MARRIAGE AND FAMILY THERAPISTS' PERCEPTIONS OF INTIMATE PARTNER AGGRESSION IN COUPLES' CASES

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I dedicate this thesis to those who directed me toward this path of research along with those who have encouraged me throughout the process.

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ABSTRACT

Intimate partner aggression (IPA) encompasses physical, sexual, or emotional aggression from a current or past romantic partner (Centers for Disease Control and Prevention, 2018). IPA is highly common in clinical samples, with around 50% or more of couples seeking therapeutic services having a history of IPA. The sheer frequency suggests Marriage and Family Therapists (MFTs) will inevitably confront IPA in their clinical careers. In fact, almost 99% of MFTs have reported working with IPA (Blasko et al., 2007). Despite the prevalence of couples' cases with a history of IPA, research has demonstrated concerns with therapists' ability to identify IPA, correctly identify the perpetrator(s), and conduct adequate risk assessments (Blasko et al., 2007; Dersch et al., 2006; Hansen et al., 1991). The purpose of this study was to examine how modality and IPA exposure impact MFTs' recognition of IPA, identification of perpetrator(s), and risk assessment in a case example among 37 MFTs.

It was hypothesized that participants who received the male unilateral modality and who had previous IPA exposure would be more likely to recognize the IPA, correctly identify the perpetrator(s), and indicate risk of future harm in their given case example. Logistic regression analyses did not reveal any significant relationships between the variables. However, it was found that 91.9% of MFTs recognized the IPA in their case example, 78.4% correctly identified the perpetrator(s), and 89.2% indicated the potential for future harm. This study emphasizes the importance of the rates reaching 100% because until that occurs some couples experiencing IPA will be overlooked and subsequently provided with inadequate treatment.

CHAPTER 1: INTRODUCTION

Statement of the Problem

Intimate partner aggression (IPA) can be defined as physical, sexual, or emotional aggression from a current or past romantic partner (Centers for Disease Control and Prevention [CDC], 2018). Compared to physical and sexual aggression, emotional aggression has the highest lifetime prevalence for women (48.4%) and men (48.8%; Breiding et al., 2014) and encompasses verbal aggression (e.g., insults) and controlling behaviors (e.g., isolation) that are mentally damaging (CDC, 2018). Physical aggression includes any act that is meant to cause physical harm (e.g., punching; CDC, 2018) and has lifetime prevalence rates of 32.9% for women and 28.1% for men (Breiding et al., 2014). However, these rates may be higher if one considers unintentional acts that result in bodily harm as well (World Health Organization, 2012). Finally, sexual aggression encompasses rape and other nonconsensual acts (e.g., unwanted fondling; CDC, 2018). Rape has lifetime prevalence rates of 9.4% for women and 2.2% for men; sexual aggression other than rape has lifetime prevalence rates of 16.9% for women and 8.0% for men (Breiding et al., 2014).

The number of Americans impacted by IPA is sobering, and the potential mental, relational, and physical consequences only serve to exacerbate the problem. Studies demonstrate that IPA exposure can contribute to depression and suicidality (Ulloa & Hammett, 2016), alcohol and substance use (Gehring & Vaske, 2017), relationship dissatisfaction and instability (Simmons et al., 2018), cigarette smoking (Crane et al., 2014), and injury or death (Breiding et al., 2014). The detrimental effects of IPA become more complex when children are exposed, leading to a greater risk of children developing aggressive behaviors, even during early childhood (Holmes, 2013).

When one form of IPA is present, it is common for other forms to occur as well, such as psychological and physical aggression (Hamby & Sugarman, 1999). Also, it is common for multiple aggressive acts to be perpetrated within the same form, such as insulting and isolating a partner (Breiding et al., 2014). It has been found that victimization increases the risk of future victimization and perpetration as well (Cui et al., 2013; Simmons et al., 2018). Overall, IPA tends to provoke more IPA.

Although IPA is rarely the presenting problem (Greene & Bogo, 2003), 50% or more of couples seeking therapy have a history of IPA (Greene & Bogo, 2003). The sheer number of IPA couples' cases suggest that it is inevitable for therapists to encounter IPA, with Blasko and colleagues (2007) finding that about 99% of Marriage and Family Therapists (MFTs) reported encountering IPA during the course of their clinical work. Despite the overwhelming frequency of IPA cases, many therapists fail to recognize and/or address the aggression (Dersch et al., 2006; Harway & Hansen, 1993). In IPA couples' cases, therapists will most often be confronted with intimate relationships where both partners perpetrate aggression within the context of specific conflicts (Anderson, 2002; Johnson & Leone, 2005; Madsen et al., 2012). Although less prevalent, therapists might also encounter intimate relationships where one partner uses aggression to control the other partner. In this context, males are more often the perpetrators and females are more often the victims in heterosexual relationships. However, females can also perpetrate IPA to control their male partners (Johnson & Leone, 2005). Although therapists will encounter the former more frequently, they will most likely treat both types of IPA couples' cases (Greene & Bogo, 2003; Johnson, 2005; Johnson & Leone, 2005).

Despite the frequency of IPA in clinical samples, studies have shed doubt on therapists' ability to accurately identify the presence of IPA (Dersch et al., 2006; Hansen et al., 1991), the modality of aggression (Blasko et al., 2007), the potential for lethality (Dudley et al., 2008; Hansen et al., 1991), and appropriate interventions (Dersch et al., 2006; Hansen et al., 1991; Harway & Hansen, 1993). Even if therapists identify IPA, their ability to treat female and male perpetrators/victims equitably has come under question as well (Karakurt et al., 2013). The present study sought to build on previous research by examining how MFTs' recognition of IPA, identification of perpetrator(s), and risk assessment varied depending on the IPA modality and previous IPA exposure within a heterosexual IPA couple's case. Specifically, whether IPA modality or previous IPA exposure assisted or hampered MFTs' performance in the above three areas. Utilizing Social Learning Theory and self-of-the-therapist research as a guide, MFTs' previous IPA experiences were connected to how participants' responses differed.

CHAPTER 2: SIGNIFICANCE OF THE PROBLEM

New Terminology: Intimate Partner Aggression

Previous research has labeled relational aggression between adults as *domestic violence*, *battering*, and *intimate partner violence*. However, some hold grievances with these terms. Johnson (2005) argued that when most people conceptualize *domestic violence* or *battering*, only male perpetrators come to mind, often in the context of utilizing severe aggression toward their female partners. The term *intimate partner violence* was meant to elicit consideration for both physical and nonphysical acts of IPA; however, physical aggression is still the form that predominates when thinking of *intimate partner violence*. Thus, this has resulted in confusion for researchers and the general populace regarding whether *intimate partner violence* truly encompasses both physical and nonphysical acts of aggression (Fincham et al., 2013). In response, some researchers now use the term *intimate partner aggression* (Hammett et al., 2017; Simmons, 2018). The hope is that switching from *violence* to *aggression* will actually call to mind the emotional form of IPA as well (Goodfriend & Arriaga, 2018). Typically, IPA describes aggression within adult relationships, while aggression within adolescent relationships (seventh to twelfth grade) has been studied as a separate phenomenon (Cui et al., 2013).

