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The Ubiquitous Clinical Problem of Adult Intimate Partner Violence: The Need for Routine Assessment

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Mental health providers need to know that the problem of intimate partner violence (IPV) is ubiquitous—that is, seemingly everywhere at once—within populations that access health care services. Because IPV is a gendered phenomenon where women predominantly tend to be victimized and because women tend to access psychological services at higher rates than men, there is an increased probability that victims of IPV will access services. Without this awareness, diagnostic procedures may be inaccurate, and providers may not intervene to reduce lethality if IPV is not evaluated as part of routine assessment procedures. This article provides concrete procedures for IPV screening and assessment in order to adequately address the problem and also presents initial safety-planning strategies.

Keywords: intimate partner violence, psychological service delivery, screening, assessment, safety planning

Health care providers must be able to accurately assess for intimate partner violence (IPV), yet there is evidence that many providers may not know how to do so. Over a decade ago, Hansen, Harway, and Cervantes (1991) and Harway and Hansen (1993) published their seminal articles on North American therapists' perceptions of family violence. These authors examined the ability of therapists to identify IPV issues. After reading a clinical vignette concerning a situation based on a true case where a male intimate partner raped and then killed his female partner shortly after their family visit to a therapist, respondents were asked to evaluate the situation. In terms of attribution/conceptualization, only 19% of the therapists surveyed said the problem was the male partner's dynamics, while 31% said the problem was couple dynamics. Sixteen percent of the respondents were vague and noncommittal, while 8% said the female partner was the problem. Perhaps most troubling of all was that only about 50% of the respondents said that safety management was the correct intervention for the male and female partners and their children. Twenty-seven percent said they needed more information before they would act, and 11% said they would focus on increasing communication between the two partners.

Hansen et al. (1991) and Harway and Hansen (1993) also found that only slightly more than half (54%) could be classified as *contextualists* who were focused on safety planning, 34% could be classified as *communication interventionists* who were focused on couple communication, 9% could be classified as *avoiders* who needed more information before acting, and 3% could be classified as *undetermined* with unclassified and vague responses. Thus, results reviewed above suggest that about half of the therapists could not correctly identify or assess the serious lethality within the clinical vignette presented. Obviously, without correct assessment, effective intervention is highly unlikely in such a situation.

Evidence from a New Zealand study further shows that mental health providers in general do not know how to correctly assess or intervene with clients who present with victimization-related issues. Agar and Read (2002) examined treatment plans at a community mental health center for clear identification of survivors of abuse. Only 36% of clinical summaries and 33% of the treatment plans for these clients even mentioned the abuse, and only 22% of abused clients received therapy directly addressing their victimization. The widespread inability to correctly assess or intervene concerning victimization-related issues is not limited to mental health providers, however, and extends into other health care arenas as well.

Goff, Shelton, Byrd, and Parcel (2003) found that the lack of effective and appropriate IPV screening was striking among physicians, dentists, and nurse practitioners located in a Texas–Mexico border community. Failure to screen was due to a generalized lack of understanding or education about the issue, as well as the lack of standardized routine screening tools. Similarly, Edin and Hogberg (2002) found that midwives in Sweden routinely failed to assess the women in their care for the presence of physical or sexual abuse victimization. Edin and Hogberg also found, however, that midwives were open to incorporating IPV assess-

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ment tools into their contacts with women and that they rated the need for professional IPV education and training as high.

Even though there are valid, short-form screening tools available for health providers (e.g., Sherin, Sinacore, Xiao-Qiang, Zitter, & Shakil, 1998), the availability of such tools is no guarantee they will be used to good effect. For example, Davis, Parks, Kaups, Bennick, and Bidello (2003) reported that IPV victimization was unrecognized and underreported in a trauma unit located in California, even after a standardized screening procedure was developed. The authors concluded that the simple provision of IPV screening tools to trauma workers was not sufficient—the workers must believe it is important enough to use these tools in the everyday course of treatment.

Training related to types of abuse other than IPV has also been a recent topic for research. Champion, Shipman, Bonner, Hensley, and Howe (2003) examined the extent of training in child-maltreatment issues in mental-health-related doctoral programs and found that, although students, on average, had some exposure to clients with these types of problems, training fell short of the American Psychological Association guidelines for minimal levels of competence. Yet there is ample evidence from other professions that training on violence issues can increase the likelihood of screening for such problems (e.g., student nurse and dentist training; Danley, Gansky, Chow, & Gerbert, 2004; Hinderliter, Doughty, Delaney, Pitula, & Campbell, 2003).

For example, medical students and residents who receive training in IPV-related issues are more likely to screen patients for violence-related problems, as well as to increase their accuracy in IPV identification (Haist et al., 2003; Korenstein et al., 2003; Sitterding, Adera, & Shields-Fobbs, 2003). Despite the demonstrated effectiveness of training medical students on violence-related issues, however, Miller, Coonrod, Brady, Moffitt, and Bay (2004) found that, in 2001, incoming medical residents were no more likely to receive violence-related training hours than those entering their residencies in 1995, and thus the likelihood of effective screening had also not increased over time.

Thus, it seems that health care providers may lack awareness of IPV issues, even though training has proven effective. To summarize, what is needed is both (a) education for service providers concerning the effects of IPV on clients who present for treatment, and (b) assessment strategies that increase the probability that a provider will correctly identify the presence of danger, thereby also reducing lethality. Treatment providers not only need to understand how widespread IPV truly is within clinical populations, but also need to recognize the devastating impact of violence on the well-being of those in their care. It is imperative for the safety of clients that providers effectively recognize and assess IPV situations. To this end, we present the following material in two sections: (a) the prevalence, severity, and psychological effects of IPV and the populations most affected (basic educational background), and (b) suggested assessment approaches leading to initial intervention strategies, specifically safety planning.

Educational Background Concerning IPV

Prevalence and Severity: Gender Asymmetry

IPV victimization is primarily a gendered phenomenon—that is, women are disproportionately victims of IPV and men are disproportionately the perpetrators, resulting in gender asymmetry. Although there have been controversies over IPV gender asymmetry in the literature (see Malloy, McCloskey, Grigsby, & Gardner, 2003, for a recent review), research overwhelmingly supports the notion that women are more negatively impacted when it comes to the consequences of IPV.

