allows

the abuser to “be preoccupied with the search for a cause” and “generally do little to take responsibility for and cease their abusive behavior” (Jenkins, 1990, p. 3).

Jenkins (1990) advocates a narrative approach to conceptualizing domestic violence, focusing on developing new constructions to existing problems. He proposes employing the ‘theory of restraint’ (Jenkins, 1990): “This theory is based on the assumption that males will relate respectfully, sensitively and nonabusively with others, unless restrained from doing so” (p. 32). He defines these restraints as the “traditions, habits, and beliefs which influence the ways that abusive males make sense of and participate in the world” (p. 32). Jenkins (1990) further argues just because certain ‘restraints’ are present in a man’s life, does not necessarily mean he will act upon those habits or beliefs: “If he does abuse, however, there is potential for the development of restraining ideas which foster the attribution of responsibility for his actions to external factors” (p. 32).

In addition, Jenkins (1990) proposes that restraints are present within certain contexts: sociocultural, developmental, interactional, and individual. From a ‘theory of restraint’ perspective, Jenkins (1990) argues that “abuse and exploitation are perpetrated in a context where the man’s sense of entitlement overrides his sense of social-emotional responsibility in relation to others” (p. 56). Jenkins (1990) approaches treating abusive men with the notion that they “do not want to hurt or abuse others and that they do want caring and respectful relationships” (p. 57). By taking this approach, the therapist is able to stop searching for an explanation of the violence and ‘invite’ the abusive man to examine and challenge restraints. These restraints may range from “socio-cultural and developmental traditions and blueprints by which he may have been

unwittingly sucked in and patterns of interaction whereby he has relied on others to face social and emotional responsibilities and take responsibility for his abusive behavior, to restraining individual habits, beliefs and misguided attempts to deal with abuse” (Jenkins, 1990, p. 57).

### **Neil Jacobson and John Gottman**

Gottman and Jacobson were the first to study the “observational, psycho-physiological and self-report perspectives” in severely violent couples (Gottman, Jacobson, Rushe, Shortt, Babcock, La Taillade, & Waltz, 1995, p. 243). Jacobson and Gottman (1998) examined marital interactions of severely violent batterers and victims. They conducted a study that observed the actual violent arguments of the batterer and victim, and not just reports of the violent arguments, as well as observing the emotional experience during these arguments: “By directly observing arguments rather than simply asking people to report on them, we can verify the accuracy of their perceptions, and judge how trustworthy their accounts of violent altercations are” (p. 20). Couples were interviewed about the violence while being monitored with electronic sensors to evaluate their physiological response. Jacobson and Gottman found that batterers could be classified into typologies, Type I and Type II batterers (Jacobson & Gottman, 1998). The Type I batterer had a lowered heart rate as they became engaged in a violent argument, they were calm, “focusing their attention, while striking swiftly at their wives with vicious verbal aggression” (p. 29). Jacobson and Gottman (1998) referred to this type of batterer as a Cobra. The Type II batterer had an increased heart rate as they became engaged in a violent argument, “they exhibited anger as a kind of slow burn, gradually increasing it in a domineering and threatening fashion” (p.29). Type II batterer was referred to as a Pit Bull (Jacobson & Gottman, 1998). Furthermore, results

from their study characterize the Type I batterer as more belligerent and contemptuous than the Type II batterer (Gottman et al., 1995).

Jacobson and Gottman (1998) describe Type I batterers as antisocial, sadistic, manipulative, criminal and emotionally independent. They found Type I batterers to also be violent towards other people in their lives and not just their wives. Type II batterers they found to be insecure, often jealous, emotionally dependent, and more than likely, learned their violent behaviors from their fathers. Type II batterer's abuse was mostly toward their wives, not others and tended to dominate their wives for fear of being left alone and abandoned (Jacobson & Gottman, 1998).

Jacobson and Gottman evaluated what function violence serves in an abusive relationship (Jacobson, Gottman, Waltz, Rushe, Babcock, & Holtzworth-Munroe, 1994). Based on their research, Jacobson et al. speculate that violence is used by abusive men to control women and that violence used by women is used for self-defense (Jacobson et al., 1994). Specifically, these researchers examined the "affect, psychophysiology and verbal content of arguments in the arguments of couples with a violent husband" (Jacobson et al., 1994, p. 982). Through their research it was found that batterers use violence as a form of psychological and social control, to instill fear in their victims (Jacobson et al., 1994). In addition, it was found that women victims used violence as a self-defense response to their husband's violence (Jacobson et al., 1994). Furthermore, this study also found that abused wives were just as angry as their abusive husbands, but that they were also more sad, tense and fearful (Jacobson et al., 1994).

As a result of their studies, Jacobson and Gottman (1998) developed conclusions about abusive relationships. They found that not all batterers are alike, that battering is a choice and that women's violence is a response to the abuse from men and is a form of self-defense (Jacobson & Gottman, 1998). They also found that batterers were likely to have substance abuse problems (Jacobson and Gottman, 1998). Through their research, Jacobson and Gottman (1998) believed that legal sanctions should be imposed on batterers, as well as treatment interventions. And most importantly, Jacobson and Gottman (1998) felt that men who accepted responsibility for their abusive behavior must genuinely feel responsible, in order for the abuse to truly end.

### **Richard Gelles and Murray Straus**

Gelles (1993) proposes that a comprehensive approach to explaining domestic violence must "consider the attributes of the family as a social institution" (p. 31). Attributes like age, sex, social structure position, race, and ethnicity all affect people and their behavior, according to Gelles. Through his studies, Gelles implies that domestic violence is a "phenomenon of youth and highest for those between the ages of 18-30 years old" (Gelles, 1993, p. 31). Gelles (1993) also suggests that men are typically the offenders of domestic violence and women, the victims. He further argues that those in lower socioeconomic classes are under more stress and as a result, resort to violence more often (Gelles, 1993). Gelles (1993) further suggests that minorities experience a higher rate of domestic violence.

Gelles and Straus conducted two landmark studies in the area of domestic violence by utilizing the Conflict Tactics Scales (CTS), which was designed to measure conflicts among family members (Straus & Gelles, 1986). Again, because of their significant contribution in the field of domestic violence research, results of their

research is presented in this chapter. The CTS examines reasoning, verbal aggression, and physical aggression or violence (Straus, 1990a). The first study was conducted in 1975 and noted as the “earliest attempt to measure the incidence of violence in America” (Straus, 1990a, p. 3). The second study was conducted in 1985 and provided researchers with the ability to “move beyond the ‘individual pathology’ model of family violence and to investigate underlying social causes” (Straus, 1990a, p. 3). Based on their studies, Gelles and Straus found that domestic violence was a result of the American culture and the notion of male dominance in our society as well as in our families (Straus, 1990a, p.7): “We believe that violence in the family is more a social problem than a psychological problem” (Straus, Gelles, & Steinmetz, 1980, p. 202).

Gelles and Straus define violence as “an act carried out with the intention or perceived intention of physically hurting another person. The ‘hurt’ can range from the slight pain caused by a slap or a spanking to harm that results in severe injury or even death” (Gelles, 1990, p. 21). However, Gelles (1990) agrees there is a lack of continuity when defining domestic violence, and often times, terms are used interchangeably and may not always have the same meaning to all: “The field of family violence must continue to improve upon the definitions of abuse, violence, and the family. Until such time as the majority of investigators are employing similar definitions for the central concepts in the field, confusion and contradiction will dominate the study of family violence” (p. 28).

Straus (1990b) discusses possible causes of domestic violence and suggests a link between stress and family violence. He suggests that the family “tends to be a group with an inherently high level of conflict and stress” (p. 182). Furthermore, Straus

(1990b) proposes that violence is just one of the possible responses to stress. Based on his studies, Straus (1990b) concluded that fathers who physically punish and hit their children, teach their children to respond to stress by using violence; that physical violence is an appropriate behavior when responding to their wife or child; that men are more likely to be violent if they do not value their marriage; that education is not directly related to stress and violence, however, low socioeconomic status could be related because it is viewed as being more stressful; and men who have dominant roles in their marriage are more violent than men who have more equal roles in their marriage; and lastly, men who were socially isolated were more violent than men who were connected with social networks.

In research conducted by Straus, Gelles and Steinmetz (1980) it was found that violence is used by one family member to control another family member's behavior. They found that wife beating occurred more in families in which men were dominant in the marriage (Straus et al., 1980): "It seems that violence is used by the most powerful family member as a means of legitimizing his or her dominant position" (p. 193).

## **Treatment Recommendations for Domestic Violence and Implications for Training Mental Health Professionals**

### **Introduction**

What are the experts in the field recommending to mental health professionals as appropriate and effective treatment interventions for domestic violence? Well, it seems as though most experts vary in terms of recommended treatment interventions for domestic violence. In addition, most experts have difficulty agreeing on what intervention is most appropriate and effective in treating domestic violence

appropriately. Various treatment approaches will be presented and discussed in this chapter.

### **Virgina Goldner**

Goldner has conducted most of her work at the Ackerman Institute for the Family in New York City. This institute provides couples and family therapy, as well as training for mental health professionals. At the Ackerman Institute, the goal of therapy is to “harness and strengthen family resources, and help family members work collaboratively towards solutions to their problems”

(<http://www.ackerman.org/treatment>). While at the Ackerman Institute, Goldner conducted the Gender and Violence Project, over a 12 year period (Goldner, 1999). The goal of this project involved “conceptualizing and treating domestic violence within a feminist-informed, conjoint framework” (Goldner, 1999, p. 325). Goldner (1999) argues that psychotherapy, specifically couples therapy is the appropriate treatment for domestic violence and not criminal sanctions or punishment. In addition, Goldner (1999) argues that mental health professionals should take a “neutral stance toward both partners, since both are struggling with an overwhelming emotional process” (p. 325). Goldner (1999) further suggests that mental health professionals who focus on just power and inequality in treatment miss “crucial elements of the relational bond” (p. 326). Goldner (1999) proposes that no singular paradigm has offered effective and appropriate conceptualization and treatment of domestic violence.

Goldner (1999) recommends mental health professionals approach treating domestic violence from multiple perspectives: “The clinical challenge is to develop a language that can contain these multiple perspectives, or that can speak to the psychological aspects of moral conflicts and the moral aspects of psychological

conflicts” (p. 328). She continues, “The challenge is to bring these multiple discourses into dialogue” (p. 329). By employing multiplicity, the mental health professional can incorporate multiple perspectives at once while retaining each perspectives’ unique characteristics (Goldner, 1999). As a particular perspective “begins to bring certain themes into focus, the interview will begin to shape along that axis until, like a kaleidoscope, another framework starts coming into focus, and the therapist begins to hear the material in another discursive register” (p. 329).

### **Rhea Almeida**

Rhea Almeida currently practices at the Institute for Family Services (IFS) with a group of family therapists in Somerset, New Jersey. At IFS, they also train postgraduate students and mental health professionals in the area of Cultural Context Model nationally and internationally (<http://www.instituteforfamilyservices.com>, 2010). The philosophy of IFS is “to embrace the resilience that all families and individuals bring to therapy and create a landscape of strength toward resolving life’s struggles” (<http://www.instituteforfamilyservices.com>, 2010). The Cultural Context Model is employed in their work with clients as well as training mental health professionals. At IFS, “Approximately 45% of IFS’s clientele are families with problems of domestic violence, sexual abuse, and addictions” (<http://www.instituteforfamilyservices.com>, 2010). The IFS measures their effectiveness and success in treating clients by their track record, and over the past 21 years of providing therapy services there have been “only two incidents of hospitalization and less than five percent of their clientele on psychotropic medication” (<http://www.instituteforfamilyservices.com>, 2010).

Almeida recommends for mental health professionals to approach the treatment of domestic violence from a Cultural Context Model (Hernandez, Almeida, & Dolan-

Delvecchio, 2005). By employing the Cultural Context Model, the therapist incorporates gender, race, culture, class, and sexual orientation into the broader conceptualization of domestic violence (Almeida & Durkin, 1999). The goal of Cultural Context Model is to raise consciousness of the batterer and victim, regarding gender, race, cultural, class, and sexual orientation with regards to domestic violence (Almedia & Durkin, 1999). Mental health professionals can incorporate the use of “cultural circles to heighten their consciousness regarding sexism and other forms of privilege and oppression” (Almedia & Durkin, 1999, p. 319). Ultimately, the goal of this model is to have all family members take responsibility by increasing their understanding and awareness: “By addressing critical consciousness, empowerment, and accountability, therapists exercise their therapeutic responsibility to bring social justice to the ways that they attend to families’ suffering” (Hernandez et al., 2005, p. 116).

### **Lenore Walker**

Walker reports her experience in working with domestic violence has not changed in the last 15 years: “The most sought-after goal that she (the victim) wants is for the therapist to somehow to fix the man by helping her to change her own behavior” (Walker, 2000, p. 154). Walker does support couples therapy as a mode of treatment for domestic violence, however initially requires individual therapy for both the man and the woman, in which the man must take full responsibility for abusive behavior (Walker, 2000). Once the violence has stopped, responsibility is taken and the man begins to make behavioral changes, then couples therapy can be employed (Walker, 2000).