Intimate Partner Aggression Typologies

IPA typologies describe the context in which the aggression is occurring. Different IPA typologies have been proposed and examined since the second wave of feminism, when the IPA epidemic in the United States was first addressed (Harway & Hansen, 1993). Second wave feminism primarily focused on male perpetrators and female victims in heterosexual relationships, with the aggression being fueled by the patriarchal acceptance of male control over women (Bograd, 1984; Walker, 1989). This is an example of a typology, as it identifies the context behind the aggression—males using aggression to control women. In the 1990s, other typologies began to surface in the literature, suggesting IPA experiences are not homogenous. This thesis focuses on two typologies, which will be described below as a brief introduction and to provide further concrete examples of what IPA typologies encompass.

Michael Johnson was one of the leading pioneers in the emerging topic of IPA typologies back in the 1990s (Johnson & Ferraro, 2000). Johnson's (2005) *Intimate Terrorism* (IT) typology best reflects second wave feminism's focus on male perpetrators and female victims in heterosexual relationships. In IT, men are more likely to be the perpetrators, and their primary motivation for aggression is to control their female partners. IT often includes more overt forms of aggression, including severe emotional and physical aggression. Although physical aggression is likely, it does not have to be present if another form of IPA (e.g., emotional) is being used to control the other partner. IT can also encompass female perpetrators and male victims in heterosexual relationships; it has just been found to be less common (Felson & Messner, 2000; Johnson, 2006). In contrast, *Situational Couple Violence* (SCV) encompasses relationships where both partners perpetrate. However, the primary motivation is not control; the aggression typically occurs due to poor problem solving within specific conflicts. Aggression in IT can also occur during conflicts, but the underlying motive for the aggression in IT is different from SCV. SCV usually only includes minor emotional and/or physical acts of aggression (Johnson & Ferraro, 2000; Johnson & Leone, 2005). Although further elaborated on later, this study's case example will describe an IPA incident that reflects SCV more than IT based on the descriptions provided by Johnson's research across the years (Johnson, 2006; Johnson & Ferraro, 2005). Overall, typologies define the context in which IPA occurs in romantic relationships.

Intimate Partner Aggression Modality

Typologies also include the modality of IPA, which specifically refers to who perpetrates the aggression. Modality is broken down into unilateral and bilateral. Unilateral IPA occurs when only one partner perpetrates, while bilateral occurs when both partners perpetrate (Madsen et al., 2012). Using IT and SCV as examples, IT reflects unilateral aggression as only one partner perpetrates, and SCV reflects bilateral aggression as both partners perpetrate. Modality does not describe the context behind the aggression, only the sex of the perpetrator(s) and victim(s).

Sex of the Perpetrator(s)/Victim(s)

When describing the modality, the sex of the perpetrator(s) and victim(s) is inherently identified as well. In heterosexual relationships, unilateral aggression can encompass both male-

to-female aggression and female-to-male aggression. When discussing bilateral IPA in heterosexual relationships, the term bilateral is often used by itself—without the perpetrator/victim sex—because the definition already acknowledges that both the male and female partners are the perpetrators and victims (Madsen et al., 2012). Although this thesis focuses on heterosexual relationships, male-to-male IPA and female-to-female IPA can also describe unilateral and bilateral aggression in same-sex couples.

For further clarification, the following will provide brief definitions of commonly used terms throughout this thesis: male unilateral aggression encompasses a male perpetrator and a female victim; female unilateral aggression encompasses a female perpetrator and a male victim; bilateral aggression encompasses the male and female as both the perpetrators and victims.

Intimate Partner Aggression Experiences

Experiences in the Family

Individuals can be exposed to IPA in numerous ways throughout the lifespan. Many are exposed to IPA during childhood in their families of origin (FOO) as they witness interparental aggression (Bradel et al., 2019; Costa et al., 2015; Fritz et al., 2012). One study found that 23% of college-aged women reported this type of exposure as children (Bradel et al., 2019). Additionally, among a large, heterogeneous sample, 31% of participants reported witnessing interparental aggression during childhood. This percentage was the same for both male and female respondents (Copp et al., 2019). Further, based on their nationwide sample, McDonald and colleagues (2006) estimated that about 15.5 million children live in households where they witness IPA.

Experiences in Romantic Relationships

Additionally, IPA in past or current romantic relationships encompasses another form of exposure (Coleman & Stith, 1984; Copp et al., 2019). In a representative sample, Cui and colleagues (2019) found that 30% of adolescents (seventh grade through twelfth grade) reported being victims of at least one incident of relational aggression. Adolescent participants were only asked if they had been victimized and male and female scores were combined. Thus, it is not possible to identify the rates of unilateral or bilateral IPA or examine potential sex differences.

Although adolescent IPA was not separated by modality, distinctions were provided for the young-adult participants (ages 24-32). It was found that five percent reported only perpetrating IPA, 13% reported only victimization, and 12% reported bilateral IPA. However, female and male scores were also combined (Cui et al., 2019), preventing readers from ascertaining how many males and females experienced each modality. Copp and colleagues' (2019) findings demonstrate higher rates of IPA for young adults as 23% of participants reported current IPA. These rates were similar for the male and female participants (Copp et al., 2019). Although Copp and colleagues (2019) provided sex differences, it was not broken down into modality. Finally, neither study gathered the context behind the IPA, rendering it impossible to identify IPA typologies.

Methodological Hinderances

Current methodological issues will be discussed further in the following section, but, as a brief overview, the inconsistency in measuring typology, modality, and the sex of the perpetrator(s)/victim(s) has fueled an ongoing debate regarding the prevalence of typologies and modalities and how the implications vary depending on the typology and modality under question. Although there is growing support for SCV being the most prevalent typology (Madsen et al., 2012; Stith et al., 2012), it is difficult for researchers to reach a consensus due to these methodological problems.