Regional surveys support increased rates of IPV victimization against women compared with men. In a sample of 3,604 respondents from the state of Washington, 23.6% of women reported experiencing IPV compared with 16.4% of men, and 21.6% of women reported experiencing injury during IPV compared with 7.5% of men (Washington State Department of Health, 2000). In a 1998 regional survey of residents in the state of South Carolina, 25% of women reported a lifetime prevalence of IPV at the hands of a partner compared with 13% of men (South Carolina Department of Health and Environmental Control, 2000).

In terms of national surveys, data collected between 1987 and 1988 from the U.S. National Survey of Families and Households showed that, of those injured as a result of IPV, 73% were women and 27% were men (Zlotnick, Kohn, Peterson, & Pearlstein, 1998). Similarly, results from the U.S. National Crime Victimization Survey showed that the rate of IPV victimization was 7.7 per 1,000 for women but only 1.5 per 1,000 for men, and that over 50% of female IPV victims were injured as a result of IPV (Bureau of Justice Statistics, 1999; Rennison & Welchans, 2000). In addition, within this data set the proportion of men killed as a result of IPV dropped significantly from 1976 to 1998, whereas the proportion of women killed increased.

The largest, most recent population survey in the United States was the National Violence Against Women Survey, sponsored jointly by the National Institute of Justice and the Centers for Disease Control and Prevention. This survey sampled 8,000 men and 8,000 women between 1995 and 1996 concerning their responses to questions about a wide range of behaviors considered to fall under IPV, including sexual violence, emotional or psychological abuse, stalking, and physical violence (Tjaden & Thoennes, 2000a, 2000b). Tjaden and Thoennes (2000a, 2000b) found that lifetime prevalence of physical assault and/or rape at the hands of an adult intimate partner was 25% for women and 7.6% for men; men in this sample reported virtually no sexual violence. Findings also showed that IPV against women was more often accompanied by emotional abuse and controlling behaviors than IPV against men. In addition, 45% of women versus 20% of men reported fear of serious injury or death at the hands of an intimate partner. Women sustained injury, required medical treatment, were hospitalized, sought mental health treatment, lost work time, reported IPV to the police, and obtained protection orders at greater rates than did men. Results also showed that women were 22.5 times more likely to be raped than men, 8.2 times more likely to be stalked, and 2.9 times more likely to be physically assaulted by an intimate partner than men. Further evidence that IPV is perpetrated primarily by men was found when examining rates of IPV from same-sex intimates. Eleven percent of women cohabiting with women experienced IPV compared with 30.4% of women cohabiting with men. On the other hand, 7.6% of men cohabiting with women experienced IPV compared with 15% of men cohabiting with men. Thus, cohabiting with a man increased the risk of IPV for both men and women.

Gender in the Therapy Room: Clients Are Most Likely Women and Women Are Most Likely Survivors of IPV

As shown above, women overwhelmingly shoulder the negative impact of IPV. Given that the most recent research suggests that about one quarter of all women in the United States have been victims of IPV at some time in their lives, service providers should not only expect but prepare for women presenting with problems directly related to IPV. This is especially true because it has been shown that women tend to access mental health services at greater rates than men. Rhodes, Goering, To, and Williams (2002) recently showed that of 7,475 Canadian individuals who responded to their survey, women's use of mental health services (providers seen in the past year) was higher than men's. Addis and Mahalik (2003) and Mahalik, Good, and Englar-Carlson (2003) also found that men tend to seek psychotherapeutic treatment at lower rates than do women. Some have explained this gender discrepancy as due to the impact of male gender roles (the strong, stoic, silent type) on help-seeking behavior, as well as inhibition of the emotional awareness needed to identify and own a personal problem (e.g., Moeller-Leimkuehler, 2002). Regardless of the underlying explanation, North American therapists can expect their clients to include a disproportionate number of women when compared with the general population.

This gender discrepancy in mental health help-seeking behavior further lends support to the assumption that IPV is ubiquitous—that is, widespread—within client populations seeking services. Walker (1994) and Herman (1992) provided reviews of the literature showing that up to 60% of women seeking mental health services also had a history of physical abuse, although they tended not to be diagnosed or treated specifically for IPV. Walker (1994) suggested that the historical invisibility of victimization within the mental health field exists because providers simply do not ask questions relevant to IPV. She further stated that, if the context of IPV is absent, the psychological sequelae of IPV in women masquerade as mental health symptoms, which can lead to misdiagnosis. As shown below, therapists need to be aware of how the context of IPV victimization affects psychological functioning.

Contextualization: Psychological Effects of IPV Victimization

Investigators have found that with couples reporting IPV, women exhibited significantly more fear of their partners than did men (Cantos, Neidig, & O'Leary, 1994; Dasgupta, 1999). For example, Dasgupta (1999) interviewed 32 women who were either court ordered or self-referred as a result of aggressive behavior against a male partner, as well as 10 men who had been the target of aggressive behavior by their female partners. Both men and women reported that, overall, the men involved were not fearful of their female partners; on the other hand, women reported significant long-term levels of fear toward their male partners. Cantos et al. (1994) also concluded that women in their sample lived in greater fear than did their male partners.

Living in fear is not the only negative psychological impact of IPV, however. Traumatic brain injury due to repeated physical assaults may present as cognitive deficits (e.g., Jackson, Philp, Nuttall, & Diller, 2002), and elevated scores on standard personality assessment tools may be found (e.g., Morrell & Rubin, 2001). Indeed, it has been known for almost 30 years that the emotional and psychological sequelae of IPV in women can present as "cognitive disturbances, high avoidance or depression behaviors, and high arousal or anxiety disturbances" (Walker, 1994, p. 70). Bloom and Reichert (1999), Herman (1992), and Walker (1994) have documented the following symptoms that may arise as a result of victimization: (a) cognitive attentional deficits that may bring about a dissociative state, (b) a chronically pessimistic cognitive style sometimes linked to depressive presentations, (c) neurological deficits as a result of repeated head beatings and head shaking, (d) avoidance behaviors including seclusion and isolation, denial, minimization, and repression of traumatic memories, (e) high arousal symptoms including anxiety, phobias, sleep disorders and nightmares, sexual dysfunctions, panic attacks, nervousness, heart palpitations, hypervigilance, hypersensitive startle responses, and obsessive–compulsive behaviors, and (f) somatic sequelae from chronic exposure to abuse, which can result in a breakdown of the immunological system, stomach or intestinal disease, susceptibility to infection, chronic headaches, and other physical diseases.