Walker advises mental health professionals to establish a trusting relationship with victims of domestic violence. Establishing rapport, building trust, and believing the victim’s story are crucial in assessing for domestic violence (Walker, 2000). Validating

experiences, developing a safety plan, and identifying the woman as a 'battered woman' should be employed during the evaluation interview (Walker, 2000): "Label her as a battered woman at some point in the interview, so that she has a name for the symptoms she is experiencing" (p. 162). Walker recommends the use of checklists to assess the frequency and severity of the violence. In addition, she supports the idea of victims discussing details about abusive incidents: "Trauma theory makes it clear that it is important for victims to repeatedly talk about their experiences so that they can gain mastery over the emotions raised and gain new cognitive schemas that give the trauma a different meaning" (Foa, Rothbaum, Riggs, & Murdock, 1991; Kolodny, 1998; as cited in Walker, 2000, p. 162).

Walker employs the Survivor Therapy Model when treating victims of domestic violence (Walker, 2000). The original model identified five stages in the treatment of domestic violence, however in 1998 it was expanded to include seven stages, "1. Identifying, assessing and labeling the abuse and its effects, 2. Helping the woman find safety and protection, 3. Regaining cognitive clarity, 4. Helping heal the PTSD and physiological effects psychological effects, 5. Addressing the psychological impact from prior experiences including childhood issues, 6. Rebuilding interpersonal relationships, and 7. Integrating the trauma into the life pattern and becoming a survivor" (Walker, 2000, p. 172).

Walker concludes "the most effective response to changing violent relationships is to change the structure of society. If women had equal status with men in social, political, economic, educational, and family areas, then they would be less likely to live with spouse abuse" (Walker, 2000, p. 155).

## Power and Control Wheel

Another approach for conceptualizing and treating domestic violence is the “Power and Control Wheel” (see Appendix C) developed by the Domestic Abuse Intervention Project (DAIP), located in Duluth, Minnesota (Yllo, 1993): “The wheel connects physical and sexual violence to the hub of power and control with a number of spokes” (p. 54). The ‘spokes’ are identified as minimizing, denying, and blaming; the use of children; the use of male privilege; the use of economic deprivation; the use of coercion and threats; the use of intimidation; the use of emotional abuse; and the use of isolation (Yllo, 1993).

The DAIP characterizes domestic violence as a “pattern of actions that an individual uses to intentionally control or dominate his intimate partner” ([www.theduluthmodel.org](http://www.theduluthmodel.org), 2010). The Power and Control Wheel describes the tactics or behaviors that men engage in while battering their victim (Yllo, 1993). This wheel illustrates the power imbalances between batterer and victim. The therapist can use this wheel to identify the types of abuse that occur and how it relates to power and control: “By naming the power differences, we can more clearly provide advocacy and support for victims, accountability and opportunities for change for offenders, and system and societal changes that end violence against women” ([www.theduluthmodel.org](http://www.theduluthmodel.org), 2010). Furthermore, an Equity Wheel (see Appendix D) was developed to illustrate the changes batterers need to make in order to become a non-violent partner. The ‘spokes’ of this wheel include non-threatening behavior; respect; trust and support; honesty and accountability; responsible parenting; shared responsibility; economic partnership; and negotiation and fairness ([www.duluthmodel.org](http://www.duluthmodel.org), 2010).

## **Alan Jenkins**

Jenkins (1990) proposes taking a narrative approach to treating domestic violence. Specifically, he suggests a constructivist perspective to working with perpetrators of domestic violence. Jenkins proposes inviting the man to take responsibility for his violent behavior by having him “discover and clarify his own goals in the relationship; address his own violence; reconsider the issue of responsibility for his violence; and to challenge restraints to accepting responsibility for the violence” (Jenkins, 1990, p. 62). Jenkins (1990) recommends a model for engagement “designed to locate responsibility for the man’s realizations and achievements within himself, so that he can more readily own an incorporate his capacity for change” (p. 62). In this ‘model of engagement’ there are nine steps according to Jenkins. The steps are as follows; “invite the man to address his violence; invite the man to argue for a non violent relationship; invite the man to examine his misguided efforts to contribute to the relationship; invite the man to identify time trends in the relationship; invite the man to externalize restraints; deliver irresistible invitations to challenge restraints; invite the man to consider his readiness to take new action; facilitate the planning of new action; and to facilitate the discovery of new action” (Jenkins, 1990, p. 63).

An example of ‘inviting the man to address his violence’ may begin with the therapist asking why the man is in therapy. The man may respond with “I was told to come” or “I don’t know, you tell me” (Jenkins, 1990, p. 64). Jenkins suggests that the man may direct the therapist’s attention to other problems in his marriage to avoid discussing the issue of violence, “we’ve got communication problems” or “she’s got the problem, she should be here” (p. 64). According to Jenkins (1990), often times the man makes attempts to minimize the violence or to avoid responsibility and blame external

factors as reasons for the violence, such as stress. Jenkins (1990) recommends asking the man to talk about the events that led up to their scheduled appointment. The therapist can 'invite' the man to address his violence by "avoiding criticism of his explanation; apologizing for interruptions and the need to ask so many questions; explaining the therapist's lack of knowledge about the situation and the need to understand more fully before being able to know how s/he can best offer help or comments; and asking permission to ask further questions about the event" (p. 66).

Furthermore, Jenkins (1990) argues that if the therapists asks the man if he can handle discussing a particular issue, the therapist in fact, is asking permission in a way that 'invites' the man to take responsibility for what is going to be discussed and challenges the man's ability to talk about sensitive issues (Jenkins, 1990). For example, the therapist would ask, "Are you sure you can handle talking about your violence?; or It isn't easy—it takes a lot of courage to face up to the fact that you really hurt someone you love; or How does it effect you to talk about your violence?" (p. 66). During this process, Jenkins (1990) recommends the therapist continue to interrupt attempts to avoid responsibility by extending invitations, seeking to challenge the client discretely and indirectly.

Jenkins (1990) is a proponent of the initial therapeutic session being individual. Individual therapy is helpful in the man "emphasizing his responsibility for the violence" (p.103). Once the man has accepted responsibility, then gender group therapy and/or couples therapy can be employed, if the couple both desire to stay in the relationship. In couples therapy, the woman is invited to consider taking responsibility for her safety and "to challenge restraints to taking responsibility for her partner's violence" and the man is

invited to “accept responsibility for his violence and challenge restraints to responsibility” (p.104). Jenkins suggests that therapists should establish a “context for safety and self-responsibility by monitoring each partner’s readiness to discuss openly sensitive issues” (p. 104). According to Jenkins, in couples therapy both partners are “invited to externalize and challenge their own restraints to the man accepting responsibility for his violence” (p. 105). The man is encouraged to externalize his restraints to accepting violence and not externalize the violence itself. Once couples are ready, they are ‘invited’ to consider ideas for taking new actions, to consider possible obstacles to these new actions and to develop criteria to evaluate the success of implementation of these new actions (Jenkins, 1990).

### **Neil Jacobson and John Gottman**

Jacobson’s approach to treating domestic violence specifically looks at “interpretations of marital dynamics” with a feminist lens (Jacobson, 1994, p. 81). He describes his approach as “feminist, scientific, and contextual” and admits that some may view “these positions as contradictory” (p. 82). He views wife abuse as a result of the “patriarchal structure of traditional marriages” (p.82). Jacobson (1994) suggests “as a contextualist”, that “human behavior in some sense is governed by factors external to that person” (p.82). Furthermore, he argues that it is important to understand the environment context when treating domestic violence (p. 82). He disagrees with couples therapy as a mode of treatment to domestic violence mostly because couples therapy would imply that it is a “relationship problem, when in fact, battering is the batterer’s problem and his alone” (p. 82).

From a scientific perspective, Jacobson (1994) proposes that “the goal of basic research must be controlled, systematic, and dispassionate” and that researching

domestic violence must not “compromise the safety of the subjects” (p. 83). Jacobson further proposes that “research from a contextual perspective is oriented toward identifying factors that predict and influence the onset, offset, intensification, deintensification, frequency, and duration of violence” (p. 84). He suggests that having an understanding of these factors has “direct treatment implications” (p. 84).

Jacobson and Gottman fully agree with the notion that batterers must be held fully accountable in any treatment modality (Jacobson & Gottman, 1998). They feel that swift criminal sanctions must be employed for batterers, and not to offer mental health treatment as an alternative to sanctions (Jacobson & Gottman, 1998): “If one truly wants to determine how motivated batterers are to stop the violence, we recommend never mandating treatment, or offering it as an alternative to prison. Make it voluntary” (p. 225). Jacobson and Gottman (1998) strongly disagree with using couples therapy as a mode of treating domestic violence. Jacobson and Gottman (1998) argue that couples therapy is employed to “solve problems that are caused by the dynamics of the marriage. With battering, the violence is most definitely not caused by marital dynamics. Battering is not about the relationship, it is about the batterer” (p. 226).

Therefore, Jacobson and Gottman suggest mental health professionals utilize coordinated community response (CCR) as a model for treating domestic violence, similar to the Duluth Model and recommendations by Lenore Walker. They state, “CCR relies on community organization and links together the criminal justice system, advocacy work and the education of batterers” and “involves the coordinated efforts of education groups for batterers, support groups for battered women, shelters, police practices, and prosecutorial tendencies” (Jacobson & Gottman, 1998, p. 231). Mental

health professionals should focus on batterers accepting responsibility for their violence (Jacobson & Gottman, 1998). According to Jacobson and Gottman (1998), treating batterers for domestic violence in a group modality is “well established and almost universally accepted” (p. 232). Furthermore, Jacobson and Gottman (1998) argue that counselors should work with batterers to “change their attitudes, so they no longer see violence as an acceptable response in any situation” (p.232).

### **Richard Gelles and Murray Straus**

According to Gelles (1993), a sociological approach offers the most comprehensive explanation of domestic violence. By examining social structures and social institutions, a sociological perspective is able to “offer a more complex formulation for the varied phenomena of violence and abuse between intimates and is applicable to a wider range of victimization than is feminist theory” (Gelles, 1993, p. 43). However, Gelles (1993) does admit because a sociological perspective is so complicated, it does not lend itself to “simple solutions, either in clinical or practice settings. One cannot easily use a sociological theory to inform clinical practice” (p. 43).

Gelles and Straus do suggest a structural family systems approach for mental health professionals when treating domestic violence. By employing a structural approach, “the therapist challenges the family’s pattern of interacting, forcing the members to look beyond the symptom of the family dysfunction (the family pattern of violence) and to examine the covert rules governing the family’s transactional patterns” (Gelles & Maynard, 1995, p. 247). The goal of the structural therapist is to establish clear boundaries. Gelles and Maynard (1995) suggest employing structural techniques of creating, joining and restructuring with the goal of restructuring the family in a way

which eliminates the violence, implements new patterns of communicating, and establishes clear boundaries.

### **Summary**

Based on the literature presented, there are certainly various schools of thought regarding the most appropriate approach in assessing and treating domestic violence. Feminist, psychological, and sociological perspectives are discussed; all vary in terms of conceptualizing domestic violence, suggested research methodologies for studying domestic violence, as well as practice and treatment implications for mental health professionals. Experts in the field studying domestic violence offer recommendations for mental health professionals in assessing in treating domestic violence. The goal of this research study is to examine how competent mental health professionals licensed in the state of Florida feel imparting their knowledge and skills in assessing and treating clients affected by domestic violence.

## CHAPTER 3 METHODOLOGY

### **Statement of Purpose**

As discussed in the review of relevant literature, domestic violence is a prevalent social problem. Mental health professionals frequently work with clients facing issues of domestic violence. Often, mental health professionals are the first responders to domestic violence. The purpose of this research study is to examine how these mental health professionals perceive their level of competency in assessing and treating domestic violence: specifically, mental health professionals licensed under the Florida Board of Clinical Social Work, Marriage and Family Therapy and Mental Health Counseling, Chapter 491.004.

### **Research Question**

RQ<sub>1</sub>: How do licensed Clinical Social Workers, Marriage and Family Therapists and Mental Health Counselors in the state of Florida perceive their level of competency in assessing and treating domestic violence?

### **Hypotheses**

Based on the review of relevant literature, review of graduate education curriculum and accrediting bodies, current state licensing requirements, as well as continuing education requirements, it is believed that:

- HO1: There are no significant differences in levels of perceived competency by discipline based on graduate coursework training in assessing and treating domestic violence.
- HO2: There are no significant differences in the levels of perceived competency by discipline based on graduate practicum and/or internship training in assessing and treating domestic violence.

- HO3: There are no significant differences in the levels of perceived competency by discipline based on postgraduate clinical contact experience in assessing and treating domestic violence.
- HO4: There are no significant differences in the levels of perceived competency by discipline based on licensure requirements or continuing education requirements in assessing and treating domestic violence.

### **Sampling and Population**

The population surveyed in this research study was mental health professionals, licensed under Chapter 491.004 of the Florida Statute. Specifically, Licensed Clinical Social Workers, Licensed Marriage and Family Therapists, and Licensed Mental Health Counselors were surveyed. These professionals were all licensed under the Florida Board of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling. All licensed mental health professionals surveyed at the time of this research study held active licenses within the state of Florida. Being actively licensed under Chapter 491.004, Florida Statute was the only criteria required for individuals to participate in this research study.