Marriage and Family Therapists' Experiences

Personal Experiences

MFTs are not immune to experiencing IPA. Dersch and colleagues (2006) found that about 18% of their sample of MFTs had witnessed interparental aggression and about 19% had experienced IPA in past marital or dating relationships. However, neither were broken down by sex, and IPA in romantic relationships was not broken down by typology or modality. Although not found to be significant, 63% of MFTs who had been exposed to more than one type of aggression recognized IPA described in a given case example; however, the type of aggression exposure was not specified (Dersch et al., 2006). Additionally, 49% of MFTs who had been exposed to at least one type of aggression reported they would address the IPA presented in the

case example. Although the type of aggression was not distinguished, these findings suggest that MFTs have had previous IPA exposure, and their exposure might influence their recognition and treatment of IPA couples' cases (Dersch et al., 2006).

Professional Experiences

Dersch and colleagues (2006) also measured different professional experiences their participants had with IPA. In their sample, MFTs had enrolled in university courses dedicated to IPA, confronted issues with IPA in supervision/practicum, enrolled in university courses with IPA integrated into the curriculum, and attended IPA trainings. Although not found to be significant, amount of education and training was positively associated with MFTs' recognition of and responsiveness to an IPA case example (Dersch et al., 2006). Although many MFT graduate programs include some form of IPA education or training, some MFTs are still not confident in the education they received from their courses or trainings (Karakurt et al., 2013). Unfortunately, there is scant research on the number of MFTs who have been exposed to IPA. Without this information, it is difficult to examine the possible links between previous IPA exposure and its impact on how MFTs assess and treat IPA. Additionally, this presents an obstacle to further analyzing how IPA typologies interact with these factors as well.

Expectations Surrounding Who Perpetrates Intimate Partner Aggression

Feminist Paradigm of Perpetration

A longstanding debate has existed regarding who perpetrates IPA more often, men or women, and the context behind why IPA perpetration occurs (Johnson & Ferraro, 2000). During the second wave of feminism, feminist scholars emphasized male unilateral aggression that is perpetrated to exert control and is fueled by patriarchy's acceptance of male domination and female subjugation. Additionally, feminists highlighted the severe forms of emotional and physical aggression that often occurred in these relationships (Bograd, 1984; Walker, 1989). Thus, when considering the IT and SCV typologies, second wave feminists' focus reflected male unilateral IT (Johnson & Leone, 2005).

The patriarchal view of IPA has informed public and professional opinion for decades. The Duluth model of batterer intervention programs (BIPs) is a primary example of how second

wave feminism has impacted the way IPA has been viewed and addressed in the United States (Feder & Wilson, 2005; O'Leary, 1999). As a result of the Duluth model, men are encouraged to attend BIPs, and women are encouraged to seek safe shelter and other resources from domestic violence organizations. In BIPs, men become educated on patriarchy and how this cultural phenomenon supports male domination over women. This psychoeducation, then, is meant to address male batterers' attitudes toward women and alter their perceptions on the acceptance of aggression (Feder & Wilson, 2005; Harway & Hansen, 1993; O'Leary, 1999). BIPs are supported by the US legal system, which often mandates male perpetrators to these types of programs (Armenti & Babcock, 2016; Barocas et al., 2016). Overall, male unilateral IT is well-known by both the public and the professional community (Johnson, 2005), and the framework established by second wave feminism on how to address IPA has been and still is widely embraced in the US.

This review of the feminist paradigm of perpetration has focused on the perspective established by second wave feminism. Although this paradigm is still commonly accepted (Armenti & Babcock, 2016; Barocas et al., 2016; Johnson, 2005), it has evolved since its birth in the 1970s. For some, the focus has shifted to examining the implicit ways patriarchal values still contribute to power imbalances in heterosexual relationships (Knudson-Martin, 2013), instead of the overt power differential often seen in male unilateral aggression within the IT typology. However, this transition does not fully address instances where both partners perpetrate in opposite-sex couples, where females perpetrate against male partners, or the perpetration of IPA in same-sex couples (Barocas et al., 2016). The purpose of addressing other typologies (e.g., SCV) and modalities within them (e.g., female unilateral) is not meant to negate male unilateral IT, but to highlight the heterogeneity of IPA experiences (Johnson, 2006).

An Emerging Paradigm of Perpetration

With male unilateral aggression established as the most common form of IPA by second wave feminism, often with physical aggression employed as a means of control, other IPA typologies, such as SCV (Johnson & Ferraro, 2000), were largely ignored until the 1990s. Johnson's discovery that SCV occurred the most frequently called into question the existing feminist paradigm of perpetration at the time (Johnson & Ferraro, 2000). Since then, research has continued to support that SCV is the most prevalent typology (Anderson, 2008; Johnson 2006;

Johnson & Leone, 2005; Madsen et al., 2012). Further, other studies have suggested that men and women perpetrate in near equal amounts (Anderson, 2002; Malone et al., 1989; Straus & Sweet, 1992), and gender symmetry has been found in the initiation of physical IPA in SCV couples as well (Swan et al., 2008). Additionally, female unilateral IPA has been receiving increased attention as well (Dutton et al., 2005; Goldenson et al., 2009).

The Feminist Paradigm Still Lingers

Although there is greater acknowledgment that IPA can encompass bilateral (Anderson, 2008; Johnson & Leone, 2005) and female unilateral aggression (Dutton et al., 2005; Goldenson et al., 2009), male unilateral aggression still appears to be regarded as the most serious modality. In support of this finding, Allen and Bradley (2018) analyzed how adults from the general population conceptualized IPA. Participants were given one of several case examples with the same physical aggression description, but with different IPA modalities. They found that both the female and male respondents viewed male perpetrated aggression as more serious than female perpetrated aggression. This bias can be seen in their finding that male perpetrated aggression was nine times more likely to be considered a crime, despite the fact that the aggressive act itself was the same for both the male unilateral and female unilateral case examples (Allen & Bradley, 2018). This drastic difference in attitudes toward female versus male perpetrators has been supported in other studies as well (Carlson & Worden, 2005). Although Allen and Bradley's (2018) sample was drawn from the general population, MFTs have also been found to demonstrate the same minimization of female perpetrated IPA (Karakurt et al., 2013).

The minimization of female perpetration seen in Allen and Bradley's (2018) study might be influenced by individuals' levels of IPA endorsement, or the extent to which IPA is deemed acceptable. For example, Copp and colleagues (2019) provided participants from the general population with different IPA scenarios (e.g., "a partner cheats on you," "a partner destroyed your property," "a partner hits you first," p. 1367) and examined the degree to which participants supported the perpetration of IPA by a hypothetical individual. Results indicated that adult females were more likely to support hitting one's partner across all 13 scenarios compared to their male counterparts. The greater acceptance of IPA demonstrated by female participants was not sex specific. In other words, the female respondents reported a greater degree of acceptance

for anyone hitting their partner in the provided scenarios (Copp et al., 2019). This study suggested that females find more justification, compared to males, in the physical perpetration of IPA, even outside of self-defense. It is possible that females' increased level of IPA endorsement contributes to the minimization of female perpetrated aggression.