While Walker (1994) stated that the above litany of negative outcomes resulting from victimization meets many of the standard criteria for posttraumatic stress disorder (PTSD), she also suggested that a more appropriate and accurate descriptive category be used—namely, *battered women syndrome*. In addition, there is clear evidence that the battered women syndrome meets standard clinical criteria of a well-defined mental health syndrome and has become admissible as evidence in court (O'Leary & Jacobson, 1997), leading to the suggestion that this diagnostic category should be codified diagnostically as a subset of or companion to PTSD. Regardless of this diagnostic controversy, many female victims of IPV have received the common misdiagnoses of schizophrenia, clinical depression, generalized anxiety disorder, obsessive–compulsive disorder, psychosexual disorders, somatoform disorders, dependent personality disorder, and borderline personality disorder without regard to the context of abuse (Dienemann et al., 2000; Gleason, 1993; Rathus & Feindler, 2004; Walker, 1991, 1994). In any case, it seems obvious that IPV victimization can lead to psychological symptoms that may be misdiagnosed if the context of victimization is neither recognized nor understood.

Given that the psychological sequelae resulting from IPV are more severe for women, it should give clinicians pause during assessment. It is quite possible that complicated forms of PTSD in female victims of IPV may masquerade as many of the standard gendered diagnoses used by mental health professions.[1] Even those researchers who are sensitive to gender differences within the mental health arena are not immune to the invisibility of the issue. For example, Rosenfield (1999) recently discussed why mental health diagnoses may vary along gender lines. She pointed out that because of gender stereotypes, role expectations, and social and institutional inequalities, women tend to have more internalizing disorders, such as depression, anxiety, and obsessive behaviors, whereas men tend to have more externalizing disorders, such as antisocial disorders and substance abuse. However, strong emphasis on the effects of widespread violence against women at

[1] This is not to suggest that trauma survivors never have other comorbid mental health issues. The point here is that without accurate identification of past or present victimization, misdiagnosis is more likely to occur.

the hands of men was missing in the analysis of gender. The downplaying and relative invisibility of the effects of IPV are not surprising and have been strikingly documented in the past by Bloom and Reichert (1999) and Herman (1992).

Summary

The above review of the background information on IPV provides a strong case for the importance of routine IPV mental health assessments within the general clinical population. This review can be summarized thus: (a) women constitute the majority of clients presenting for mental health services, (b) victims of IPV are overwhelmingly women, and thus are likely to suffer from psychological symptoms as a result of IPV victimization, (c) clear, predictable psychological symptoms result from IPV victimization, which may be commonly misdiagnosed by a clinician who does not understand or assess the context of IPV, and (d) it is important that mental health clinicians understand this shortcoming and educate themselves about IPV so that effective assessment, diagnosis, and initial safety-planning strategies may be used. Below we present a suggested clinical assessment approach based on conceptual and theoretical issues that heavily emphasize safety, as well as years of clinical experience within the field of IPV. It should be noted here that this approach is designed specifically for use by nonforensic practitioners in the regular course of therapy and assessment. Use in forensic arenas may require a higher level of empirical support than is available here.

IPV Assessment Approaches

This section presents ways that mental health clinicians can incorporate IPV materials into routine screening and assessment approaches. It should be noted that these approaches would likely be most effective when used for all adult clients, not just female clients presenting for treatment. Although it has been shown that women are the most common victims of IPV, men can also be victims: It is helpful to keep this in mind throughout the discussion presented below.

Initial Assessment/Screening

Clients presenting for services can be asked a series of basic questions concerning the presence or absence of IPV-related issues in their lives. See Figure 1 for an assessment flowchart that is recommended for clinical use. The flowchart shows various choice points throughout the clinical decision-making process. As part of routine clinical practice, adults within couples or families can be separated and screened privately for the presence or absence of IPV issues. It cannot be overstated: Safety is the reason for separating adult partners during couple or family therapy for IPV assessment procedures (Rathus & Feindler, 2004). For some clients, this may be the first disclosure to any official social agent and can represent extreme danger to the victim (Bograd & Mederos, 1999; Davies, 1994; McCloskey & Fraser, 1997). It is not unusual for disclosure by the victim to be followed by severe levels of violence from the perpetrator. This crucial safety issue must be kept in mind by the clinician during the initial contact, as well as throughout all future contacts with either the victim or perpetrator (Bograd & Mederos, 1999; Campbell, 2002; Davies, 1994).

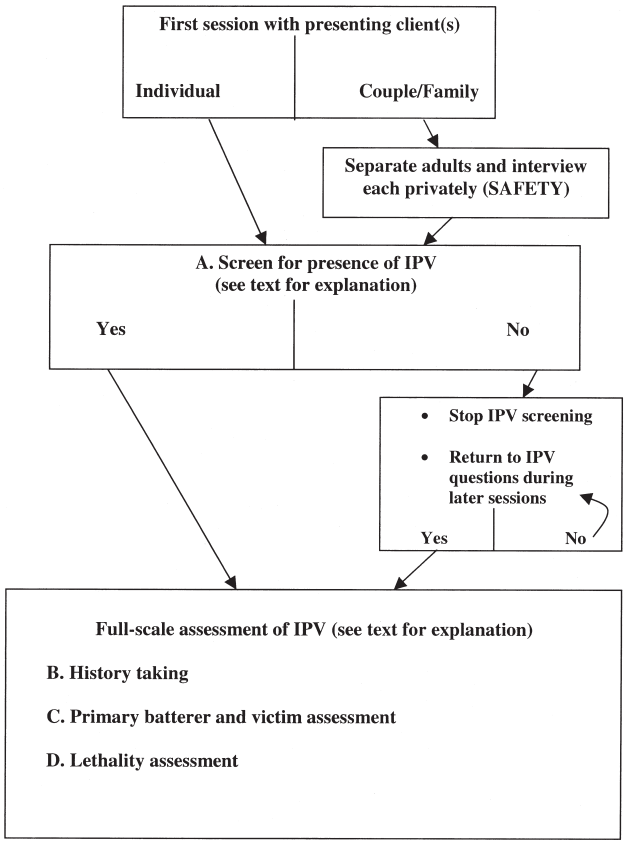

Figure 1. Flowchart showing decision points throughout the intimate partner violence (IPV) screening and assessment process (assessment processes are presented in more detail within the appendixes).