A list of licensed mental health professionals was obtained by contacting by phone the Florida Department of Health, Division of Medical Quality Assurance. The requested list was E-mailed to the researcher. Included in this list were license number, profession or discipline, original issue date, expiration date, current license status, full name, mailing address, phone number and E-mail address (when provided) of all active and inactive licensed professionals.

According to the Division of Medical Quality Assurance, as of 2010, there were a total of 16,033 actively licensed mental health professionals in the state of Florida, under Chapter 491.004. However, not all 16,033 licensed professionals provided an E-mail address to the Division of Medical Quality Assurance. The Division of Medical

Quality Assurance does not require licensed professionals to provide an E-mail address when applying for or renewing their professional license. As a result, only 8,866 E-mail addresses were obtained by this researcher, specifically 3,786 Licensed Clinical Social Workers, 820 Licensed Marriage and Family Therapists, and 4,260 Licensed Mental Health Counselors.

Therefore, this survey was sent to the 8,866 licensed professionals for which individual email addresses were obtained. It was determined that if a larger sample were to be needed, an E-mail invitation to participate in this survey would have been sent to the Counselor Education and Supervision Network (CESNET) listserv for Mental Health Counselors, the National Association of Social Workers (NASW) Advocacy listserv for Social Workers, and the National Council on Family Relations (NCFR) listserv for Marriage and Family Therapists. Furthermore, the email invitation would clearly state that this survey was intended for mental health professionals licensed in the state of Florida, under Chapter 491.004 only.

The type of sampling method used in this research study is referred to as census method. With census sampling, everyone in a population is surveyed (Dooley, 2001). This study employed a census of the Florida Department of Health list of actively licensed mental health professionals, under Chapter 491.004. Based on the comprehensive list of actively licensed mental health professionals obtained by the Florida Department of Health, it is assumed that a representative sample was obtained.

### **Research Design and Relevant Variables**

The approach selected for this research was quantitative, specifically descriptive research, in which licensed mental health professionals in the state of Florida were surveyed by E-mail. This study proposed to establish an association between perceived

levels of competency and various independent variables. Quantitative approach was used in order to generalize to a larger population, specifically, to the mental health profession as a whole. This research study examined the professionals' competency in assessing and treating domestic violence as perceived by the mental health professionals themselves.

As mentioned in the review of current literature, mental health professionals receive minimal training in assessing and treating domestic violence. This research study identified how professionals feel about their ability to assess and treat domestic violence. The advantage of using a quantitative approach in critical research is the ability to generalize to a larger population, as well as the ability to collect large amount of data with relative ease, in a relatively short period of time. The population to whom this study will be generalized is all mental health professionals practicing in the United States.

A cross sectional survey design was implemented in this research study. Cross sectional design refers to gathering data all at one point in time, as opposed to a longitudinal survey design which collects data multiple times, over a period of time (Dooley, 2001). In this research study, data was collected immediately after the survey was administered.

For the purposes of this research study, the dependent variable was the perceived competency of the Florida licensed mental health professional under Chapter 491.004, in the area of domestic violence. The independent variables were graduate coursework training, graduate internship and/or practicum training, postgraduate clinical contact experience and licensure, and continuing education requirements of Florida licensed

mental health professionals, in the area of assessing and treating domestic violence. Again, this research study looked for associations between perceived competency and the various independent variables.

### **Instrumentation**

Based on the review of relevant literature, the Domestic Violence Perceived Competency Survey was developed and used to evaluate the levels of perceived competency of these mental health professionals (see Appendix A). This cross sectional survey was specifically designed for this research study. Cross sectional surveys are used to obtain and collect data from one point in time (Dooley, 2001). Approval to conduct this research study and distribute the Domestic Violence Perceived Competency Survey was obtained from the Institutional Review Board (IRB), at the University of Florida.

The Domestic Violence Perceived Competency Survey was delivered by E-mail and was self-administered. Questions were closed-ended with four unipolar ordinal scale categories, Very Competent, Competent, Slightly Competent, and Not Competent. Other scales included Very Aware, Aware, Slightly Aware, and Not Aware. According to Dillman, Smyth and Christian (2009), “unipolar ordinal scales measure graduation along one dimension where the zero point falls at the one end of the scale” (p. 135). Questions were also construct-specific, making it easier for the respondent to identify his or her level of perceived competency.

Construct-specific questions require the researcher to “clearly define the construct of interest” (Dillman et al., 2009, p.138). Dillmen et al. (2009) argue that construct-specific questions in a survey can decrease “acquiescence response bias” as well as “cognitive burden” (p. 138) making it easier for the participant to respond. Dillman,

Smyth and Christian (2009) emphasize the importance of developing good survey questions. In doing so, the researcher should strive to develop questions that “every potential respondent will be willing to answer, will be able to respond to accurately, and will interpret in the way the surveyor intends” (Dillman, Smyth & Christian, 2009, p. 67).

Survey content for the Domestic Violence Perceived Competency Survey was chosen after a lengthy review of current and relative literature. As a result of this review, certain themes and issues repeatedly emerged among various theorists and social scientists regarding the issue of domestic violence. Recommendations from experts in the field such as Lenore Walker, Virginia Goldner, and Michele Bograd contributed to the content of this survey. In addition, review of current research in the area of domestic violence illustrated a need to promote and further investigate training practices for mental health professionals working with clients affected by domestic violence.

The first page of the survey included the purpose statement, contact information of researcher, and researcher’s supervisor as well as the informed consent. Item 1 asked respondents to select I Agree or I Do Not Agree to the statement, “I have read and understand the procedures outlined for participating in this survey. I voluntarily agree to participate in this survey”. The second page included instructions for completing the survey, including the number and type of questions being asked. On this page respondents were asked to reflect on their training and work experiences. There are a total of 39 questions on the Domestic Violence Perceived Competency Survey, nine of which are questions regarding demographic information of the

respondent. The term domestic violence was defined on page three of the survey for clarification purposes. This researcher defined domestic violence as:

The physical, psychological, or sexual abuse of one family or household member by another family or household member. Physical abuse includes but not limited to hitting, slapping, kicking, punching, with or without a weapon, which causes pain or injury. Psychological abuse includes, but is not limited to stalking, humiliation, verbal abuse, false imprisonment, social isolation, economic deprecation or any other controlling type behavior. Sexual abuse includes, but not limited to any unwanted, coerced, forced, or threat of forced sexual acts or attempted sexual acts.

Respondents were asked to evaluate their perceived level of competency in assessing and treating domestic violence as Very Competent, Competent, Slightly Competent, or Not Competent. Respondents could only make one selection. Items 2-15 asked respondents to evaluate their knowledge of concepts and theories of domestic violence; their ability to identify signs of domestic violence; knowledge of facts and myths of domestic violence; knowledge of interpersonal dynamics in a violent relationship; knowledge of domestic violence treatment approaches and their ability to implement domestic violence treatment approaches; knowledge of how gender, race, class, and sexual orientation influence their understanding of domestic violence; how their own culture influence their perceptions of domestic violence; knowledge of the cycles of violence, knowledge of typologies of perpetrators; ability to identify risk factor and assess for violence during a therapy session, as well as their ability to provide safety planning for clients and refer to agencies that provide victim assistance.

Items 16-20, asked respondents to evaluate their practicum and/or internship training as it related to domestic violence. Respondents evaluated their perceived level of competency by responding to their awareness of domestic violence during practicum and/or internship training. Respondents could only make one selection, Very Aware,

Aware, Slightly Aware, or Not Aware. Respondents were asked how aware they were of domestic violence during face-to-face client contact practicum experience, face-to-face client contact internship experience, individual supervision experience, and group supervision experience. Respondents were also asked how aware the site staff was of domestic violence during their practicum and/or internship experience. In item 21, respondents were also asked if they were trained by their faculty advisor to assess and treat for domestic violence. Respondents replied Yes or No to item 21. In item 22, respondents were provided the opportunity to comment on additional information regarding their domestic violence training and clinical experience, in an open text box. In item 23, respondents were asked in a Yes or No format, if Florida licensure requirements promoted competency in assessing and treating for domestic violence.

Respondents were then asked to reflect on their graduate school experiences in terms of evaluating their competency in assessing and treating domestic violence. Item 24 asked how many courses were taken specific to domestic violence. Items 25-26 asked how many client contact hours they obtained during practicum and internship training. Finally, in items 27-28 respondents were asked since postmaster's graduation, how many client contact hours were obtained with clients facing issues of domestic violence and how many continuing education hours had they completed.

Item 29 asked respondents to rate their overall level of competence in assessing and treating domestic violence. If respondents rated themselves High, Above Average, or Average, respondents were then asked what mostly likely attributed to their level of perceived competency.

Finally, in items 31-39 respondents were asked questions regarding their demographic information, such as gender, age, license status, highest level of education, year degree(s) were received, licenses held, how many years practicing, number of years licensed, and which discipline they identify with most, if multiple licenses were held.

### **Data Collection**

The use of the Internet for data collection has increased greatly in the last decade (Dillman, Smyth & Christian, 2009). The ability to access large populations with relative ease and minimal costs to the researcher has made Internet surveys very appealing (Dillman et.al, 2009). For these reasons, this researcher chose E-mail survey for the method of collecting data.

The Domestic Violence Perceived Competency Survey was created using SurveyMonkey®. By using SurveyMonkey® the researcher was able to design a survey, collect responses, and analyze results all within a secure environment (<http://www.surveymonkey.com>). Detailed survey templates are provided on SurveyMoneky.com, as well as 15 options for survey themes (<http://www.surveymonkey.com>). The Yellow Metal template was selected for clarity and ease of reading with the goal of reducing nonreponse error.

SurveyMonkey® reports using the most advanced technology for Internet security. Secure Sockets Layer® (SSL) is used to protect respondent information using both server authentication and data encryption. SurveyMonkey® requires the researcher to create a unique username and password that must be used each time the researcher logs on. In addition, SurveyMonkey® is hosted in a secure environment that utilizes firewalls and other technology to prevent access from outside intruders. The data

center is monitored 24 hours daily and is highly protected with multiple levels of restricted physical access (<http://www.surveymonkey.com>).

The Domestic Violence Perceived Competency Survey was E-mailed to all actively licensed Clinical Social Workers, Marriage and Family Therapists, and Mental Health Counselors in Florida. Again, E-mail addresses of all licensed professionals were obtained by the Florida Department of Health, Division of Medical Quality Assurance. The E-mail survey was sent from a Yahoo® account created by this researcher, specifically for this survey. The account name was [domesticviolencesurvey@yahoo.com](mailto:domesticviolencesurvey@yahoo.com). This E-mail included a cover letter (see Appendix B) introducing the survey to the potential respondent. In addition, a link to <https://www.surveymonkey.com/s/3NJD25Y> was provided in the cover letter, which immediately directed the potential respondent to the survey.

For the purposes of testing the instrument and increasing reliability, a pilot study was conducted. Four subjects with a background in domestic violence were recruited as pilot respondents. All respondents met the criteria of being actively licensed mental health professionals, under Chapter 491.004. Each respondent was E-mailed the Domestic Violence Perceived Competency Survey, as well as the cover letter introducing the survey. Three of the four respondents recruited for the pilot study responded and completed the survey. According to Cone and Foster (1993), “pilot work is important because what you plan to do may look good on paper but not work out very well when you actually try it out with real subjects” (p. 201). Data collected from the pilot test was not included in the results of this research study.

Results of the pilot study identified a few issues with the wording of some questions on the survey. In addition, feedback regarding the order of the survey questions was discussed by pilot respondents. As a result of this feedback, some revisions were made to the Domestic Violence Perceived Competency Survey. Revisions involved the specific wording of some questions, as well as the order of questions on the survey. All revisions were made to increase clarity of questions and reduce uncertainty. In addition, all revisions made to the instrument were approved by the Institutional Review Board (IRB).

All pilot study respondents reported a need for research in the area of domestic violence competency. One pilot study respondent in particular commented on the thoroughness of the survey questions asked regarding competency in assessing and treating domestic violence. In addition, pilot study respondents felt that more rigorous scientific studies were needed regarding domestic violence competency and that some professionals may be practicing “by the seat of their pants” when it comes to assessing and treating domestic violence.

### **Data Analysis**

The dependent variable in this research study is the perceived competency of the mental health professional in assessing and treating domestic violence. The independent variables are graduate coursework training, graduate practicum and/or internship training, postgraduate clinical contact and licensure and continuing education requirements.

Cohen (1992) emphasizes the importance of the researcher addressing the issue of power analysis and sample size when conducting research. According to Cohen (1992), “the statistical power of a significance test is the long term probability, given the

population ES (effect size),  $\alpha$  (criterion), and N (sample size) of rejecting the  $H_0$  (null hypothesis)" (p. 156). Based on Cohen's (1992) requirements for using ANOVA analysis with three groups (clinical social workers, marriage and family therapists, and mental health counselors) the necessary sample size per group is 52. The total minimum sample size needed is 156, to attain a power = .80 and a medium effect size with a probability level = .05. When using the Chi-Square test, to detect a medium degree of association in the population with a probability level = .05, minimum sample size needed is 121 for three degrees of freedom and 87 for one degree of freedom (Cohen, 1992).