Acknowledging Contradictory Findings

As discussed above, methodological issues have prevented the field from coming to a consensus on the prevalence of different IPA typologies and different modalities. Varying samples have further contributed to this ongoing debate. Gathering data from domestic violence shelters, hospitals, or court records has resulted in higher rates of male unilateral IT. This is a logical finding as male unilateral IT is most likely to lead to injury (Anderson, 2008; Johnson, 2005). Injury, then, is more likely to place victims in shelters, more likely to necessitate medical attention, and more likely to result in interactions with law enforcement. In contrast, gathering data from community samples has resulted in higher rates of SCV, as IPA cases that do not lead to severe harm or contact with the legal system can be included as well (Johnson, 2005). Research has found SCV to be the most common in clinical samples as well (Anderson, 2002; Johnson & Leone, 2005; Madsen et al., 2012). However, this might be due to the fact that a controlling partner might be less likely to attend therapy or allow their partner to attend therapy.

Additionally, contradictory findings have been attributed to the lack of consistency in researchers examining the motivations behind perpetrating IPA (Anderson, 2003; Johnson, 2006). For example, even if a study finds gender symmetry in perpetration, the reason behind perpetrating is critical, especially when it comes to treating perpetrators (Anderson, 2013). Also, gender symmetry does not guarantee the consequences for both partners are the same (Simmons et al., 2018; Ulloa & Hammett, 2016). With this lack of clarity, therapists are left to operate from inconsistent conceptualizations of IPA, negatively impacting their ability to distinguish different types of IPA. If IPA typology or modality cannot be accurately identified, then the resulting treatment suffers as well (Anderson, 2013; Johnson, 2006).

Therapists' Perceptions of IPA

In the 1970s, the second wave of feminism began lobbying for legislation protecting survivors of IPA. The work of these pioneering feminists directed therapists' attention toward IPA (Harway & Hansen, 1993). Although therapists were becoming aware of IPA at this time, their treatment of such cases only began to be analyzed around the early 1990s (Cervantes, 1993). Just as feminists led the way in raising IPA awareness, they also led the way in examining therapists' effectiveness with IPA cases.

Hansen and colleagues (1991) conducted one of the first studies on this topic. The participants included 362 members of the American Association for Marriage and Family Therapy (AAMFT). The respondents completed a survey in which they received one of two IPA vignettes, both of which were real-life cases. The authors chose the cases based on the similarity in their presenting problem, or the severe male unilateral IPA, which better reflects IT than SCV. The cases included different families; thus, they differed in the composition and the nature of the intimate partners' relationship. Additionally, the aggressive incidents themselves were different, but both encompassed severe male unilateral IPA. Unstated to the participants, one of the case examples was based on a real relationship where the female partner was eventually murdered. The authors did not specify which case example resulted in the death. After reading the vignettes, respondents were given open-ended questions and asked to identify what they perceived as the problem, how they would address the problem, and what outcomes would likely occur without intervention (Hansen et al., 1991).

Hansen and colleagues (1991) discovered disturbing results. Based on the reports from both vignettes, around 40% of therapists simply ignored the aggression when describing their assessments. Also, over 90% of the sample minimized the aggression severity, often referring to it as "mild or moderate" (Hansen et al., 1991, p. 229). This minimization was evident in their chosen interventions, with a little over 50% believing the aggression did not require prompt action from the therapist. Additionally, no participants indicated lethality as a potential concern, despite the severity of the physical aggression. The findings suggest either therapists were unable to accurately identify the IPA, leading to poorly chosen interventions, or they could identify the IPA, but did not know how to intervene. Regardless, both demonstrate that therapists might be likely to provide ineffective services in IPA cases, even those reflecting immediate danger (Hansen et al., 1991).

A follow-up study included 405 members of the American Psychological Association (Harway & Hansen, 1993). Participants were presented with only one of the male unilateral IPA case examples utilized by Hansen and colleagues (1991) and were informed that the female was later murdered by the male. The psychologists were asked, via open-ended questions, to explain how they would intervene if they had the opportunity to treat only the female partner beforehand. Similar to Hansen and colleagues (1991), 50% did not identify seeking protection for the female as the priority intervention (Harway & Hansen, 1993). When describing their interventions, 54% focused on implementing safety measures, 34% intervened based on perceived couple dynamics, and 9% provided little detail, believing they did not have enough information. The last two groupings' reasons for not focusing on safety might provide an explanation for the minimization found in Hansen and colleagues (1991). However, this is especially alarming as the respondents knew of the murder and many still chose not to seek protection for the female partner (Harway & Hansen, 1993).

Dersch and colleagues (2006) replicated Hansen and colleagues' (1991) study but compensated for the main limitation: not knowing if participants simply did not recognize the IPA or if they did and were unsure of how to respond. Dersch and colleagues recruited 112 therapists, including MFTs (2006), who read a couple's case example that only included signs that indicate IPA might be occurring, instead of describing explicit abuse (e.g., "one partner was a childhood witness to parental violence" and the couple demonstrated "high reactivity;" Dersch et al., 2006, p. 321). After reading, they answered open-ended questions regarding how they conceptualized the case and how they would treat the couple. Although not directly asking about whether participants recognized the IPA, allowing them to describe their assessment of the case and initial treatment plan gave participants the opportunity to discuss IPA. The study also examined variables that might impact therapists' responses, including previous personal and professional IPA experiences (Dersch et al., 2006).

Dersch and colleagues (2006) found that close to 58% of the sample recognized the possibility of IPA occurring within the relationship. Of those who recognized potential IPA, only 46% described addressing the potential IPA in some manner. Although not found to be significant, those with past IPA experiences were more likely to both recognize and respond to the IPA indicators in their responses. Participants holding higher levels of education (i.e., bachelor's, master's, or doctoral degrees) were also more likely to recognize IPA. This study

highlighted variables that might explain why some therapists recognize and/or respond to IPA while others do not (Dersch et al., 2006).

In another replication of Hansen and colleagues' (1991) study, Dudley and colleagues (2008) provided 111 therapists with a severe male unilateral physical aggression case example. Like the above studies, Dudley and colleagues (2008) utilized open-ended questions to assess participants' conceptualizations of the case example. After these open-ended questions, participants were informed that the female was later raped and killed by her partner and were given the opportunity to indicate whether they would change any of their earlier responses. The results demonstrated a significant improvement from the early 1990s, with 78% of participants stating the IPA was the primary root of conflict in the case example and around 80% recommending crisis intervention services. Despite the improvement, only one participant identified possible fatality as an outcome, despite the severity of the physical aggression. Although percentages of the participants who changed their responses were provided, information on how the responses were changed or why was not provided in the study. Overall, the findings suggest a greater awareness of and ability to address IPA, but the continued lacking risk assessment is concerning, especially considering the severity of the IPA in the case example (Dudley et al., 2008).