During the initial contact, if the individual adult denies that IPV is present in her or his life, stop the initial screening process for that session. However, because many victims (and especially perpetrators) do not initially admit to or describe violence within their relationships when first asked, for numerous valid reasons such as fear, shame, and guilt (Campbell, 2000, 2002), revisiting the screening process whenever appropriate throughout later sessions is very helpful. Relationship content brought up by the client throughout later sessions presents an ideal opportunity for the clinician to once again complete an IPV screening. Should the client disclose IPV concerns later in therapy, the full-scale assessment can be completed at that time.

The suggested content of an IPV screening is presented in Appendix A and represents part of the screening portrayed in Figure 1 ("A. Screen for Presence of IPV"). The screening is a series of questions that asks about arguments between partners that have occurred in a client's relationship, beginning in a general sense and becoming quite specific in terms of partner and client behavior. These questions can be converted into standardized interview questionnaires that the clinician follows during the session or can be memorized with practice by the clinician to eliminate the need for a written format. To save time, some clinicians may be tempted to create a client IPV paper-and-pencil screening questionnaire to be filled out during standard paperwork intake procedures. However, it has been shown that clients tend to self-

disclose painful and sometimes shameful IPV material at a greater rate during face-to-face interviews than on paper-and-pencil questionnaires (Campbell, 2000; Murphy & O'Leary, 1993). Thus, the recommendation remains that the screening be completed interpersonally between therapist and client, perhaps supplemented with paper-and-pencil questionnaires.

The screening questions in Appendix A assume that clients are presently in an intimate relationship with an adult partner. If clients are not in a current relationship, therapists should still consider completing the screening in the context of past relationships because past victimization influences current psychological symptom presentation and concerns.

Full-Scale Assessment of IPV

Once the therapist has determined the presence of IPV in a client's life, a full-scale IPV assessment can be completed. The first section of this assessment consists of history taking, the second addresses the determination of the primary batterer and victim, and the third assesses the degree of lethality. These three areas help the clinician assess the frequency, duration, and intensity of IPV as well as possible avenues for effective intervention.

History taking. Appendix B shows the content questions needed to complete a full history of IPV-related issues and represents a portion of the assessment portrayed in Figure 1 ("B. History Taking"). As can be seen in Appendix B, the questions are grouped into three content areas: (a) IPV across time in context (including injuries), (b) intervention by others (including the criminal justice system), and (c) co-occurrence of drug use or other mental health issues.

Determining the primary batterer and victim. The identities of the primary perpetrator and the victim are sometimes obvious from the results of the initial screening as well as the history obtained earlier from portions of the full-scale assessment. However, there may be controversy concerning the person responsible for the continuing abuse in the relationship, especially with same-sex intimate partners. This may sometimes arise with opposite-sex partners also, such that determining the pattern of control and intimidation becomes difficult. The second section of the full-scale assessment is designed to specifically address this issue. Even though the victim's identity may be obvious from earlier clinical data, we still recommend that the following portion of the assessment be completed. This is so the psychological effects of IPV can be more completely described for each client and to aid in diagnosis. The actual content of this section is presented in Appendix C and represents portions of the assessment presented in Figure 1 ("C. Primary Batterer and Victim Assessment"). Appendix C provides both questions to elicit the way clients attribute meaning to the IPV incidents and conceptual factors to help the clinician organize each client's viewpoints and IPV attributions so that the primary batterer and victim can more easily be determined. The conceptual factors in Appendix C are primarily the work of victim advocates from the Artemis Center for Alternatives to Domestic Violence (1992) and from McCloskey and Fraser (1997). These factors represent a liberal adaptation, integration, and expansion of their original presentations.

Appendix C provides conceptual factors so that the clinician may categorize client responses in a reasonable fashion. It should be noted that for both primary batterers and victims, there are important exceptions to the rule for every indicator. Thus, therapists may wish to use this information in a checklist format so that the preponderance of clinical evidence drives their determination. For example, if a particular client fits a majority of indicators in the victim list, then it bolsters clinician confidence that the client indeed is the primary victim in the relationship.

Lethality assessment. Appendix D presents a portion of the full-scale assessment from Figure 1 ("D. Lethality Assessment"). This provides a conceptual way for the therapist to determine, in aggregate, the lethality of the batterer on the basis of information obtained during prior sections of the assessment. For safety reasons, the lethality assessment must be completed in every reported instance of IPV and should be updated throughout the course of treatment (i.e., when new information comes to light because of periodic therapist inquiry and/or spontaneous client self-disclosure). This lethality conceptualization is grouped into six content areas: (a) severity of violence, (b) obsessive and stalking behaviors, (c) psychological risk factors, (d) other criminal behaviors, (e) failure of past interventions, and (f) other. A predominance of risk factors should help the therapist determine the severity of the situation and the urgency with which she or he must act. This lethality assessment is liberally adapted from victim advocacy work (Artemis Center for Alternatives to Domestic Violence, 1992), results of community collaboration within the state of Ohio (Montgomery County Criminal Justice Council, 1996), and empirical research in the field (e.g., Campbell, 2002).