Analysis of variance (ANOVA) was used with most of the data collected. ANOVA is designed to test the significance of group differences. Specifically, ANOVA was used to test differences among each discipline, clinical social work, marriage and family therapy, and mental health counseling. Data from each of these disciplines were analyzed to see if one group over another reported higher levels of competency in assessing and treating domestic violence. The assumptions for ANOVA are: that (1) the population is normal, (2) the sample is randomly selected and independent, and (3) the populations have equal standard deviations or variances (Schacht & Aspelmeier, 2005; Iversen & Norpoth, 1987). If assumptions are not met, the researcher runs the risk of a Type I error, rejecting the null hypothesis when in fact it is true, or a Type II error, not rejecting the null hypothesis when in fact it is false (Schacht & Aspelmeier, 2005). The Tukey HSD post-hoc analysis was also used for those ANOVA items resulting in statistical significance.

Chi-Square test was also used in this research study to analyze data. The Chi-Square is a statistical test in which categorical variables are analyzed (Schacht &

Aspelmeier, 2005). Chi-Square examines whether two random variables are independent (Schacht & Aspelmeier, 2005). Specifically, Chi-Square was used to compare graduate coursework training, graduate practicum and/or internship training, postgraduate clinical contact experience, and continuing education and licensure requirements by discipline, and levels of perceived competency. Chi-Square “determines if there is a statistically significant difference between expected versus observed relative frequencies” (Schacht & Aspelmeier, 2005, p. 259).

The data collected in this research study was analyzed using the Statistical Package for Social Sciences® (SPSS®) Version 18. Data was downloaded from SurveyMonkey.com and transferred to SPSS® for analysis. Results of this analysis are presented in Chapter 4 and conclusions based on these results are discussed in Chapter 5.

## CHAPTER 4 RESULTS

The purpose of this research study was to evaluate the perceived level of competency in assessing and treating domestic violence among Florida licensed mental health professionals. Additionally, this study sought to determine if one discipline over another reported feeling more competent in the assessment and treatment of domestic violence and if so, what factors contributed to this increased perceived level of competence. This chapter describes the results of this study.

The Domestic Violence Perceived Competency Survey was developed specifically for this research study. A pilot study was conducted to test the reliability of this instrument. This cross sectional survey was created using SurveyMonkey.com and distributed by E-mail to all potential respondents. Data were collected through SurveyMoneky.com and then analyzed by transferring collected data to SPSS® (Version18).

This chapter begins with the presentation of demographic characteristics of the respondents who participated in this research study. Next, item statistics are presented as well as discussion on reliability. Results of this research study are organized by research question for the remainder of this chapter. The first research question addresses the level of perceived competency based on the professional's graduate coursework training. The second question addresses the level of perceived competency based on the professional's graduate practicum and internship training, in terms of their awareness of domestic violence during practicum and internship training. The third question examines level of perceived competency based on postgraduate clinical contact experience. The last question addresses perceived competency based

on licensure and continuing education requirements. Chapter 5 will provide discussion regarding significant findings and implications for future research based on the results presented in this chapter.

### **Participants and Demographic Characteristics**

Participants for this research study were obtained from a list of Florida mental health professionals, licensed under Chapter 491 Florida Statute. This list was obtained from the Florida Department of Health. As of 2010, there were a total of 16,033 licensed professionals. However, only 8,866 professionals provided E-mail addresses to the Florida Department of Health when applying for or renewing their professional license. All 8,866 professionals were E-mailed an invitation to participate in this study by means of completing the Domestic Violence Perceived Competency Survey. Only one invitation was E-mailed to each licensed professional.

A total of 618 licensed professionals responded to the survey. Of those, 591 respondents fully completed the survey. Of the 8,866 invitations E-mailed, 573 were returned due to invalid E-mail addresses. The Florida Department of Health did not have a correct record of E-mail addresses for some mental health professionals. In addition, 36 respondents E-mailed the researcher and declined to participate in the study. Reasons given by respondents for declining the survey included not having time to complete the survey, not having interest in the subject matter, and not having clinical encounters with clients affected by domestic violence. Of the 8,866 potential respondents, 618 actually responded to the E-mail invitation and participated in the Domestic Violence Perceived Competency Survey. This number resulted in a response rate of 7.5%.

As shown in Table 4-1, the demographic characteristics of respondents reported were license status, gender, age, highest degree held, license type, and number of years in practice. In terms of licensed status, 589 respondents (99.8%) held active licenses, and 1 respondent (.2%) held an inactive license. Of the 618 respondents, 143

Table 4-1. Characteristics of Respondents (N=618)

Characteristic	N	%
Licenses status		
Active	589	24.2
Inactive	1	0.2
Gender		
Male	143	24.4
Female	444	75.6
Age		
18-28 years old	1	0.2
29-39 years old	76	13
40-49 years old	129	22
50-59 years old	229	39.1
60-69 years old	135	23
70+ years old	16	2.7
Highest degree held		
Masters Degree	448	76.8
Specialist Degree	25	4.3
Doctoral Degree	110	18.9
License type		
LCSW	254	43.3
LMFT	69	11.8
LMHC	286	48.7
Years as licensed professional		
less than 1 year	0	0
1-5 years	91	15.7
6-10 years	130	22.4
11-20 years	230	39.6
more than 20 years	130	22.4

(24.4%) were male and 444 (75.6%) were female; 31 respondents skipped this question. Age was reported in ranges: 1 (.2%) was 18-28 years old, 76 (13%) were 29-39 years old, 129 (22%) were 40-49 years old, 229 (39.1%) were 50-59 years old, 135 (23%) were 60-69 years old, 16 (2.7%) were 70 or older, and 32 respondents skipped this question. In terms of highest degree achieved, 448 (76.8%) reported holding a Master's Degree, 25 (4.3%) reported holding a Specialist Degree, 110 (18.9%) reported holding a Doctoral Degree, and 35 respondents skipped this question. Regarding type of license held, 254 (43.3%) reported being licensed as a Clinical Social Worker (LCSW), 69 (11.8%) reported being licensed as a Marriage and Family Therapist (LMFT), 286 (48.7%) reported being licensed as a Mental Health Counselor, and 31 respondents skipped this question. Lastly, regarding number of years in practice as a licensed professional, 0 (0%) reported less than one year, 91 (15.7%) reported in practice for 1-5 years, 130 (22.4%) reported in practice for 6-10 years, 230 (39.6%) reported in practice for 11-20 years, 130 (22.4%) reported in practice for over 20 years, and 37 respondents skipped the question.

### **Item Analysis and Reliability (Coursework)**

The influence of graduate coursework training is presented in this analysis as Coursework (items 2-15). Reliability analysis was conducted by using Cronbach's alpha which was .942 when  $n=14$ . Calculation of Cronbach's alpha is shown in Table 4-2. Item statistics for Coursework are presented in Table 4-3 when  $N=580$ . The item-total statistics are presented in Table 4-4 and the scale statistics (mean, variance, and standard deviation) are presented in Table 4-5.

Table 4-2. Coursework: Reliability Statistics

	Cronbach's alpha	N of items
Coursework	.942	14

Table 4-3. Coursework: Item Statistics (N=580)

Item	Mean	SD
Knowledge of concepts and theories of domestic violence	1.66	.591
Ability to identify signs of domestic violence during client contact	1.59	.591
Knowledge of facts and myths of domestic violence	1.56	.595
Knowledge of the on-going interpersonal dynamics between individuals in a violent relationship	1.63	.603
Knowledge of domestic violence treatment approaches	2.05	.716
Ability to implement these domestic violence treatment approaches	2.08	.780
Knowledge of how gender, race, class and sexual orientation influence your understanding of domestic violence	1.81	.671
Knowledge of how one's own culture influences perceptions of domestic violence	1.67	.638
Knowledge of cycles of violence	1.52	.620
Knowledge of typologies of perpetrators of domestic violence	2.02	.746
Ability to assess for domestic violence, during a therapy session	1.64	.644
Ability to identify risk factors for domestic violence	1.55	.602
Ability to provide safety planning for clients experiencing domestic violence	1.73	.712
Ability to refer clients experiencing domestic violence to agencies that provide victim assistance	1.43	.597

Table 4-4. Coursework: Item Discrimination

Item	corrected item – total correlation
Knowledge of concepts and theories of domestic violence	.729
Ability to identify signs of domestic violence during client contact	.742
Knowledge of facts and myths of domestic violence	.742
Knowledge of the on-going interpersonal dynamics between individuals in a violent relationship	.761
Knowledge of domestic violence treatment approaches	.774
Ability to implement these domestic violence treatment approaches	.756
Knowledge of how gender, race, class and sexual orientation influence your understanding of domestic violence	.692
Knowledge of how one's own culture influences perceptions of domestic violence	.675
Knowledge of cycles of violence	.698
Knowledge of typologies of perpetrators of domestic violence	.680

Table 4-5. Coursework: Scale Statistics (N=14)

Mean	Variance	SD
23.93	47.764	6.911

### ANOVA (Coursework)

The influence of graduate coursework training was then examined by discipline using ANOVA. Did one discipline over another report a higher level of competency in assessing and treating domestic violence, based on respondent's graduate coursework training? An ANOVA analysis was conducted to test the significance of group differences. Table 4-6 presents the between-subject factors and Table 4-7 shows the test of between-subjects effects. Results showed no statistical significance for Licensed Clinical Social Workers,  $F(1,576) = .214, p = .644$ , Licensed Marriage and Family Therapists,  $F(1,576) = .041, p = .839$  and Licensed Mental Health Counselors,  $F(1,576) = .052, p = .819$  and perceived level of competency in assessing and treating domestic violence, based on graduate coursework training. There was not one

Table 4-6. Between-Subject Factors (Coursework)

	N
LCSW	244
LMFT	68
LMHC	279

Note: LCSW=Licensed Clinical Social Worker, LMFT=Licensed Marriage and Family Therapist and LMCH=Licensed Mental Health Counselor.

Table 4-7. Tests of Between-Subjects Effects (dependent variable= Coursework)

Source	Type III SS	df	MS	F	Sig.
Corrected Model	.191 <sup>a</sup>	3	.064	.297	.827
Intercept	1282.547	1	1282.547	5986.8222	.000
LCSW	.046	1	.046	.214	.644
LMFT	.009	1	.009	.041	.839
LMHC	.011	1	.011	.052	.819
Error	123.396	576			
Total	6864.378	580			
Corrected Total	123.587	579			

<sup>a</sup>R squared = .002 (Adjusted R Square = -.004)

discipline over another that reported higher levels of perceived competency based on graduate coursework training. The conclusion is to fail to reject the null hypothesis and

conclude there are no significant differences in levels of perceived competency by discipline based on graduate coursework training in assessing and treating domestic violence.

### **Chi-Square Test (Coursework)**

Item 24 asked respondents how many courses were taken that specifically related to domestic violence. The influence of graduate coursework training was examined by discipline using the Pearson Chi-Square Test. The Chi-Square analysis was used to test whether two categorical variables were independent of each other. Did one discipline over another report a higher level of competency in assessing and treating domestic violence, based on their graduate coursework training? Table 4-8 presents results for the Chi-Square test examining graduate coursework by discipline. Results showed no statistical significance between Licensed Clinical Social Workers,  $X^2 (3, N=584) = 5.566, p = .135$ , Licensed Marriage and Family Therapists,  $X^2 (3, N=584) = .409, p = .938$  and Licensed Mental Health Counselors,  $X^2 (3, N=584) = 7.430, p = .059$  and graduate coursework training. The conclusion is to fail to reject the null hypothesis and conclude that there is no significant difference in levels of perceived competency by discipline based on graduate coursework training in assessing and treating domestic violence.

Table 4-8. Chi-Square Test for Graduate Coursework Training (N = 584)

	$X^2$	df	p
LCSW	5.566	3	.135
LMFT	.409	3	.938
LMHC	7.430	3	.059

*Note:* LCSW = Licensed Clinical Social Worker, LMFT = Licensed Marriage and Family Therapist and LMHC = Licensed Mental Health Counselor.

### Item Analysis and Reliability (Practicum/Internship)

The influence of graduate practicum and/or internship training is presented in this analysis as Practicum/Internship (items 16-19). Reliability analysis was conducted using Cronbach's alpha which was .911 when n=4. Calculation of Cronbach's alpha is shown in Table 4-9. Item statistics for Practicum/Internship are presented in Table 4-10 when N=569. The item-total statistics are presented in Table 4-11 and the scale statistics (mean, variance, and standard deviation) are shown in Table 4-12.

Table 4-9. Practicum/Internship: Reliability Statistics

	Cronbach's alpha	N of items
Practicum/Internship	.911	4

Table 4-10. Practicum/Internship: Item Statistics (N=569)

Item	Mean	SD
Face-to-face client contact practicum experience.	2.06	.873
Face-to-face client contact internship experience.	2.05	.838
Individual supervision experience.	1.93	.820
Group supervision experience.	2.04	.835

Table 4-11. Practicum/Internship: Item Discrimination

Item	Corrected item - total correlation
Face-to-face client contact practicum experience.	.757
Face-to-face client contact internship experience.	.826
Individual supervision experience.	.832
Group supervision experience.	.775

Table 4-12. Practicum/Internship: Scale Statistics (N=4)

Mean	Variance	SD
8.08	8.936	2.989

### ANOVA (Practicum/Internship)

The influence of graduate practicum and/or internship training was then examined by discipline. Did one discipline over another report a higher level of competency in assessing and treating domestic violence, based on graduate and/or internship training? Did respondents have an awareness of domestic violence during their practicum and/or internship training? An ANOVA analysis was conducted to test the significance of group differences. Table 4-13 presents the between-subject factors and Table 4-14 shows the test of between-subjects effects.