Unlike the above studies, Blasko and colleagues (2007) utilized a bilateral IPA scenario, which best reflects SCV as there was not an explicit indication of control as the motivation, both partners perpetrated aggression, and the IPA occurred within a specific conflict. This methodological choice was crucial because most IPA cases have been found to encompass bilateral aggression. The sample included 347 AAMFT members who were asked to read one of three case examples that included both verbal and physical aggression; only the couple's sexual orientation varied. The physical aggression in the incident was prevalent as multiple acts were included (i.e., grabbing, slapping, knocking one partner to the ground, kicking, and pushing). Additionally, the physical aggression led to one partner receiving a bloody nose and black eye. The injury was known to the participants as it was included in the vignette. After the vignette, participants were asked to indicate if they agreed the case example encompassed IPA and were asked to select the perpetrator(s) and victim(s) in the case example.

Blasko and colleagues (2007) found that MFTs tended to identify the heterosexual vignette as male unilateral IPA, while they tended to label the gay and lesbian couples as

bilateral IPA. The results call into question MFTs' ability to accurately assess modality and also reflect the male unilateral abuse bias informed by the second wave feminist paradigm—males are the perpetrators and females are the victims (Blasko et al., 2007). The same bias has been seen in other studies including MFTs, with Karakurt and colleagues (2013) finding that both male and female participants leaned toward describing IPA as situations in which there was a male perpetrator and a female victim.

The IPA case examples provided in the above studies demonstrate a continued focus on male unilateral IPA despite the growing awareness of the prevalence of SCV, which is problematic as the heterogeneity of IPA experiences is being neglected in the literature. Further, without consideration of the prevalence of SCV, it is impossible to accurately examine therapists' responses to IPA in diverse couples' cases. Although the paradigm of perpetration established by second wave feminism still appears to dominate public and professional attention, the movement deserves immense credit for confronting the IPA epidemic in the U.S. Feminists advocated for not only protections and resources for victims, but also for mechanisms to hold perpetrators accountable for their actions. However, at that time, resources were primarily directed toward female victims and mechanisms of accountability were primarily directed toward male perpetrators.

Risk of Harm

As demonstrated in the above section, multiple studies have examined risk of harm in male unilateral IPA scenarios (Dudley, 2008; Hansen et al., 1991; Harway & Hansen, 1993). The severe aggression seen in these studies is more reflective of IT rather than SCV, as SCV does not encompass unilateral aggression and does not typically encompass dangerous physical aggression (Anderson, 2008; Johnson & Leone, 2005). According to Johnson (2005), control as the motivation for IPA is defined as the primary distinguisher between IT and SCV. Johnson hypothesized that the existence of control in IT is the main factor that elicits the severe aggression often seen in this typology (2005; Johnson, 2006; Johnson & Leone, 2005). Studies have supported this hypothesis in that victims of IT have been found to be more frequently abused, more likely to be injured, and more likely to be continuously abused throughout the relationship (Anderson, 2008; Johnson & Leone, 2005; Swan et al., 2008). SCV tends to not include severe aggression, but aggression leading to injury can still occur (Madsen et al., 2012).

Although the mechanism behind why severe aggression can still occur in SCV is not fully understood, other researchers believe this suggests that control is not the only factor that can elicit severe aggression (Anderson, 2008). Overall, although research demonstrates that IT holds the greatest risk of harm for victims, SCV can lead to injury as well.

Other researchers have examined risk of harm in different IPA contexts as well. Jacobson and Gottman (1998) identified two types of male perpetrators in heterosexual relationships that fit within the IT typology, which they labeled as *Pitbulls* and *Cobras*. First, *Pitbulls* exert control over their partners due to a fear of abandonment, and they look for any indicators that their partner will leave them. When triggered, *Pitbulls* become more and more physiologically aroused during conflict. Similar to a pot of water on a stove, the *Pitbull's* anger intensifies until it boils over. This is when physical aggression typically occurs. *Cobras* on the other hand exhibit a need for control in all aspects of their lives and are willing to do whatever it requires to achieve this goal. Unlike *Pitbulls*, *Cobras* tend to strike swiftly and aggressively as they begin the conflict with severe emotional and/or physical aggression. Like the cobra that appears calm right before the attack, these men experience a decrease in their physiological arousal. Similar to previous research, Jacobson and Gottman (1998) discovered that these perpetrators will most likely remain aggressive, emphasizing the likelihood of injury or possible death for victims (Anderson, 2008; Johnson & Leone, 2005). If MFTs come upon victims of *Pitbulls* or *Cobras*, safety should be the top priority, referring them to domestic violence shelters and other necessary resources (Jacobson & Gottman, 1998). Although these findings were based on male unilateral IPA, females can also use aggression to control, as IT can encompass female unilateral aggression as well (Johnson & Leone, 2005).

Jacobson and Gottman (1998) also identified a third type of aggressive couple, termed *low-level violent*. These couples exhibit the lowest risk of harm and are comparable to SCV couples in that the physical aggression is often minor (e.g., pushing), aggression mainly occurs during arguments, and a pattern of control is not present (Jacobson & Gottman, 1998). Thus, the physical aggression that occurs in this type of relationship does not typically lead to the severe injury often seen in relationships with *Pitbulls* and *Cobras*, meaning *low-level violent* victims might not require immediate safe shelter or other types of emergency services. When aggression does occur in these types of couples, it is primarily a result of limited conflict and anger management skills (Kelly & Johnson, 2008). Fortunately, these skills can be taught, potentially

in couple's therapy, depending on the type of aggression present (Armenti & Babcock, 2016; Stith et al., 2012).

Given that the risk of harm varies depending on the IPA typology, it is crucial that therapists conduct thorough risk assessments when working with IPA couples' cases. It is important that therapists do not neglect risk assessment when working with a couple whose IPA typology appears to reflect SCV rather than IT. Although minor aggression tends to be the most common in SCV, aggression that leads to injury can transpire. Additionally, even if the reported aggression is minor, this should not minimize the extent to which therapists *take it seriously*, especially since IPA tends to instigate future IPA (Cui et al., 2013). When considering the poor risk assessments seen in previous studies that provided blatant examples of physical aggression (Dudley et al., 2008, Hansen et al., 1991; Harway & Hansen, 1993), it is also likely that therapists might fail to give thought to risk of harm when the aggression is not as obvious.