In addition to the standard items assessing risk for homicide and suicide (e.g., items for intent, plan, time, place, and means; Bennett, 2003; Sanchez, 2001; Shneidman, 2001), there are other lethality red flags unique to IPV situations found within Appendix D. As shown in the literature (Campbell, 2002; Kropp & Hart, 1997; McFarlane, Campbell, & Watson, 2002), the following batterer behaviors and beliefs should alert the clinician to the presence of extreme risk of lethal violence: (a) batterer perception that relationship is threatened and/or ending (infidelity, separation, divorce, etc.), (b) past or present threats by batterer to kill self or partner (including statements such as "I can't live without you" and "If I can't have you, no one will"), (c) batterer unemployment (suggests that batterer has nothing to lose), (d) past or present batterer violence, including attempted strangulation of victim, (e) batterer stalking and monitoring behavior, and (f) batterer drug or alcohol use. The presence of all six of the above factors should alert the clinician that outside help for the batterer is warranted (hospitalization, contacting the police, etc.). The presence of even one of these factors is a sign that the clinician needs to be highly wary of future lethal violence and needs to provide safety plans to both the batterer and the victim accordingly.

Therapist knowledge of barriers in the environment. We highly recommend that therapists know the resources available in the community and firmly imbed client experiences within the surrounding environment (Davies, Lyon, & Monti-Catania, 1998; Dutton, 1992; Grigsby & Hartman, 1997; McCloskey & Fraser, 1997). Three issues emerge that have not been addressed in detail earlier in this article. First, we recommend that therapists educate themselves about the local criminal justice system's response to IPV, most notably regulations and assumptions of county and state laws that impact their communities. For safety reasons, therapists should be able to understand their crisis intervention options in the face of high risk (e.g., criteria for hospitalization of the batterer versus police intervention) and should convey accurate information concerning legal options to victims. At the very least, thera-

pists should have referral information on hand to direct clients to the appropriate resources (IPV court advocates, etc.). Second, we recommend that therapists be cognizant of the effects that cultural and gender-based societal expectations can have on clients and how these expectations may present barriers to effective intervention. For example, past negative interactions with socially sanctioned officials by members of minority populations may create barriers to accessing community services that could help reduce lethality. Third, it is quite helpful for therapists to examine their own psychological conceptualizations in order to recognize and honor not only the dangerousness inherent in IPV cases, but also the extreme impact that IPV can have on victims and children. This issue brings a therapist squarely into the reinterpretation of standard assessment techniques within an IPV context. In other words, clinicians must be able to embed and integrate standard psychological assessment and intervention strategies within the issues shown in Appendix E.

Initial safety planning. Once the IPV screening and full-scale assessment are completed, the clinician will have a good idea of the level of lethality inherent in the situation. Hopefully, the clinician will also have embedded specific client information within the possible barriers to safety within the environment. With this information in hand, an initial safety plan can be developed that is tailored to each unique situation. For example, in the clinical vignette mentioned earlier concerning the male intimate partner who raped and then killed his female partner shortly after their family visit to a therapist (Hansen et al., 1991; Harway & Hansen, 1993), the partners would have been separated, and the IPV screening would have commenced. The clinician would then have completed the full-scale assessment procedures with each partner, ending with a determination of the primary victim and batterer and completion of the lethality assessment. Once barriers to safety were identified for both the victim and perpetrator, safety planning could then have been tailored to the unique characteristics of both the clients and the situation.

Once the presence of IPV has been established, there are two major issues that clinicians should consider for safety reasons. First, the contextualization of IPV within available resources requires a profound understanding of the barriers in the environment that support ongoing violence. If these barriers are not understood, safety planning may well be ineffective or may put clients at greater risk. Second, it cannot be overstated that even when a safety plan is in place, there is no guarantee the victim will be safe.

Many times, clinicians may be drawn to first intervene with the victim of IPV because this individual usually is the most motivated for change (McCloskey & Fraser, 1997) and may be the only presenting party in the therapy room. Yet it is also recommended that clinicians intervene with the primary batterer when present (such as in couple or family therapy), build compliance as much as possible, and be willing to bring in outside authorities if lethality is high (similar to managing homicidality or suicidality in other clinical situations; Bennett, 2003; McFarlane et al., 2002; Sanchez, 2001; Shneidman, 2001). The therapist's engagement of resources outside the therapy room (hospitalizing the batterer, contacting the police, involving other adult family members, etc.) will be a judgment call based on the level of lethality. As discussed above, presence of the most lethal, high-risk factors may tell the clinician that outside authorities should be contacted to keep all parties safe.

If the victim is the only individual presenting for services, safety plans can still be devised. By discussing the issues shown in Appendix F with victims, the therapist is underscoring the level of danger the batterer represents and sending the message that the therapist takes this risk very seriously. It is possible that Appendix F could be reproduced by the therapist as a handout and given to victims after explanation in the session has occurred and any possible barriers to implementing the plan are explored. However, the victim is usually not the family member who is in most danger of using lethal violence, although it is possible that victims may use violence as a self-defense measure (Malloy et al., 2003).

Although an in-depth discussion of long-term intervention strategies is outside the scope of this article, we refer readers to Campbell (2002), McCloskey and Fraser (1997), and Walker (1994) for further discussions of IPV safety planning, initial treatment plans, and long-term intervention risk factors, respectively. Clinicians should be cognizant of conceptualizations that directly address the psychological impact of IPV in order to effectively intervene once the immediate safety of clients has been established.

Summary

We presented concrete intervention strategies, beginning with initial screening procedures and ending with in-depth assessment approaches. The recommended assessment began with very specific, direct questions concerning IPV as part of screening and history taking, which included examination of specific violent behaviors, the occurrence of IPV across time, intervention by others, and the comorbid presence of substance abuse or other mental health issues. The assessment then moved to questions assessing the meaning that clients attribute to IPV as well as the effects of IPV, followed by a conceptual model with which the therapist can organize all the preceding information in order to determine the primary victim and batterer in the IPV situation.

Finally, all the information gleaned from this assessment was integrated into a lethality assessment as an aid for determining the seriousness of the violence and the urgency with which the therapist should intervene, all within the context of possible barriers to safety found in the environment. The assessment moved from the concrete to the abstract. Thus, this approach was designed specifically to incorporate both clinical data collection and conceptualization.