Table 4-13. Between-Subject Factors (Practicum/Internship)

	N
LCSW	237
LMFT	69
LMHC	274

Note: LCSW=Licensed Clinical Social Worker, LMFT=Licensed Marriage and Family Therapist and LMHC=Licensed Mental Health Counselor.

Table 4-14. Tests of Between-Subjects Effects (dependent variable= Practicum/Internship)

Source	Type III SS	df	MS	F	Sig.
Corrected Model	.887 <sup>a</sup>	3	.296	.528	.663
Intercept	925.666	1	925.666	1653.351	.000
LCSW	.046	1	.400	.714	.398
LMFT	.009	1	.885	1.580	.209
LMHC	.011	1	.374	.668	.414
Error	316.328	565	.560		
Total	5370.938	569			
Corrected Total	317.215	568			

<sup>a</sup>R squared = .003 (Adjusted R Square = -.002)

Results show no statistical significance for Licensed Clinical Social Workers,  $F(1, 565) = .714$ ,  $p = .398$ , Licensed Marriage and Family Therapists,  $F(1, 565) = 1.580$ ,  $p = .209$ , and Licensed Mental Health Counselors,  $F(1, 565) = .668$ ,  $p = .414$  and perceived level of competency, based on practicum and/or internship training. There was not one discipline over another that reported higher levels of perceived competency

based on graduate practicum and/or internship training. The conclusion is to fail to reject the null hypothesis and conclude that there are no significant differences in levels of perceived competency by discipline based on graduate practicum and/or internship training in assessing and treating domestic violence.

### **Chi-Square Test (Practicum/Internship)**

Item 25 asked respondents how many contact hours had been obtained with clients facing issues of domestic violence while respondents completed practicum training. The influence of graduate practicum training was examined by discipline using the Pearson Chi-Square Test. The Chi-Square analysis was used to test whether two categorical variables were independent of each other. Did one discipline over another report a higher level of competency in assessing and treating domestic violence, based on graduate practicum training? Table 4-15 presents results for the Chi-Square test examining graduate practicum training by discipline. Results showed no statistical significance between Licensed Clinical Social Workers,  $X^2(3, N=572) = 3.620, p = .306$ , Licensed Marriage and Family Therapists,  $X^2(3, N=572) = 2.605, p = .457$  and Licensed Mental Health Counselors,  $X^2(3, N=572) = 4.482, p = .214$  and graduate practicum training as it relates to perceived level of competency.

Items 26 asked respondents how many contact hours had been obtained with clients facing issues of domestic violence while respondents completed internship training. The influence of graduate internship training was examined by discipline using the Pearson Chi-Square Test. The Chi-Square analysis was used to test whether two categorical variables were independent of each other. Did one discipline over another report a higher level of competency in assessing and treating domestic violence, based on graduate internship training? Table 4-16 presents results for the Chi-Square test

examining graduate internship training by discipline. Results showed no statistical significance between Licensed Clinical Social Workers,  $X^2(3, N=573) = 6.484, p = .090$ , Licensed Marriage and Family Therapists,  $X^2(3, N=573) = .414, p = .937$  and Licensed Mental Health Counselors,  $X^2(3, N=573) = 6.346, p = .096$  and graduate internship training as it relates to perceived level of competency. The conclusion is to fail to reject the null hypothesis and conclude that there is no significant interaction between graduate practicum and/or internship training and perceived level of competency in assessing and treating domestic violence by discipline.

Table 4-15. Chi-Square Test for Graduate Practicum Training (N = 572)

	$X^2$	df	p
LCSW	3.620	3	.306
LMFT	2.605	3	.457
LMHC	4.482	3	.214

*Note:* LCSW = Licensed Clinical Social Worker, LMFT = Licensed Marriage and Family Therapist and LMHC = Licensed Mental Health Counselor.

Table 4-16. Chi-Square Test for Graduate Internship Training (N = 573)

	$X^2$	df	p
LCSW	6.484	3	.090
LMFT	.414	3	.937
LMHC	6.346	3	.096

*Note:* LCSW = Licensed Clinical Social Worker, LMFT = Licensed Marriage and Family Therapist and LMHC = Licensed Mental Health Counselor.

### **Chi-Square Test (Postgraduate Clinical Contact Experience)**

Does postgraduate clinical contact experience have any influence on the mental health professionals' perceived level of competency in assessing and treating domestic violence? The null hypotheses states there are no significant differences in levels of perceived competency by discipline based on postgraduate clinical contact experience in assessing and treating domestic violence.

The influence of postgraduate clinical contact experience is presented in this analysis. Specifically, item 27 addresses postgraduate clinical contact experience as it relates to competency in assessing and treating for domestic violence. The influence of postgraduate clinical contact was examined by discipline using the Pearson Chi-Square Test. The Chi-Square analysis was used to test whether two categorical variables were independent of each other. Did one discipline over another report a higher level of competency in assessing and treating domestic violence, based on their postgraduate clinical contact experience? Table 4-17 presents results for the Chi-Square test examining postgraduate clinical contact experience by discipline. Results showed no statistical significance between Licensed Clinical Social Workers,  $X^2(3, N=586) = 2.083, p = .555$ , Licensed Marriage and Family Therapists,  $X^2(3, N=586) = 4.962, p = .175$  and Licensed Mental Health Counselors,  $X^2(3, N=586) = 1.774, p = .621$  and postgraduate clinical contact experience as it relates to perceived level of competency. The conclusion is to fail to reject the null hypothesis and conclude that there is no significant interaction between post graduate employment experience and perceived level of competency in assessing and treating domestic violence by discipline.

Table 4-17. Chi-Square Test for Postgraduate Clinical Contact Experience (N = 586)

	$X^2$	df	p
LCSW	2.083	3	.555
LMFT	4.962	3	.175
LMHC	1.774	3	.621

*Note:* LCSW = Licensed Clinical Social Worker, LMFT = Licensed Marriage and Family Therapist and LMHC = Licensed Mental Health Counselor.

### **Chi-Square Test (CE/Licensure)**

Does licensure and continuing education requirements have any influence on the mental health professionals' perceived level of competency in assessing and treating

domestic violence? The null hypotheses states there are no significant differences in levels of perceived competency by discipline based on licensure and continuing education requirements in assessing and treating domestic violence.

The influence of licensure and continuing education requirements is presented in this analysis. Items 23 and 28 specifically address mental health professionals' perceptions about licensure requirements and continuing education requirements, as it relates to competency in assessing and treating domestic violence. Item 23 asks if respondents feel the state of Florida promotes competency in assessing and treating domestic violence when they are obtaining and maintaining a professional license. The influence of licensure requirements was examined by discipline using Pearson Chi-Square test. This analysis is used to test whether two categorical variables were independent of each other. Did one discipline over another report a higher level of competency in assessing and treating domestic violence, based on requirements to obtain and maintain professional license? Table 4-18 presents results for the Chi-Square test examining licensure by discipline. Results show a statistical significance between Licensed Clinical Social Workers,  $X^2(1, N=568) = 6.723, p = .010$  and Licensed Mental Health Counselors,  $X^2(1, N=568) = 5.080, p = .024$  and requirements to obtain professional license, as it relates to promoting competency. However, results showed no statistical significance between Licensed Marriage and Family Therapists,  $X^2(1, N=568) = .000, p = 1.000$  and requirements to obtain professional license, as it relates to promoting competency. In addition, results show no statistical significance between Licensed Clinical Social Workers, [ $X^2(1, N=576) = 1.142, p = .285$ ], Licensed Marriage and Family Therapists [ $X^2(1, N=576) = .000, p = 1.000$ ] and Licensed Mental

Health Counselors [ $X^2 (1, N=576) = .188, p = .665$ ] and requirements to maintain professional license, as it relates to promoting competency.

Item 28 asks how many continuing education hours had been obtained specifically about domestic violence, since obtaining Florida licensure. The influence of continuing education requirements was examined by discipline using the Pearson Chi-Square Test. The Chi-Square analysis was used to test whether two categorical variables were independent of each other. Did one discipline over another report a higher level of competency in assessing and treating domestic violence, based on continuing education requirements? Table 4-19 presents results for the Chi-Square test examining continuing education requirements by discipline. Results showed no statistical significance between Licensed Clinical Social Workers,  $X^2 (3, N=584) = 2.021, p = .568$ , Licensed Marriage and Family Therapists,  $X^2 (3, N=584) = 3.149, p = .369$  and Licensed Mental Health Counselors,  $X^2 (3, N=584) = 2.127, p = .546$  and continuing education requirements as it relates to perceived level of competency. The conclusion is to reject the null hypothesis and conclude that there is a significant interaction between licensure requirements or continuing education requirements and perceived level of competency in assessing and treating domestic violence by discipline.

Table 4-18. Chi-Square Test for Licensure Requirements (N = 568 & 576)

To obtain license	N	$X^2$	df	p
LCSW	568	6.723	1	.010
LMFT	568	.000	1	1.000
LMHC	568	5.080	1	.024
To maintain license	N	$X^2$	df	p
LCSW	576	1.142	1	.285
LMFT	576	.000	1	1.000
LMHC	576	.188	1	.665

*Note:* LCSW = Licensed Clinical Social Worker, LMFT = Licensed Marriage and Family Therapist and LMHC = Licensed Mental Health Counselor.

Table 4-19. Chi-Square Test for Continuing Education Requirements (N = 584)

	$\chi^2$	df	p
LCSW	2.021	3	.568
LMFT	3.149	3	.369
LMHC	2.127	3	.546

Note: LCSW = Licensed Clinical Social Worker, LMFT = Licensed Marriage and Family Therapist and LMHC = Licensed Mental Health Counselor.

### ANOVA (Level of Competence)

Items 29 asked respondents to rate their own level of competence in assessing and treating domestic violence as either, High, Above Average, Average, or Low. An ANOVA analysis was conducted to test the significance of group differences. Results are presented in Table 4-32 for item 29. Licensed Clinical Social Worker is represented as LCSW, Licensed Marriage and Family Therapist is represented as LMFT, and Licensed Mental Health Counselor is represented as LMHC. Results show no statistical significance for these variables, LCSW,  $F(1,517) = .188$ ,  $p = .665$ , LMFT,  $F(1,517) = 1.497$ ,  $p = .222$  and LMHC,  $F(1,517) = .000$ ,  $p = .999$ .

Table 4-20. Tests of Between-Subjects Effects. (dependant variable=How do you rate your own level of competence in assessing and treating domestic violence?)

Source	Type III SS	df	MS	F	Sig.
Corrected Model	67.752 <sup>a</sup>	11	6.159	13.896	.000
Intercept	291.298	1	291.298	657.191	.000
Coursework	3.052	2	1.526	3.443	.033
Postgraduate Clinical Contact	35.525	2	17.762	40.073	.000
CE/Licensure	3.071	2	1.535	3.464	.032
Self-learn	3.619	2	6.810	15.363	.000
LCSW	.083	1	.083	.188	.665
LMFT	.663	1	.663	1.497	.222
LMHC	1.507E-6	1	1.507E-6	.000	.999
Error	229.159	517			
Total	5203.000	529			
Corrected Total	296.911	528			

<sup>a</sup>R squared = .228 (Adjusted R Square = .212)

Note: Coursework = graduate coursework and clinical training, Postgraduate Clinical Contact = post graduate clinical work experience, CE/Licensure = continuing education credits/licensure requirements, Self-Learn = self-initiated learning, LCSW = Licensed Clinical Social Worker, LMFT = Licensed Marriage and Family Therapist and LMHC = Licensed Mental Health Counselor.

Also in this ANOVA analysis, graduate coursework and clinical training are represented as Coursework. Postgraduate clinical work experience is represented as Postgraduate Clinical Contact. Continuing education credits and licensure requirements are represented as CE/Licensure. And Self-initiated learning is represented as Self-learn. Results show a statistical significance for these variables, Coursework,  $F(1,517) = 3.443, p = .033$ , Postgraduate Clinical Contact,  $F(1, 517) = 40.073, p = .000$ , CE/Licensure,  $F(1, 517) = 3.464, p = .032$  and Self-learn,  $F(1,517) = 15.363, p = .000$ .

### Tukey HSD Post-Hoc

As a result of significant findings in the ANOVA analysis for variables Coursework, Postgraduate Clinical Contact, CE/Licensure and Self-learn, a Tukey HSD post-hoc analysis was conducted. The Tukey's HSD post-hoc analysis first examined the effect of Coursework in terms of influencing levels of perceived competency, if respondents rated themselves as High, Above Average or Average. It was determined there was no significant difference between Coursework and Greatly, Somewhat, or Not at All attributing to perceived levels of competency. A table of means is presented in Table 4-33. The conclusion is to fail to reject the null hypothesis and conclude that there is no significant interaction between graduate coursework and clinical training and perceived level of competency in assessing and treating domestic violence.