Research on victims in general has shown that female victims are more likely to be injured than male victims (CDC, 2018; Swan et al., 2008). Males' tendency to be stronger than their female partners in heterosexual relationships (Felson & Messner, 2000) has been hypothesized to contribute to women's increased risk of injury (Holtzworth-Munroe, 2005). Female victims might also face more injury, as it has been found that men tend to perpetrate physical aggression more often, including severe physical aggression (Madsen et al., 2012). Somewhat contrary to Johnson (2005), Madsen and colleagues (2012) found that most incidents of physical aggression occurred in bilaterally aggressive couples. This might be due to the fact that when two people are committing physical IPA, the combined number of acts might be higher than if only one partner was physically aggressive. Madsen and colleagues' (2012) results reflect the necessity of continued risk assessment, even if the aggressive appears minor as the frequency might increase the possibility of future harm for both partners.

Theoretical Underpinnings

Social Learning Theory

Alfred Bandura's Social Learning Theory (SLT) has historically been a leading theoretical explanation for the perpetration of any form of aggression, including IPA (Copp et al., 2019). Also sometimes referred to as Intergenerational Transmission (Corvo & Johnson,

2013), SLT describes aggression formation through a focus on socialization; specifically, exposure to aggression in one's environment places individuals at risk for aggressive offending in the future (Fritz et al., 2012; Mihalick & Elliott, 1997). To learn any behavior, individuals must observe how others react in different situations. This becomes *observational learning* when an observer retains the model's behaviors for possible guidance in similar situations (Newman & Newman, 2015). Imitating occurs when an individual observes another person and then engages in similar behaviors (Grusec, 1992). This is also referred to as *modeling*, or when the observer learns through imitation. When individuals evaluate the consequences of the observed behavior, *vicarious learning* takes place (Newman & Newman, 2015). The ability to evaluate is a critical cognitive process in deciding which models to use as guides in a variety of contexts. The following discussion on self-regulation and self-efficacy describes how individuals develop this capacity.

Self-Regulation

Self-regulation is a cognitive process that assists people with understanding these environmental messages. The development of self-regulation begins early as young children observe important authority figures in their lives (Grusec, 1992). With maturation and exploration, children integrate these observations into personal standards. These standards *regulate* individuals as they remain the same across situations, providing people with a baseline in which to interpret future content. Once individuals develop personal standards, they can evaluate their actions and consider others' responses to the model's behavior, influencing the development of self-efficacy (Grusec, 1992).

Self-efficacy

Self-efficacy encompasses the way in which individuals perceive their own capabilities. These self-perceptions influence how individuals view their ability to succeed along with their view on how much effort is worth exerting in different situations (Grusec, 1992). Self-efficacy is formed through comparison to others, previous successes/failures, and self-awareness of one's state during a specific context. Combined with one's standards, self-efficacy contributes another

evaluative component, determining whether the individual performs the behavior in question (Grusec, 1992).

Connecting SLT to IPA

Caregivers and current/past romantic partners have been considered influential models in the development of IPA in previous research (Bradel et al., 2019; Costa et al., 2015; Cui et al., 2013; Fritz et al., 2012; Holmes, 2013). If IPA was common or acceptable in individuals' FOOs or romantic relationships, then they might imitate those models who engaged in IPA in future situations that mirror what they previously observed. If these individuals perpetrate and feel they have achieved their desired outcome, they might develop an internal standard endorsing their own use of aggression and might view themselves as capable of using aggression successfully. Moving forward, this standard and perceived self-capability will regulate how these individuals behave in similar situations. SLT does not assert that those who have witnessed and/or directly experienced aggression will become aggressive; it only increases the likelihood of future aggression (Copp et al., 2019). Overall, individuals who witness and/or experience IPA (*environment*) are at a greater risk of developing the belief (*cognition*) that IPA is acceptable and might be more likely to perpetrate or be victims of IPA (*behavior*) in the future (Copp et al., 2019).

MFTs might have experienced IPA in their FOOs or in romantic relationships as well. Although therapists exposed to IPA might never perpetrate, be victimized, or explicitly endorse IPA, learning still occurred during their past exposures. According to SLT, the learning process transpires regardless of whether or not the individual is currently acting on the behaviors being observed (Newman & Newman, 2015). In other words, standards can and do develop outside of conscious awareness. Additionally, the degree to which individuals approve of IPA can vary depending on the situation, not restricted to seeing it as simply *right* or *wrong* (Copp et al., 2019). Thus, therapists might falsely assume that previous IPA exposure had little or no impact on them if they have never perpetrated aggression or do not consciously support IPA. These unchecked assumptions, then, might eventually find their way into the therapy room.

Self-of-the-Therapist

Self-of-the-therapist research has examined the transmission of therapists' preexisting attitudes and values into the therapy room (Winter & Aponte, 1987). Revisiting SLT, individuals utilize their previous experiences and preexisting standards to guide their behaviors. Therapists do the same along with incorporating their training when treating clients. Clients present with human problems that often resemble experiences of the therapist, pulling on MFTs' formulated values and a diverse range of emotional reactions (Aponte, 1985). Reflecting SLT, these values are developed over time and derive from previous external exposures (Aponte, 1985; Winter & Aponte, 1987). Once internalized, they guide how MFTs conceptualize their cases, including problem identification, treatment goals, and interventions. In other words, MFTs' preexisting standards influence how they conduct therapy (Aponte, 1985). Thus, therapists' unconscious biases will inevitably arise in the therapy room, regardless of whether or not they recognize it.

Connecting Self-of-the-Therapist to IPA

Working with IPA cases is no exception (Dersch et al., 2006). IPA exposure in one's FOO and romantic relationships is an unfortunate reality for too many people. Although these personal experiences are a critical component in the development of IPA attitudes, other exposures are as important as well, such as professional experiences (e.g., education and training; Dersch et al., 2006). Regardless of the environment where the exposures originated, the resulting formulated biases might arise in IPA cases and influence how MFTs help these clients. The possible ramifications of inadequate treatment are too severe for MFTs to be unaware of their role in IPA cases. Only through self-reflection can MFTs begin to address their potential blind spots (Kissil et al., 2018).

Purpose of the Study

The purpose of the present study was to examine how IPA modality and previous IPA exposure impacted MFTs' recognition of IPA, identification of perpetrator(s), and risk assessment in a heterosexual couple case example. SLT and self-of-the-therapist served as the lenses through which previous IPA exposure was analyzed. Although discussed further in the methodology section, this study's focus was on modality, not typology. Because typology and

modality inherently overlap, it was not possible in the context of this study to provide case examples of both IT and SCV that included all three modalities.