We hope that this approach will help clinicians become more mindful of the ubiquitous presence of IPV in clients' lives. We also hope that the presentation of concrete strategies for assessing dangerousness will increase the chances that therapists will assist clients in remaining safe.

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Appendix B

Appendix A

Initial IPV Screening Questions

- How do arguments usually begin?
- Why do you think these arguments keep happening?
- During your last argument, where were you? (Give as much detail as you can, such as where you were standing and where your partner was located).
- How long did the incident last?
- How did it end?
- What happened when it was over?
- During your arguments, did you or your partner ever (be VERY specific):

Slap	Grab	Punch	Kick	Bite
Push	Push to ground	Pin to ground/wall	Pull hair	Hold
Twist arm	Hit with an object	Break objects	Tear clothes	Throw food
Punch fist through wall	Break down door	Strangle/choke	Beat up	Use gun
Use knife	Use other weapons	Force sexual activities	Threaten to hit	Threaten to kill
Harm/neglect kids	Harm/neglect pets	Threaten kids/pets	Threaten others	Threaten suicide

IF CLIENT SAYS THAT NONE OF THE ABOVE VIOLENCE OCCURRED, ask if it has EVER occurred since the relationship started, or in past relationships.

IF NO, you may end the screening. Go on to the other partner and complete the next screening.

IF YES, complete the full-scale assessment (see below).

History Taking

Intimate Partner Violence Across Time

- What is the FIRST incident you remember?
- What is the WORST incident you remember?
- What happened during the MOST RECENT incident?
- Were there any injuries? If so, to whom and what kind? How were they handled?
- Were children involved in these incidents, or did they observe what happened?
- Were you (or your partner) pregnant during any of these incidents?
- Have you (or your partner) ever been stopped from getting help or accessing emergency services (locked in house, phone pulled from wall, etc.)?
- Were you afraid for your safety? Why or why not?
- Are you (or your partner) currently considering leaving the relationship? Are you currently separating?
- If your partner were here, how would he/she describe the incident(s)?

Intervention by Others

- Was there any outside intervention during the incident(s)? Did someone try to stop it (children, family, friends, neighbors, police, etc.)?
- Were the police called after any of these instances?
- If yes, have you seen the police report? If I had the police report in front of me, what would it say?
- Have you (or your partner) ever been arrested/convicted of domestic violence? If so, where and when?
- Have you (or your partner) ever been arrested/convicted for any other criminal activity? If so, what, where, and when?
- Have you (or your partner) ever hurt someone or been violent in front of others? If so, who, where, and when?
- Have you (or your partner) ever threatened or harassed family members, friends, or coworkers? If so, who, where, and when?
- Have you (or your partner) ever obtained a protection order against the other? If so, where was it obtained and for what?

(*Appendixes continue*)

• Have you (or your partner) ever violated a protection order or ignored the orders of a police officer, judge, or probation/parole officer? If so, where and when?

Mental Health and Substance Abuse Issues

• Were you (or your partner) drinking or using any other drugs at the time of the incident? If so, what and how much?

• Have you (or your partner) ever received treatment for a mental health issue? If so, when was it obtained, and for what? (Consider obtaining release of information to talk with other provider.)

• Have you (or your partner) ever received treatment for domestic violence? If so, when and with whom? (Consider obtaining release of information.)

• Have you (or your partner) ever been treated for depression or past suicidal thoughts or attempts? If so, when, where, and how? (Consider obtaining release of information.)

• Have you (or your partner) ever said you would kill yourself or others? If so, when, where, and how?

• Do you (or your partner) have access to weapons of any sort, or have you (or your partner) received weapons training in the past?

Appendix C

Primary Batterer and Victim Assessment

Client Meaning Making of IPV Incidents

• Given that the violence has been going on for a while, what is different right now that has led you to seek help?
• How is this situation a problem for you?
• What do you think has caused the violence?
• What seems to keep the violence going?
• What needs to change for the violence to be reduced or solved?
• What do you think will happen if the violence is not stopped?
• What do you want to see happen?
• What is the best/worst that could happen?
• What would be the long-term result of the best/worst that could happen?
• What would the best/worst outcome say about you, your partner, your children, your family, and so forth?
• What has been tried to stop the violence? Who tried it? Was it successful? Why or why not?
• Who else knows about the violence? Why do others know, or why not?
• If your partner (parents, children, friends, neighbors, etc.) were here, what would she/he (they) say about the violence?
• Do you think this relationship will continue?
• How are decisions made in your relationship?
• What do you expect of your partner?
• What would happen if you changed your regular role in the relationship?
• What has been the effect on you (Changes in eating, sleeping, weight, activities, energy, anxiety, depression, time alone, work or school activities, friendships, etc.)?
• How do you explain these effects on you?
• Who is responsible for the violence, as well as the effects on you?

Note. This material is liberally expanded on and synthesized from *Training/Reference Manual for Volunteers and Interns,* by Artemis Center for Alternatives to Domestic Violence, 1992, Dayton, OH: Author; and from "Using Feminist MRI Brief Therapy During Initial Contact With Victims of Domestic Violence," by K. A. McCloskey and J. S. Fraser, 1997, *Psychotherapy, 34.*

Table C1
Conceptual Indicators in Determining the Primary Victim and Batterer

Indicator	Exceptions
Primary victim	
Fear: Victims express genuine fear of what partner will do next; they may describe a long-standing pattern of living in fear of their partners' behavior.	Batterers may express fear if they believe it will convince others of their own victimization, or in the presence of victims' weapons.
Takes Responsibility: Victims assume responsibility for partner's' violence (e.g., "I said the wrong thing . . . I knew not to do that . . . I started the argument.").	Batterers rarely take initial responsibility, although this is possible in latter stages of treatment.
Admission of Own Violence: Victims admit to their own violence in self-defense or retaliation; they will also admit to hitting first.	Batterers rarely admit to their own violent behavior in the absence of confronting evidence.
Pattern of Abuse: Victims usually report numerous violent or abusive incidents and can identify a pattern of escalation and what typically precedes the incidents.	Batterers rarely perceive a pattern unless it is pointed out by others, can not identify preceding situations.
Being Threatened: Victims report that partners have threatened to harm them, children, pets, family members, coworkers, and so forth.	Batterers may identify partners' statements about ending the relationship as a threat; in extremely violent situations, the victim may also issue physical threats to the batterer in self-defense.