Table 4-21. Tukey HSD Test: Level of competence in assessing and treating domestic violence and Graduate Coursework/Clinical Training

Coursework attributed to competency	N	Subset 1
Somewhat	291	3.02
Not at all	163	3.04
Greatly	75	3.17
Sig		.140

*Note:* Based on observed means. The error term is Mean Square (Error) = .443  
 Uses Harmonic Mean Sample Size = 130.977. The group sizes are unequal. The harmonic mean of the group sizes is used. Type I error levels are not guaranteed.  
 Alpha = 0.05. Coursework = Graduate Coursework/Clinical Training.

Next, a Tukey’s HSD post-hoc analysis examined the effect of Post Graduate Clinical Contact in terms of influencing levels of perceived competency, if respondents rated themselves as High, Above Average, or Average. It was determined there was a significant difference between Post Graduate Clinical Contact and Greatly attributing to perceived levels of competency. A table of means is presented in Table 4-34. The conclusion is to reject the null hypothesis and conclude that there is a significant interaction between postgraduate clinical contact experience and perceived level of competency in assessing and treating domestic violence.

Table 4-22. Tukey HSD Test: Level of competence in assessing and treating domestic violence and Postgraduate Clinical Contact Experience

Employment attributed to competency	N	Subset	
		1	2
Not at all	19	2.42	
Somewhat	135	2.64	
Greatly	375		3.22
Sig		.252	1.000

*Note:* Based on observed means. The error term is Mean Square (Error) = .443 Uses Harmonic Mean Sample Size = 47.843 The group sizes are unequal. The harmonic mean of the group sizes is used. Type I error levels are not guaranteed. Alpha = 0.05. Employment = Postgraduate Work Experience.

A Tukey’s HSD post-hoc analysis examined the effect of CE/Licensure in terms of influencing levels of perceived competency, if respondents rated themselves as High, Above Average or Average. It was determined there was no significant difference between CE/Licensure and Greatly, Somewhat, or Not at All attributing to levels of perceived competency. A table of means is presented in Table 4-35. The conclusion is to fail to reject the null hypothesis and conclude that there is no significant interaction between continuing education credits/licensure requirements and perceived level of competency in assessing and treating domestic violence.

Table 4-23. Tukey HSD Test: Level of competence in assessing and treating domestic violence and Continuing Education Credits/Licensure Requirements

CE/Licensure attributed to competency	N	Subset 1
Somewhat	280	3.01
Greatly	213	3.07
Not at all	36	3.22
Sig		.094

*Note:* Based on observed means. The error term is Mean Square (Error) = .443 Uses Harmonic Mean Sample Size = 83.232. The group sizes are unequal. The harmonic mean of the group sizes is used. Type I error levels are not guaranteed. Alpha = 0.05. CE/Licensure = Continuing Education Credits/Licensure Requirements.

Lastly, a Tukey’s HSD post-hoc analysis examined the effect of Self-learn in terms of influencing levels of perceived competency, if respondents rated themselves as High, Above Average, or Average. It was determined there was a significant difference between Self-learn and Greatly attributing to perceived levels of competency. A table of means is presented in Table 4-36. The conclusion is to reject the null hypothesis and conclude that there is a significant interaction between self-initiated learning and perceived level of competency in assessing and treating domestic violence.

Table 4-24. Tukey HSD Test: Level of competence in assessing and treating domestic violence and Self-initiated Learning

Self-learn attributed to competency	N	Subset	
		1	2
Not at all	13	2.38	
Somewhat	149	2.74	
Greatly	367		3.19
Sig		.063	1.000

*Note:* Based on observed means. The error term is Mean Square (Error) = .443 Uses Harmonic Mean Sample Size = 34.739. The group sizes are unequal. The harmonic mean of the group sizes is used. Type I error levels are not guaranteed. Alpha = 0.05. Self-learn = Self-initiated Learning.

### Summary of Reliability

In sum, reliability is the consistency of a measure or “the extent to which a measure reflects systematic or dependable source of variation rather than random error” (Dooley, 2001, p. 350). Again, a pilot study was conducted for the purposes of

improving reliability of the Domestic Violence Perceived Competency Survey. Based on feedback from the pilot study, the wording and order of survey questions were revised to increase clarity and to reduce uncertainty of the Domestic Violence Perceived Competency Survey. Cronbach's alpha was used to test for internal consistency in this research study. Results of the reliability statistics, for variables Coursework and Practicum/Internship ( $\alpha = .942$ ,  $\alpha .911$  respectively), confirm that the Domestic Violence Perceived Competency Survey was a reliable indicator of how well various items measured the same concept.

The purpose of this study was to evaluate perceived competency levels in assessing and treating domestic violence among Florida licensed mental health professionals. Analysis of variance (ANOVA) and Chi-Square tests were conducted to determine associations between independent variables: graduate coursework training, practicum and/or internship training, postgraduate clinical contact experience, and licensure and continuing education requirements and the dependent variable, perceived levels of competency in assessing and treating domestic violence. The Domestic Violence Perceived Competency Survey was specifically designed to measure associations between these independent variables and the perceived level of competency of these professionals. Results of the data collected indicate no significant relationship between graduate coursework training, graduate practicum/internship training, and perceived level of competency. In addition, results indicate no significant relationship between types of licenses held/disciplines and perceived level of competence. However, results do indicate a significant relationship between postgraduate clinical contact experience and self-initiated learning and level of

perceived competency. Chapter 5 will discuss implications of these significant findings in detail.

## CHAPTER 5 DISCUSSION

### **Restatement of Purpose**

The purpose of this research study was to examine Florida mental health professionals perceived level of competency in assessing and treating domestic violence. The primary goal of this study was to determine how competent these mental health professionals felt about working with clients affected by domestic violence. In addition, this study examined if one mental health discipline over another reported higher levels of competency in assessing and treating domestic violence.

The Domestic Violence Perceived Competency Survey was developed by the researcher specifically for this study. The instrument was created after reviewing relevant literature in the area of domestic violence. In addition, a pilot study was conducted, prior to the main study, for the purposes of testing the instrument. Some revisions were made to the survey after receiving feedback from the pilot study.

A total number of 8,866 potential respondents were E-mailed an invitation to participate. There were a total of 618 respondents that actually participated in the study, of which 591 fully completed the survey.

### **Discussion of Results**

#### **Graduate Coursework Training**

Results of the ANOVA analysis and Chi-Square test for the variable of graduate coursework training indicated no significant difference between their Coursework Training and perceived level of competency among Florida mental health professionals in the assessment and treatment of domestic violence, by discipline. As a result, the conclusion was to fail to reject the null hypothesis that there are no significant

differences in levels of perceived competency by discipline based on graduate coursework training in assessing and treating domestic violence.

However, findings are not consistent with current literature which argues that mental health professionals need specific skills and knowledge in order to appropriately assess and treat domestic violence (Bograd & Mederos, 1999). Furthermore, additional literature suggests “academician awareness needs to be heightened for adding domestic violence interventions coursework into existing curriculums” (Wingfield & Blocker, 1998, p. 92). Moreover, Campbell, Raja and Grinning (1999) purport that victims of domestic violence are at greater risk of secondary victimization, if the mental health professional is not appropriately educated and trained to assess and treat domestic violence.

Based on current literature one can infer that more knowledge and training in the area of assessing and treating domestic violence would result in higher levels of perceived competency. However, results of this research study suggest that there is no significant relationship between graduate coursework training and perceived levels of competency among Florida licensed mental health professionals. That is, the study findings show that Florida licensed mental health professionals that reported a High, Above Average, or Average level of competency in assessing and treating domestic violence did not attributed graduate coursework training to their level of competency.

### **Graduate Practicum/Internship Training**

Results of the ANOVA analysis and Chi-Square test for the variable of graduate practicum and/or internship training indicated no significant difference between their Practicum/Internship Training and perceived level of competency among Florida licensed mental health professionals in the assessment and treatment of domestic

violence. As a result, the conclusion was to fail to reject the null hypothesis that there are no significant differences in the levels of perceived competency by discipline based on graduate practicum and/or internship training in assessing and treating domestic violence.

Interestingly, findings are consistent with current literature which argues that most graduate level programs only provide a general overview for working with clients involved in violent relationships. Only one of the three accrediting bodies of mental health graduate curriculums actually articulate in their core competencies that students must develop specific skills to screen for domestic violence and to have skills and understanding in the area of family violence (CSWE standards, 2001; CACREP standards, 2009; AAMFT, 2004). Often, graduate students do not obtain any practicum and/or internship experience involving clients with issues of domestic violence.

Based on the findings of this study Florida licensed mental health professionals that reported a High, Above Average or Average level of competency in assessing and treating domestic violence did not attribute practicum and/or internship training to their level of competency. Again, results of this research study suggest that there is no significant relationship between graduate practicum and/or internship training and perceived levels of competency by discipline, among Florida licensed mental health professionals.

### **Postgraduate Clinical Contact Experience**

Results of the Chi-Square test, ANOVA, and Tukey HSD analyses for the variable of Postgraduate Clinical Contact Experience do indicate a significant relationship between Postgraduate Clinical Contact and perceived level of competency among Florida mental health professionals in the assessment and treatment of domestic

violence. As a result, the conclusion was to reject the null hypothesis that there are no significant differences in the level of perceived competency based on post graduate clinical contact experience in assessing and treating domestic violence. Findings show that Florida licensed mental health professionals that reported a High, Above Average, or Average level of competency, attributed their level of competency to their postgraduate clinical contact experience. Again, study results showed a significant relationship between their post graduate clinical contact experience and perceived level of competency.

Findings are consistent with current literature which argues “virtually any mental health practitioner who works with women needs to have some understanding of the different forms of violence against women and the assessment and treatment effects of such violence” (Walker, 1994, p.4). Because most graduate level curriculums do not require specific coursework in the assessment and treatment of domestic violence (CSWE standards, 2001; CACREP standards, 2009; AAMFT, 2004), it seems as though most mental health professionals are obtaining their knowledge and skills through on-the-job training in assessing and treating domestic violence.

### **CE/Licensure Requirements**

Results of Chi-Square test indicate a significant difference between Requirements to Obtain Licensure and perceived competency. In addition, results of an ANOVA analysis for the variable to Maintain Licensure and Continuing Education Requirements indicated no significant difference between Licensure and Continuing Education Requirements and perceived level of competency among Florida licensed mental health professionals in the assessment and treatment of domestic violence. As a result, the conclusion was to reject the null hypothesis that there are no significant differences in

the levels of perceived competency by discipline based on licensure requirements or continuing education requirements in assessing and treating domestic violence.

Findings show that Florida licensed mental health professionals that reported a High, Above Average, or Average level of competency in assessing and treating domestic violence did not attribute licensure and continuing education requirements to their level of competency. However, Licensed Clinical Social Workers and Licensed Mental Health Counselors did report requirements to obtain professional licensure did promote competency in assessing and treating domestic violence.

Literature presented in this study is consistent with research findings. The state of Florida only requires two continuing education hours per every six years in the area of domestic violence (2009 Florida state statute, Chapter 491.004). In addition, the state of Florida does not have any requirements specific to domestic violence training for professionals seeking licensure as clinical social worker, marriage and family therapist, or mental health counselor. Findings in this research study show that mental health professionals do not feel the state of Florida promotes competency in assessing and treating domestic violence based on requirements to maintain professional licensure.

### **Self-Initiated Learning**

Results of the Chi-Square test, ANOVA, and Tukey HSD analyses for the variable of Self-initiated Learning do indicate a significant relationship between Self-learn and perceived level of competency among Florida mental health professionals in the assessment and treatment of domestic violence. Results show that mental health professionals who reported a High, Above Average, or Average level of competency, attributed their level of competency to Self-initiated Learning. Findings are consistent with literature, which suggest, mental health professionals are not obtaining the

knowledge and skills needed to assess and treat for domestic violence during their graduate school education (Windfield & Blocker, 1998). Research shows that mental health professionals are seeking knowledge and practice outside of traditional academic graduate school training programs. Again, “academician awareness needs to be heightened for adding domestic violence interventions coursework into existing curriculums” (Windfield & Blocker, 1998, p. 92).

### **Perceived Competency by Discipline**

Does one discipline over another report a higher level of competency when assessing and treating domestic violence? The answer is no. Results from the ANOVA analysis show no significant relationship between discipline (clinical social work, marriage and family therapy, and mental health counseling) and perceived level of competency. One discipline over another did not report a higher level of competency when assessing and treating domestic violence.

### **Implications for Training Florida Licensed Mental Health Professionals**

Given the findings of this research study it is reasonable to assume that most Florida licensed mental health professionals obtain their knowledge and skills of assessing and treating domestic violence by on-the job training and self-initiated learning, such as workshops and seminars, specific to domestic violence. That on-the-job training and self-initiated learning contribute to increased levels of perceived competency in assessing and treating domestic violence.

In addition, based on research findings one can also infer that one discipline over another does not better prepare their practitioners in assessing and treating domestic violence. There were no significant differences among disciplines studied, clinical social

work, marriage and family and mental health counseling, in their perceived level of competency in assessing and treating domestic violence.

Furthermore, one can infer that Florida licensed mental health professionals do not feel that their Graduate Coursework, Practicum and/or Internship Training or Licensure and Continuing Education Requirements contributed to their perceived competency level in assessing and treating domestic violence. Results found no significant differences in these variables.

Findings of this study suggest current curriculum guidelines do not require specific knowledge and skills to be obtained in the area of assessing and treating domestic violence. In addition, Florida laws do not articulate that mental health professionals seeking licensure under Chapter 491.004 have to master skills specific to assessing and treating domestic violence.