This study contributed to the literature in several ways. First, the present study was one of few to examine bilateral IPA rather than focusing solely on male unilateral IPA. Additionally, the inclusion of male unilateral, bilateral, and female unilateral modalities allowed for comparison across the three. Also, this study allowed for comparisons between previous studies in regard to how therapists have progressed in recognizing IPA, identifying perpetrators, and conducting adequate risk assessment. Further, including pervious IPA exposure as an independent variable allowed for conjectures to be made on why MFTs conceptualize IPA the way they do, with SLT and self-of-the-therapist guiding how participants' responses were interpreted. Finally, this study was exclusive to MFT participants, specifying the results to the MFT field.

The above advantages were critical to the field due to the inconsistency in considering the potential influence IPA modality and IPA exposure exert on case conceptualization. Without this consideration, MFTs might inadvertently harm couples experiencing IPA by missing IPA altogether (Dersch et al., 2006; Harway & Hansen, 1993), misidentifying the perpetrator (Blasko et al., 2007), and conducting inadequate risk assessment (Dudley et al., 2008; Hansen et al., 1991; Harway & Hansen, 1993). These failures have an astronomical influence on the mental, relational, and physical well-being of both partners in IPA couples' cases. With 50% or more of couples' cases consisting of a history of IPA (Greene & Bogo, 2003), and with almost 99% of MFTs reporting previous clinical work with IPA cases (Blasko et al., 2007), it is both a disservice to clients and the field to ignore the impact of IPA modality and exposure on case conceptualization. The present study aimed to fill these gaps.

Research Questions and Hypotheses

Research Question 1: How does previous IPA exposure and modality of the vignette influence MFTs' recognition of IPA?

Hypothesis 1a: MFTs will be less likely to recognize IPA in the bilateral and female unilateral vignettes compared to the male unilateral vignette.

Hypothesis 1b: MFTs who report more professional and personal IPA exposures will be more likely to recognize IPA.

Research Question 2: How does previous IPA exposure and modality of the vignette influence MFTs' accurate identification of the perpetrator(s)?

Hypothesis 2a: MFTs will be less likely to accurately identify the perpetrator(s) in the bilateral and female unilateral vignettes compared to the male unilateral vignette.

Hypothesis 2b: MFTs who report more professional and personal IPA exposures will be more likely to accurately identify the perpetrator(s).

Research Question 3: How does previous IPA exposure and modality of the vignette influence MFTs' risk assessment of future harm?

Hypothesis 3a: MFTs will be less likely to state future harm will occur in the bilateral and female unilateral vignettes compared to the male unilateral vignette.

Hypothesis 3b: MFTs who report more professional and personal IPA exposures will be more likely to state future harm will occur.

CHAPTER 3: METHODS

Participants

Participants included only those who were clinically practicing as an MFT at the time of the survey. These encompassed graduate students, both master's and doctoral, those who were graduated and gaining clinical hours, and those who had either an associate's license or a full license. The goal was to collect 200 participants.

Procedure

Before collecting data, this study received IRB approval at Purdue University Northwest (IRB #2020-746). Data were collected through Qualtrics, a program that allows researchers to create an online survey and collect participants' responses, from June 2020 to September 2020. Participants were recruited using snowball sampling, emailing the survey to MFT professionals and posting the survey on MFT social media accounts along with requesting the survey be shared with others who met the inclusion criteria. MFT professionals included faculty located at the author's graduate program and Program Directors at a variety of MFT graduate programs across the nation. A call for participants was also posted on MFT-specific webpages at Purdue University Northwest, AAMFT, and the National Council for Family Relations. The survey advertisement that was distributed included the title of this study along with describing the purpose of this study as gathering MFTs' responses to "relational violence" in couples' cases. Additionally, the survey advertisement included a short description of the inclusion criteria, approximate length of time needed to finish the survey, and a request for individuals to share the survey with others who met the inclusion criteria. Please see Appendix A for a copy of the survey advertisement.

Survey Process

Those who participated were first given the informed consent. Participants who consented were next asked whether they were currently practicing as an MFT during the time of the survey. Participants who met the inclusion criteria answered demographic questions (e.g., age, ethnicity) and were then randomly assigned one of the three vignettes. After reading the

vignette, participants indicated whether the vignette encompassed IPA. Participants who said "no" skipped to questions asking about their personal and professional experiences with IPA. Participants who said "yes" were then asked to identify the perpetrator(s), indicate whether future harm could occur, and provide their definition of harm. These participants then proceeded to the questions about personal and professional IPA experiences. At the end of the survey, participants were given the option to enter into a drawing for one of three $20.00 Amazon gift cards. To opt in, participants followed a separate link to a new survey asking for their name and email. Utilizing a separate survey prevented participants' survey responses from being connected to their identifiable information. Please see Appendix B for a copy of the survey.

Sampling Method

Snowball sampling includes both advantages and disadvantages. Advantages include assisting researchers with reaching participants who might otherwise be difficult to recruit. In turn, this also helps with increasing the sample size (Fowler, 2014). With the present study, the inclusion criteria were specific to a certain population. However, snowball sampling does not qualify as random sampling as the opportunity to participate relies on one's connections, introducing bias into the study (Field, 2018; Fowler, 2014).

Utilizing snowball sampling with webpages includes the same pros and cons. Additional advantages include providing potential respondents with an easy way to participate in online studies as simple advertisements are enough to make them aware of the opportunity. Further, advertisements on social media webpages are easily shareable to others who might meet the inclusion criteria (Kosinski et al., 2015). One drawback specific to webpages is that they are often filled with multiple advertisements, meaning there is competition for potential respondents' interest and time. As is the case with online surveys in general, the same issue of participants easily exiting the survey is another potential disadvantage (Kosinski et al., 2015).

Vignettes

To test the present study's research questions, participants randomly received one of three vignettes. Each vignette included the same IPA incident that occurred between partners in a heterosexual relationship. One vignette encompassed male unilateral IPA, one encompassed

bilateral IPA, and one encompassed female unilateral IPA. To differentiate the modality, the perpetrator's sex and the pronouns used changed in each vignette. *Jacob* indicated a cisgender male and *Sarah* indicated a cisgender female who both identified as heterosexual. Below, each vignette is provided along with a brief description on how it qualifies as male unilateral IPA, bilateral IPA, or female unilateral IPA. In each vignette, IPA is defined by the act of throwing and hitting one's partner with a cellphone.

Male Unilateral IPA Vignette

> "You just had an intake with Jacob and Sarah who are seeking couple's therapy. During the couple portion of the intake, they disclosed an incident that occurred a couple of weeks ago. In the incident, both partners were returning home from work around the same time. After settling in from work, both partners became angry that the other partner had not cleaned the apartment before he/she had left for work. At this point, they began arguing, and sometime during the course of the argument, Jacob threw his cell phone at Sarah, hitting her in the arm. The argument ended there, and both partners went to separate rooms in the apartment."