Table C1 (*continued*)

Indicator	Exceptions
Primary victim (*continued*)	
Trauma Effects: Victims report dissociation, somatic complaints, depression, anxiety, sleep problems, hypervigilance, startle response, and so forth.	Batterers rarely report trauma effects unless they believe it will convince others of their own victimization.
Goal of Services: Victims' typical goal is to "stop the abuse" *and* keep the relationship intact; they may wish to access help to get safe or to leave the relationship.	Batterers rarely address the violence in goal setting; they usually want help to keep things the same in the relationship.
Patterns of Injury: Victims' reported injuries are consistent with being attacked by another: black eyes; bruises on head, back, stomach, thighs, and upper arms; grip or slap marks on skin, and so forth.	Batterers easily report injury, yet usually of a defensive nature; do not use these reports alone because determination is accurate only by comparison to partner injury.
Strangled or Choked: Victims reports of being strangled by their partners at some time in the relationship are common; visible injury is not apparent until a few days later (if ever), whereas there is the report of defensive injuries on batterers.	Batterers rarely report being strangled or choked by victims.
Admission of Arrests: Victims will admit criminal history and give details, can describe socially unacceptable behaviors toward police during incident that may have led to arrest (for women, there may have been a gender bias operating at time of arrest).	Batterers rarely admit to a criminal history, exceptions include justification for own violence or victims' use of weapons.
Criminal Investigation Sounds Incomplete: If applicable, arrests of victims usually result from the lack of a full narrative, incomplete evidence, or failure to interview witnesses.	Batterers may also report or show incomplete investigative reports; thus, do not use alone.
Primary batterer	
Calm, Cool, and Collected: Batterers are overly calm and confident and have no fear or apprehension about violent incidents (or court process, if applicable).	Victims may dissociate or present with little or no emotion. Cultural barriers can also cause this.
Vague Accounts and Inconsistent Chronologies: Batterers give vague generalized accounts lacking in detail and timelines that do not hold; they may say, "My partner just acts crazy."	Victims may have memory impairment or may have been under the influence at the time of the incident. Cultural barriers may also result in reduced disclosure.
Denial: Batterers give outright denial of violence against partner.	Victims may deny presence of violence because of fear, shame, guilt, and so forth.
Minimization: If confronted with evidence of their own violent behavior, batterers will minimize the impact: "I didn't do it, but if I did it was no big deal" or "I may have put my hands around partner's neck, but I didn't squeeze."	Victims rarely deny their own retaliatory or self-defensive violence.
Persuasion: Batterers will try to convince clinicians that they are the injured parties, will try to ally with therapist, and will sometimes try to ingratiate themselves with "wink-and-nod" presentations.	Victims who are beginning to understand their victimization or who blame themselves may also do this.
Angry or Demeaning: Batterers will aggressively criticize their partners, namecall, or refer to their partners in demeaning ways.	Victims fully experiencing anger may do this, although it is rare.
Ownership of Partner: Batters convey strong sense of ownership, jealousy, and/or obsession concerning partner.	Victims may feel these things, and this should not be considered alone.
Revenge: Batterers are focused on extramarital affairs, child custody, or money issues; they may be smug or gloat over negative results of violence against partner (including criminal charges); ulterior motives are common.	Victims may sometimes focus on infidelity or express fears around child custody (especially perpetrators' threats to remove children).
Power and Control: Batterers state that they have power and control over their partners (make decisions, control money, set relationship rules and enforces those rules, etc.).	Victims may control some parts of relationship or may overreport control to feel safe or because of cultural norms (i.e., the need to appear "tough").
Goals of Therapy: Batterers want to get partner to do what client wants but do not necessarily want to reduce violence; they want help in convincing partner to stay in relationship, want to maintain "the status quo" in their relationship without getting in legal trouble.	Victims may also want help in keeping relationship intact but also want violence to stop.
Size Difference Inconsistent With Facts: Batterers report IPV incidents inconsistent with their size or that of their partner.	Never use size differential alone, especially with same-sex partners and in instances with weapon use.
Defensive Injuries: Batterers have scratches around arms or hands, bruised hands or feet; their injuries should be compared with injuries of their partners.	These injuries must be compared with injuries reported from other partner and can not be considered alone.
Criminal Record or Court Knowledge: Batterers have a history of arrest or conviction and/or of violating court orders; they are very familiar with the justice system and are vague in describing criminal history, whereas partners know history well.	Some victims have been arrested, even though they were acting in self-defense, and thus they know the court system.

Note. This material is liberally expanded on and synthesized from *Training/Reference Manual for Volunteers and Interns,* by Artemis Center for Alternatives to Domestic Violence, 1992, Dayton, OH: Author.

(*Appendixes continue*)

Appendix D

Lethality Assessment

Severity of Violence

- Serious injury
- Attempts to kill (partner, children, pets, others)
- Threats to kill (partner, children, pets, others)
- Violence/threats in public
- Use of weapons
- Threats with weapons
- Sexual assault/abuse
- Repeated/escalating violence
- Strangles/chokes partner
- Sadistic/terrorist/hostage acts
- Violence during pregnancy
- Child abuse
- Violence in presence of children
- Threats to abduct child
- Property damage to intimidate and control
- Forcible entry to gain access to partner
- Pet abuse

Other Criminal Behaviors

- Assaults on others
- Threats/harassment of others (family members, friends, coworkers, neighbors, etc.)
- Previous criminal charges
- Pending criminal charges
- History of other criminal behaviors

Failure of Past Interventions

- Family members, children, friends, neighbors, coworkers have intervened but violence continues
- Numerous police calls
- Prior intimate partner violence (IPV) arrests/convictions
- Ignores police/court/probation orders
- Violates protection or restraining orders
- Prior IPV treatment