Literature presented in this research study certainly makes a case for the need of professionals to be trained in assessing and treating domestic violence. Current statistics show that one in four women will experience domestic violence in her lifetime (Tjaden & Thoennes, 2000). Each day at least three women in the United States die as a result of domestic violence (Bureau of Justice Statistics, 2005). Women are twice as likely to be killed by an intimate partner than men (Bureau of Justice Statistics, 2008). Experts in the field recommend various approaches for professionals working with clients facing issues of domestic violence. The mental health profession needs to ensure that practitioners in the field are being appropriately educated and trained to work this specialized population.

Based on these research findings, it is recommended that graduate training programs and accrediting bodies evaluate current curriculum requirements for graduate students in the area of domestic violence. Specifically, these institutions should examine required course work as well as required clinical experience specific to domestic violence. Accrediting bodies should articulate requirements for students to develop competencies in assessing and treating domestic violence. It is also suggested that graduate programs require students to take course work specific to domestic violence. In addition, graduate programs could also develop a domestic violence certificate program, in which students would be able to obtain specialized training in domestic violence theory, assessment, treatment intervention, as well as clinical contact with clients affected by domestic violence.

### **Recommendations for Future Research**

Results of this research study will benefit the mental health field as a whole. In addition, education policy makers, accrediting bodies, and licensure boards should pay particular attention to the results presented. Based on study findings, Florida licensed mental health professionals report that their graduate coursework training, graduate practicum and/or internship training as well as licensure and continuing education requirements do not contribute to their perceived level of competency in assessing and treating domestic violence. These results raise questions regarding current curriculum requirements in graduate education and well as clinical experience requirements for professional licensure. Results suggest that education policy makers, accrediting bodies, and licensure boards should consider re-evaluating current guidelines established for education and training in the area of domestic violence.

Future research in the area of domestic violence competency could examine more closely what kind of self-initiated learning professionals are seeking. By examining what is being self-learned, perhaps educational policy makers and accrediting bodies could implement changes to graduate curriculum programs so practitioners would feel more competent in working with issues of domestic violence. In addition, future research could examine what kind of postgraduate clinical contact experiences contribute to increased levels of competency and consider implementing changes to existing practicum and/or internship guidelines.

Lastly, results from this research study reported that current requirements to maintain professional license and continuing education did not increase levels of competency in assessing and treating domestic violence. Perhaps further research could be conducted to investigate how the state of Florida could better prepare mental health professionals in working with clients facing issues of domestic violence, by evaluating current requirements to maintain professional license, as well as requirements for continuing education.

### **Limitations of Research Study**

#### **Research Design**

As in most research studies there may be some limitations to the research design itself. One limitation in this research study relates to the population being surveyed. Of the 16,033 actively Florida licensed mental health professionals surveyed, only 8,866 have provided a contact E-mail address to the Florida Department of Health. This quantity equates to approximately 55% of the total sample population. The Florida Department of Health currently does not require licensed professionals to provide E-mail addresses when applying for or renewing a professional license. As a result, the

Domestic Violence Perceived Competency Survey was only E-mailed to those professionals who provided E-mail addresses to the Florida Department of Health.

### **Sample Size**

Another limitation of the sample used in this research study is that all disciplines are not equally represented. There are currently 3,786 Licensed Clinical Social Workers (LCSW) and 4,260 Licensed Mental Health Counselors (LMHC) in the state of Florida. However, there are only 820 Licensed Marriage and Family Therapists (LMFT). There are twice as many LCSW and LMHC represented than LMFT. As a result, this researcher will obtain more responses from the disciplines of clinical social work and mental health counseling, than of marriage and family therapy. However, this disparity does seem to be reflective of current trends in professionals seeking licensure in the state of Florida.

### **Social Desirability**

Asking individuals to evaluate themselves in terms of their knowledge and skills may present as another limitation to this research study. Respondents may want to represent themselves in the most socially desirable way, that is being very knowledgeable and skillful. There is a possibility that respondents in this study may have selected answers in a way that would make themselves appear more competent than they really are in the area of assessing and treating domestic violence.

### **Information Recall**

Also, some limitations may have resulted from the respondent not being able to remember information or experiences accurately. Dillman et al., (2009) found that it may be difficult for some respondents to recall the information the surveyor is asking

due to the fact memory fades over time. For some mental health professionals that have been practicing for many years, they might not be able to recall the exact coursework they had in graduate school or if training on domestic violence was obtained during graduate school or as continuing education, after licensure. As a result, respondents may not be able to answer some questions accurately.

### **Quantitative Methodology**

The quantitative method chosen for this research study may have limitations in terms of what results could be produced. For example, item 22 of the Domestic Violence Perceived Competency Survey allowed respondents to comment on their own training and clinical experience in the area of domestic violence. However, because responses were in a narrative format this data was not used in the analysis phase of this research study. Perhaps this narrative data collected could be used to further research competencies in assessing and treating domestic violence from qualitative approach. Qualitative research methods lends itself to more illustrative results by using interview, open questioning, and being more involved in the research. Overall, this quantitative research study established a foundation for future research in the area of evaluating practitioner competency in assessing and treating domestic violence.

### **Response Rate**

Invitations to participate in this research study were E-mailed to 8, 866 potential respondents, of which 573 were returned due to invalid E-mail address. In addition, 36 respondents E-mailed the researcher and declined to participate in the study. A total of 618 licensed professionals responded to the survey, of which 591 respondents fully completed the survey. As a result, a response rate 7.5% was obtained. This low response rate places limitations on the representativeness of the sample surveyed.

Dillman, Smyth and Christian (2009), suggest researchers looking to improve response rates do so by utilizing mixed mode surveys: “One of the most important ways that mixed-mode surveys have been shown to enhance data quality is by improving response rates (Dillman et al., 2009, p.304); that is, offer multiple ways for potential respondents to participate in the study, such as online as well as paper surveys. By offering more than one way to complete the survey, the researcher can improve chances of obtaining a representative sample (Dillman et al., 2009).

### **Nonresponse Error**

According to Dillman, Smyth and Christian (2009), paper surveys are preferred by respondents, as opposed to E-mail surveys. Dillman et al. stated, “There is no technological barrier with mail surveys in that most people receive and are comfortable with open postal mail” (Dillman et al., 2009, p. 447). Another limitation to this research study may have been the E-mail survey mode in which the survey was distributed. Some potential respondents could have been concerned about opening the E-mail invitation from someone they did not know for fear of receiving a virus on their computer. This may have resulted in respondents choosing not to respond to the survey invitation, contributing to the overall low response rate of this study.

Nonresponse error could have also been related to respondents not receiving the E-mail invitation to participate in this research study. Dillman, Smyth and Christian (2009) recommend sending “Individual E-mails rather than using bulk mailing options, and not using the “CC” or “BCC” fields to avoid the survey being flagged as spam” (p. 285). Furthermore, Dillman, Smyth and Christian (2009) recommend researching spam filters to gain the most up-to-date information, just prior to administering the survey. These techniques were not employed when E-mailing the Domestic Violence Perceived

Competency survey and as a result could have prevented a large number of potential respondents from ever receiving the E-mail invitation to begin with.

In addition, Dillman, Smyth and Christain (2009) recommend sending follow-up E-mails to remind potential respondents to participate in a research study. Reminder E-mails were not sent to potential respondents in this research study which may have contributed to the nonresponse error, resulting in a low response rate. Dillman et al. (2009) argue that follow-up reminders are “the most powerful way of improving response rates” (p. 360).

### **Coverage Error**

Another limitation worth mentioning relates to coverage error. As stated in Chapter 3, as of 2010 there were a total of 16,033 Florida mental professionals, licensed under Chapter 491.004. However, the Department of Health only had E-mail addresses for 8,866 of those 16,033 professionals. Therefore, a survey invitation could not be email to 7,167 potential respondents. Again, Dillman, Smyth and Christian (2009) recommend reducing coverage error by administering mixed-mode surveys. Mailing addresses were provided by the Department of Health for all 16,033 licensed professionals. Perhaps paper surveys could have been mailed to the 7,167 respondents without E-mail addresses, in addition to the 8,866 E-mail surveys.

### **Conclusion**

This quantitative cross-sectional research study examined Florida licensed mental health professionals' perceived level of competency in assessing and treating domestic violence. Various theoretical frameworks were presented regarding the assessment and treatment of domestic violence. Certainly current research and statistics demonstrate a need to focus on improving our knowledge about domestic violence.

Based on results of this study, it seems as though mental health professionals are obtaining knowledge and skills outside of traditional graduate academia training. Most professionals reported receiving domestic violence training on-the-job or through self-initiated means, like workshops and seminars. In conclusion, findings of this study demonstrate the need for continued education and research in the area of domestic violence training.

## APPENDIX A

### DOMESTIC VIOLENCE PERCEIVED COMPETENCY SURVEY

#### Domestic Violence Perceived Competency Survey

##### Informed Consent

Dear Mental Health Professional:

Thank you for taking the time to participate in my research study. I am a graduate student in the School of Human Development & Organizational Studies in Education at the University of Florida. The purpose of this study is to examine mental health professionals licensed in the state of Florida under Chapter 491, specifically Licensed Clinical Social Workers, Licensed Mental Health Counselors and Licensed Marriage and Family Therapists, and their perceived level of competence in assessing and treating domestic violence. The information you provide will potentially benefit the mental health profession, in terms of increasing professionals' competency in assessing and treating domestic violence.

Completing this survey is voluntary and you may withdraw your consent at any time. Your responses will be anonymous and there are no anticipated risks associated with completing this survey. There are no benefits to you for participating in the study. You should allow yourself approximately 15-20 minutes to complete survey. There is no compensation to you for participating in the study.

SurveyMonkey provides data security by using Secure Sockets Layer (SSL) technology to protect user information using both server authentication and data encryption. This ensures that user data is safe, secure, and available only to authorized persons.

SurveyMonkey requires users to create a unique user name and password that must be entered each time a user logs on. SurveyMonkey issues a session "cookie" only to record encrypted authentication information for the duration of a specific session. The session cookie does not include either the username or password of the user.

Furthermore, SurveyMonkey is hosted in a secure data center environment that uses a firewall, intrusion detection systems, and other advanced technology to prevent interference or access from outside intruders. The data center has several levels of physical access security and 24-hour surveillance.

Lastly, all email IP addresses of participants will be decoupled from their responses.

If you have any questions concerning this survey please contact me at [domesticviolencesurvey@yahoo.com](mailto:domesticviolencesurvey@yahoo.com). You can also contact my supervisor Dr. Silvia Echevarria-Doan at the School of Human Development & Organizational Studies in Education, University of Florida, PO Box 117046, 1215 Norman Hall, Gainesville, FL 32611-7046, 352-273-4323(phone) or [silvia@coe.ufl.edu](mailto:silvia@coe.ufl.edu) (email). For information regarding your rights as a research participant contact the IRB office at 352-392-0433.

If you would like a copy of the results of this survey please email me at [domesticviolencesurvey@yahoo.com](mailto:domesticviolencesurvey@yahoo.com).

By selecting 'I Agree' you are stating you voluntarily agree to participate in this survey. Once you indicate your consent, select the 'Next' button to proceed to the instructions page.

Thank you again,

Jacqui Knowles, Ed.S., LMHC  
Principal Investigator  
Doctoral Candidate  
School of Human Development & Organizational Studies in Education  
University of Florida

## Domestic Violence Perceived Competency Survey

### Informed Consent (continued)

**1. I have read and understand the procedures outlined for participating in this survey. I voluntarily agree to participate in this survey.**

I agree

I do not agree

## Domestic Violence Perceived Competency Survey

### Instructions

You will be asked to answer 30 multiple choice questions evaluating your perceived competency in assessing and treating domestic violence.

There are an additional 9 questions regarding your demographic information at the end of this survey.

Please take your time reflecting on your experiences. You will not have to answer any questions you do not wish to answer. Please answer questions honestly. Your responses will be anonymous.

Select the 'Next' button to proceed to the definitions page.

## Domestic Violence Perceived Competency Survey

### Definitions

For the purposes of this survey, DOMESTIC VIOLENCE is defined as:

the physical, psychological or sexual abuse of one family or household member by another family or household member. Physical abuse includes, but not limited to hitting, slapping, kicking, punching, with or without a weapon, which causes pain or injury. Psychological abuse includes, but is not limited to stalking, humiliation, verbal abuse, false imprisonment, social isolation, economic deprivation or any other controlling type behavior. Sexual abuse includes but not limited to any unwanted, coerced, forced, or threat of forced sexual acts or attempted sexual acts.

Please select the 'next' button to proceed to the survey.

## Domestic Violence Perceived Competency Survey

How competent do you feel about your:

### 2. Knowledge of concepts and theories of domestic violence.

- Very Competent
- Competent
- Slightly Competent
- Not Competent

### 3. Ability to identify signs of domestic violence during client contact.

- Very Competent
- Competent
- Slightly Competent
- Not Competent

### 4. Knowledge of facts and myths of domestic violence.

- Very Competent
- Competent
- Slightly Competent
- Not Competent

## Domestic Violence Perceived Competency Survey

How competent do you feel about your:

**5. Knowledge of the on-going interpersonal dynamics between individuals in a violent relationship.**

- Very Competent
- Competent
- Slightly Competent
- Not Competent

**6. Knowledge of domestic violence treatment approaches.**

- Very Competent
- Competent
- Slightly Competent
- Not Competent

**7. Ability to implement these domestic violence treatment approaches.**

- Very Competent
- Competent
- Slightly Competent
- Not Competent

## Domestic Violence Perceived Competency Survey

How competent do you feel about your:

**8. Knowledge of how gender, race, class, and sexual orientation influence your understanding of domestic violence.**

- Very Competent
- Competent
- Slightly Competent
- Not Competent

**9. Knowledge of how one's own culture influences perceptions of domestic violence.**

- Very Competent
- Competent
- Slightly Competent
- Not Competent

**10. Knowledge of cycles of violence.**

- Very Competent
- Competent
- Slightly Competent
- Not Competent

## Domestic Violence Perceived Competency Survey

How competent do you feel about your:

**11. Knowledge of typologies of perpetrators of domestic violence.**

- Very Competent
- Competent
- Slightly Competent
- Not Competent

**12. Ability to assess for domestic violence, during a therapy session.**

- Very Competent
- Competent
- Slightly Competent
- Not Competent

**13. Ability to identify risk factors for domestic violence.**

- Very Competent
- Competent
- Slightly Competent
- Not Competent

## Domestic Violence Perceived Competency Survey

How competent do you feel about your:

**14. Ability to provide safety planning for clients experiencing domestic violence.**

- Very Competent
- Competent
- Slightly Competent
- Not Competent

**15. Ability to refer clients experiencing domestic violence to agencies that provide victim assistance.**

- Very Competent
- Competent
- Slightly Competent
- Not Competent

## Domestic Violence Perceived Competency Survey

How aware were you of domestic violence in your:

**16. Face-to-face client contact practicum experience.**

- Very Aware
- Aware
- Slightly Aware
- Not Aware

**17. Face-to-face client contact internship experience.**

- Very Aware
- Aware
- Slightly Aware
- Not Aware

**18. Individual supervision experience.**

- Very Aware
- Aware
- Slightly Aware
- Not Aware

**19. Group supervision experience.**

- Very Aware
- Aware
- Slightly Aware
- Not Aware

## Domestic Violence Perceived Competency Survey

**20. Were you trained how to assess and treat for domestic violence by your site staff during your:**

	Yes	No
Practicum	<input type="radio"/>	<input type="radio"/>
Internship	<input type="radio"/>	<input type="radio"/>
Individual Supervision	<input type="radio"/>	<input type="radio"/>
Group Supervision	<input type="radio"/>	<input type="radio"/>

**21. Were you trained how to assess and treat for domestic violence by your faculty advisor during your graduate studies?**

- Yes  
 No

**22. Is there anything else that I need to know regarding your domestic violence training and clinical experience that I have not asked?**

## Domestic Violence Perceived Competency Survey

**23. Do you feel the state of Florida requirements for licensure under Chapter 491, promotes competency in assessing and treating domestic violence?**

	Yes	No
To obtain license	<input type="radio"/>	<input type="radio"/>
To maintain license	<input type="radio"/>	<input type="radio"/>

**24. During your graduate training how many courses did you take that were specifically about domestic violence?**

- 0
- 1-2 courses
- 3-4 courses
- more than 5 courses

## Domestic Violence Perceived Competency Survey

**25. How many contact hours did you obtain with clients facing issues of domestic violence while completing your graduate practicum training?**

- None
- 1-50 contact hours
- 51-100 contact hours
- over 200 contact hours

**26. How many contact hours did you obtain with clients facing issues of domestic violence while completing your graduate internship training?**

- None
- 1-50 contact hours
- 51-100 contact hours
- over 200 contact hours

**27. Since graduating with your Masters degree, how many contact hours have you completed with clients facing issues of domestic violence?**

- None
- 1-100 contact hours
- 101-200 contact hours
- over 200 contact hours

## Domestic Violence Perceived Competency Survey

**28. Approximately how many continuing education hours have you obtained that were specifically about domestic violence, since licensure?**

- 0-10 hours  
 11-20 hours  
 21-30 hours  
 over 30 hours

**29. How do you rate your own level of competence in assessing and treating domestic violence?**

- High  
 Above Average  
 Average  
 Low

**30. If you rated yourself Average, Above Average or High (in #29), do you attribute your level of competence to your:**

	greatly	somewhat	not at all	n/a
Graduate coursework and clinical training	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Post graduate work experience	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Continuing education credits/licensure requirements	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Self-initiated learning	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

## Domestic Violence Perceived Competency Survey

### Demographic Information

#### 31. Current license status

- active
- inactive

#### 32. Gender

- Male
- Female

#### 33. Age

- 18-28 years old
- 29-39 years old
- 40-49 years old
- 50-59 years old
- 60-69 years old
- 70+ years old

## Domestic Violence Perceived Competency Survey

### Demographic Information

**34. Highest level of education**

- Masters Degree  
 Specialist Degree  
 Doctoral Degree

**35. What year(s) did you receive your degree(s):**

Masters degree   
Specialist degree   
Doctoral degree

**36. What license(s) do you hold under Chapter 491 (select all that apply):**

- LCSW  
 LMFT  
 LMHC

## Domestic Violence Perceived Competency Survey

### Demographic Information

**37. How many years have you been practicing as a licensed professional under Chapter 491?**

- less than one year
- 1-5 years
- 6-10 years
- 11-20 years
- more than 20 years

**38. Number of years licensed under Chapter 491**

**39. If you hold multiple licenses, which profession do identify with the most? (select one)**

- Marriage and Family Therapy
- Mental Health Counseling
- Clinical Soical Work

APPENDIX B  
COVER LETTER

Dear Mental Health Professional,

I am emailing you to participate in a research study that I am conducting for my doctoral dissertation at the University of Florida. The purpose of my study is to evaluate mental health professionals' perceived level of competency when assessing and treating domestic violence. Specifically, I am surveying all actively Licensed Clinical Social Workers, Licensed Mental Health Counselors and Licensed Marriage and Family Therapists, in the state of Florida, licensed under Chapter 491. Results from this survey may provide insight to the mental health profession, accrediting bodies, licensure boards, educators and policy makers regarding training needs in the area of assessment and treatment of domestic violence.

Participation is voluntary and your answers will remain anonymous. This survey will only be administered online. It should take approximately 15-20 minutes to complete. Please click the link [www.surveymonkey.com/s/3NJD25Y](http://www.surveymonkey.com/s/3NJD25Y) to access the survey. You will first be directed to the 'informed consent' page. Select 'I Agree' if you chose to participate in this study. Next you will be directed to the 'instructions page' and then the survey itself.

If you have any questions, please feel free to contact me at [domesticviolencesurvey@yahoo.com](mailto:domesticviolencesurvey@yahoo.com).

Thank you so much for your time and participation.

Sincerely,

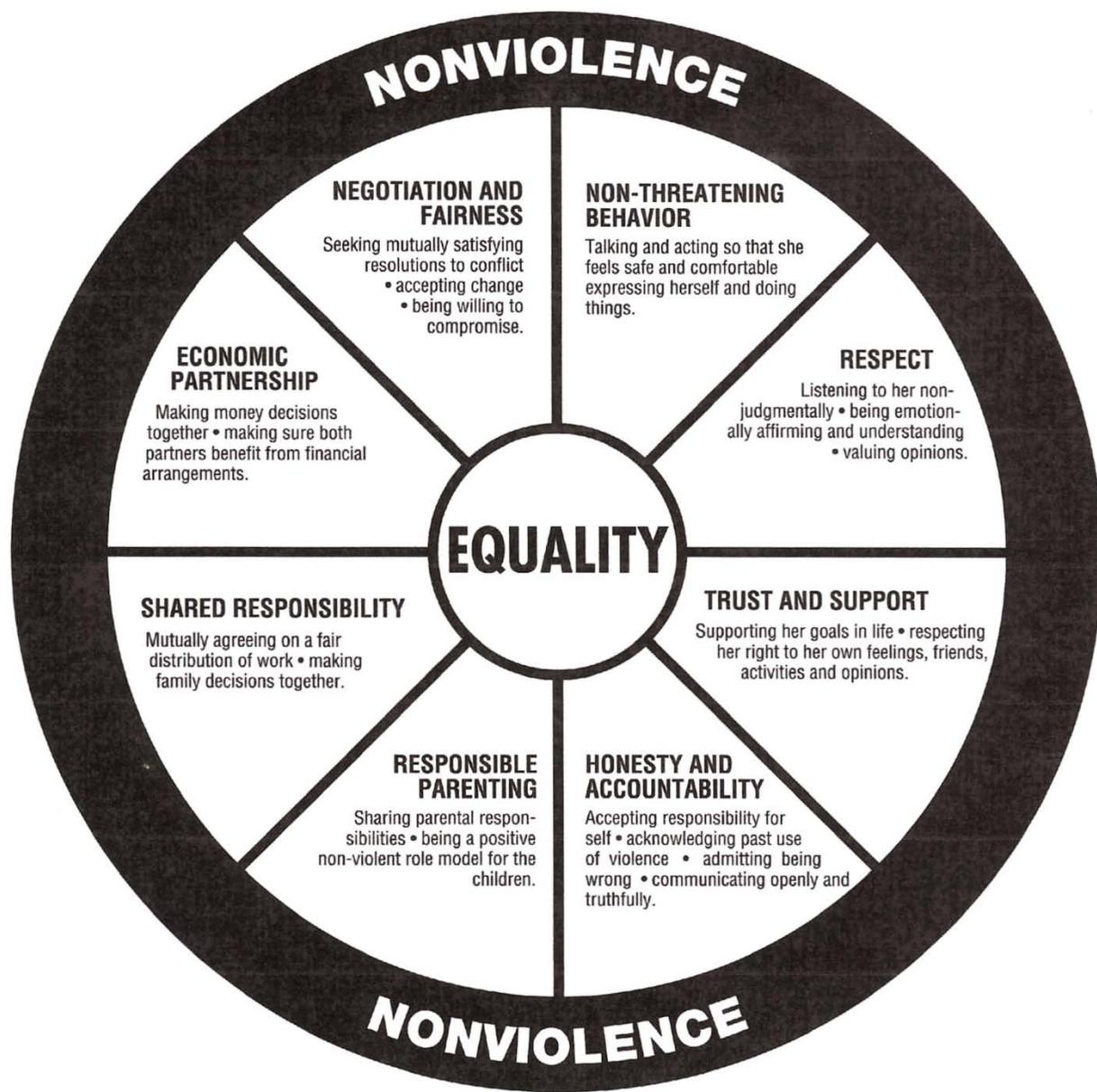
Jacqui Knowles, Ed.S., LMHC  
Doctoral Candidate  
School of Human Development and Organizational Studies in Education  
University of Florida

APPENDIX C  
POWER AND CONTROL WHEEL



DOMESTIC ABUSE INTERVENTION PROJECT  
202 East Superior Street  
Duluth, Minnesota 55802  
218-722-2781  
www.duluth-model.org

APPENDIX D  
EQUITY WHEEL



**DOMESTIC ABUSE INTERVENTION PROJECT**

202 East Superior Street  
Duluth, Minnesota 55802  
218-722-2781  
[www.duluth-model.org](http://www.duluth-model.org)

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## BIOGRAPHICAL SKETCH

Jacqueline Kirkwood Knowles was born in Fort Lauderdale, Florida, and is a native Floridian. She was raised in Coral Springs, Florida, by her parents Kevin and Elaine Kirkwood. She has one sister, Kristine Kirkwood Simone. She received her Bachelor of Arts degree from the University of Florida in 1994, majoring in criminal justice with a minor in business administration. Later that same year she attended and completed six months of training at the Institute of Public Safety at Santa Fe Community College (the police academy) as a police officer recruit. However, she did not pursue a career in law enforcement but instead continued her education. In January of 1995 she began her graduate studies in the Department of Counselor Education at the University of Florida. She received her Master's/Specialist degree in Marriage and Family Therapy in 1997. After graduation, she began working with the Gainesville Police Department as a Victim Advocate. This position was grant-funded and short term. Later that same year in 1997, she began working for the State of Florida, Department of Corrections, as a Psychological Specialist. Specifically, she worked in an outpatient mental health clinic at the North Florida Reception Center which served adult male inmates serving prison sentences in the Florida Department of Corrections. Her work included initial psychological assessments for inmates entering the correctional system, individual therapy, group therapy, some inpatient work including suicide observations, as well as disciplinary confinement evaluations. Inmates varied in terms of sentence and crimes; some were serving one year, one day for burglary, and others life sentences for homicide. During that time she obtained licensure from that State of Florida for Mental Health Counselor. In 1998, while working for the Department of Corrections, she decided to further pursue studies for her Ph.D. in Mental Health Counseling in the

Department of Counselor Education at the University of Florida. She left the Department of Corrections in 2003, six months after her first child was born, but continued her studies toward her Ph.D. Studies included co-teaching a graduate family violence course, as well as undergraduate level counseling courses. She currently lives in Alachua, FL with her husband Bart and two children, Cale and Reese. And after a long road traveled, she will finally complete her Ph.D. studies...surprising most of her family, friends, professors, and mostly, herself.