Obsessive and/or Stalking Behaviors

- Following (to work, school, store, daycare, etc.)
- Watching (frequent drive-bys, drop-ins at work/school, etc.)
- Monitoring (checking telephone bills, caller ID, credit cards, computer log-ins, listening in on conversations, etc.)
- Enlisting others to follow/watch/monitor
- Telephone harassment (home, work, etc.)
- Requiring frequent "check-ins" when partner is away (work, school, store, etc.)
- Requiring debriefing after absence (partner must recount time spent away in great detail)
- Isolation of partner (physical, social, financial, etc.)
- Ownership: partner as property

Psychological Risk Factors

- Previous homicidal/suicidal attempts
- Homicidal threats
- Suicidal threats
- Previous mental health hospitalizations
- Severe depression
- External life stressors (job loss, death in family, etc.)
- Drug/alcohol abuse or addiction

Other

- Victim attempting separation from batterer
- Interference with victim access to emergency services or other help (pulling phone from wall, etc.)
- Weapons access
- Weapons training
- Any other unusual or concerning behavior reported by victim

Appendix E

Barriers in the Environment

Concrete Environmental Forces

1. Legal system and laws
   - Mandatory arrest laws
   - Mandatory sentencing
2. Police/court responses
   - Enforcement of laws
   - Enforcement of protection orders
   - Diversion vs. time served
3. Medical/mental health responses
   - Identifying causes of injury
   - Believing battered women
   - Counseling to keep marriage intact
4. Shelter availability
5. Advocacy center availability
6. Local social oppression against minorities and/or immigrants
7. Money
   - Batterers' control over finances
   - Woman's employment
   - Permanent food and shelter for family
   - Transportation
   - Social and legal aid
   - Knowledge of resources
8. Batterer himself
   - Woman physically isolated (locked in house)
   - Woman socially isolated because of batterer's influence
   - Increased risk of death/extreme violence by batterer during attempts to leave
   - Threats and violence against children

Family and Sociocultural Roles

1. The belief that being a good woman means putting yourself last
2. The belief that being a good mother means never raising children without a father
3. Religious beliefs and norms
   - Pastoral counseling to keep marriage intact
   - Beliefs about women's place

4. Family beliefs and norms: breaking rules of family of origin
5. Beliefs about divorce
6. Violence as normal within relationship
7. Definition of self as victim
8. Degree of cultural identification

Consequences of Battering Relationship

1. Brainwashing
   - Results of repetitious violence and control
   - Psychological warfare
2. Posttraumatic stress disorder
   - Denial and numbing
   - Terror and fear are normal states
   - Exhaustion
   - Low emotional resources
3. Learned helplessness
   - Low self-esteem and self-worth
   - Extreme self-doubt/immobilization
4. Stockholm syndrome
   - Identifying with batterer
   - Taking on batterer's belief system
   - Prisoner-of-war psychological impact
5. Battered women's syndrome
   - Personality change as result of battering
   - May present as mental health problem
   - Recovery occurs after violence ends
   - Most women do not enter into another violent relationship
6. Cognitive deficits/other disabilities
   - Head trauma
   - Other physical injuries
7. Forced/coerced illegal activities
   - Prostitution
   - Illicit drug use/sale
   - Other criminal activity

Intrapsychic Forces

1. History of abuse: physical and sexual abuse as child
2. Personal variables
   - Resiliency
   - Strengths and weaknesses

Note. This material is liberally expanded on and synthesized from "The Barriers Model: An Integrated Strategy for Intervention With Battered Women," by N. Grigsby and B. R. Hartman, 1997, *Psychotherapy, 34.*

Appendix F

Safety Planning Hand Outs for Clients Who Are Victims of Intimate Partner Violence

- Call police: 911 (program phone with these numbers).
- Go to shelter (address and phone number).
- If currently safe, consider contacting advocacy center (address and phone number).
- If in same room with abuser and violence occurs, avoid rooms with no outside doors and those containing weapons (kitchen, bathroom, bedroom, garage).
- Change locks, code on house alarm system, garage door opener, answering machine access code, log-in on computer, and so forth.
- Identify two or three persons who are your main supporters and know of the situation and who can help you if a crisis occurs.
- Stay with family or friends who will keep you safe (hidden from abuser).
- Inform neighbors of the situation. Ask them to call the police if they notice anything suspicious.
- Obtain protection order against abuser (civil or criminal).
- Develop safety plan with children: (a) stay in bedroom during argument. (b) leave house and go to friends or neighbors, (c) tell a relative, (d) call 911.
- Create a code word with children, friends, and neighbors so that they can call for help.
- Give school and/or day care written instructions about (a) who can pick up children and (b) copies of custody papers or protection orders.
- Pack a "safety bag," and put it in a safe, accessible place during a crisis. This should include extra cash, clothes, documents, extra sets of car and house keys, bus tokens, quarters for phone calls and laundry.
- Save a little money each week and hide it in a place only you know about (not in a car or a bank the abuser has access to). Open own bank account with statements mailed to a safe place.
- Important documents include the following:

Birth certificates	Marriage/driver's licenses	Car title
School/medical records	Insurance information/forms	Bank account/savings passbooks
Welfare/immigration cards	Divorce papers	Other court documents
Social Security cards	Credit cards/ATM cards	Lease/rental agreements
House deed/mortgage papers	Keys for car/house	Keys for safety deposit boxes
Medications/prescriptions	Clothing (self and children)	Comfort items (self and children)
Address book (friends etc.)		

THE MOST IMPORTANT THING IS YOUR SAFETY!
MAKE SURE YOU ARE SAFE BEFORE DOING ANYTHING ELSE.
IF YOU OR YOUR CHILDREN ARE INJURED,
MAKE SURE YOU ARE TREATED FOR YOUR INJURIES.

REHEARSE THIS SAFETY PLAN REGULARLY.
CHANGE THE PLAN AS NEEDED.
TRUST YOUR OWN JUDGMENT ABOUT WHAT IS SAFEST AT THIS TIME—
ANYTHING THAT WORKS TO KEEP YOU AND YOUR CHILDREN SAFE.

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