This vignette is classified as male unilateral IPA because Jacob was the only partner who perpetrated aggression, qualifying Sarah as the only victim during this incident.

Bilateral IPA Vignette

> "You just had an intake with Jacob and Sarah who are seeking couple's therapy. During the couple portion of the intake, they disclosed an incident that occurred a couple of weeks ago. In the incident, both partners were returning home from work around the same time. After settling in from work, both became angry that the other partner had not cleaned the apartment before he/she had left for work. At this point, they began arguing, and sometime during the argument, they threw their cellphones at one another, both hitting one another in the arm. The argument ended there, and both partners went to separate rooms in the apartment."

This vignette is classified as bilateral IPA because both Sarah and Jacob perpetrated aggression, qualifying both as the victims as well.

Female Unilateral IPA Vignette

> "You just had an intake with Jacob and Sarah who are seeking couples' therapy. During the couple portion of the intake, they disclosed an incident that occurred a couple of weeks ago. In the incident, both partners were returning home from work around the same time. After settling in from work, both became angry that the other partner had not cleaned the apartment before he/she had left for work. At this point, they began arguing, and sometime during the course of the argument, Sarah threw her cell phone at Jacob, hitting him in the arm. The argument ended there, and both partners went to separate rooms in the apartment."

This vignette is classified as female unilateral IPA because Sarah was the only one who perpetrated aggression, qualifying Jacob as the only victim.

Overall, the vignettes encompass only an act of physical IPA, as there are no instances of nonconsensual sexual behaviors (i.e., sexual IPA) and no instances of verbal aggression or controlling behaviors (i.e., emotional IPA; CDC, 2018). Although the vignettes indicated an argument ensued before the physical IPA, no description was provided regarding what occurred during the argument, and an argument does not inherently classify as emotional IPA.

Measures

Demographics

Demographic questions were included at the beginning of the online survey. They encompassed MFT licensure status, ethnicity, sex, gender identity, sexual orientation, and age.

Independent Variables

Modality

Modality encompassed unilateral male IPA, bilateral IPA, and unilateral female IPA. The modality type was distinguished by the sex of the perpetrator/victim by changing the names and pronouns in each vignette.

To ensure that the modality was the only difference between vignettes, the language used to describe the physical IPA incident remained consistent across the vignettes. This can be seen in the description of the intake, how the incident was revealed, the context leading up to the IPA during the incident, the physical aggression used in the incident itself, and the outcome after the

IPA occurred. Utilizing consistent language was necessary so as to not bias the participants' responses across the different vignettes. Introducing this bias would limit the ability to examine how modality might potentially influence participants' responses.

Based on descriptions from previous research, the IPA incident used in the three vignettes better reflects SCV as the aggression occurred within a specific conflict and did not result in serious injury. Because only one incident of IPA was included in the description, it is not possible to establish whether a pattern of control exists—making it impossible to definitively state whether the case example is SCV or IT. Although the incident better reflects SCV, in IT, a physical IPA incident can also occur during conflict, and every act of physical aggression in IT does not necessarily have to lead to severe injury, or even injury in general. Thus, although the IPA incident itself better reflects SCV based on descriptions from previous research, IT could still be occurring in the hypothetical couple's relationship.

The ability for all three modalities to fit within the incident's description was a requirement, or the possible influence of each modality could not be examined. Thus, since typology and modality inherently overlap, it was not possible in the context of this study to incorporate male unilateral IT, female unilateral IT, and SCV without changing the description of the IPA incident across the three vignettes.

The author modeled the vignettes after Blasko and colleagues' (2007) case example, as the authors intentionally chose to describe a more ambiguous IPA incident. The ambiguity in their example forced participants to rely more on their current perceptions of IPA (Blasko et al., 2007). This methodological choice fit well with this study as one aim was to examine the potential influence of previous IPA exposure on participants' conceptualizations of IPA. However, as a brief reminder, the physical aggression in Blasko and colleagues' (2007) study included multiple acts and resulted in injury that included bloodshed. Although their intent was to describe an ambiguous incident, the author of this study would argue that the IPA scenario in the current study was even more ambiguous than Blasko and colleagues (2007).

Previous Intimate Partner Aggression Exposure

Professional IPA Experiences

Professional IPA experiences included attending a university course dedicated to IPA, attending a university course that included IPA material in the curriculum, attending an IPA training, and working with those who have experienced IPA (Dersch et al., 2006). In the Qualtrics survey, participants were able to select all that applied to them.

During the analyses, all four professional IPA experiences were weighted to differentiate the likely difference in the amount of exposure to IPA material among them. The author did not inquire about the extent to which participants were exposed to these different experiences (e.g., how many hours). Thus, the professional experiences were weighted based on hypothesized intensities of each, with a value of "1" being the lowest and a value of "4" being the highest (1 = "attending a university course that included IPA material in the curriculum"; 2 = "attending an IPA training"; 3 = "attending a university course dedicated to IPA"; 4 = "working with those who have experienced IPA"). The total scores ranged from 0-10 for each participant.

It was hypothesized that "attending a university course that included IPA material in the curriculum" would likely have the lowest exposure as it might have only been discussed in one class period or only in a few readings. Thus, it was believed it had the potential for the least amount of exposure. "Attending an IPA training" was next as many trainings often range from a few hours to one or two full days of content, which would likely be longer than the amount of time spent in the former category. "Attending a university course dedicated to IPA" followed as IPA-specific content in this context would have likely transpired for eight or 16 weeks, depending on the length of the course. Finally, "working with those who have experienced IPA" was given the highest weight both due to the believed increased time commitment and hands-on learning aspects of this type of exposure.

Personal IPA Experiences

Personal IPA experiences included witnessing physical and emotional IPA in the FOO and being directly involved with IPA in romantic relationships during the past year. Witnessing interparental IPA was measured using the Physical Assault subscale and the Psychological Aggression subscale from the Revised Conflict Tactics Scale (CTS2; Straus et al., 1996).

Previous studies have adapted the subscales' prompt from the original application to romantic relationships to an application for witnessing interparental IPA (Straus et al., 1996). The current study used this same adapted prompt for both the Physical Assault and Psychological Aggression subscales when measuring interparental IPA: "How often did either one of your parents…." Sample items of the Physical Assault subscale include, "throw something at the other parent" and "push, shove, or grab the other parent." Sample items of the Psychological Aggression subscale include "insulted or swore at the other parent" and "threatened to hit or throw something at the other parent." The responses ranged from "this has never happened" to "more than 20 times" for both subscales (Straus et al., 1996).

The same Physical Assault and Psychological Aggression subscales from the CTS2 were used to measure IPA in romantic relationships during the past year. The original prompt created by Straus and colleagues (1996) for romantic relationships was used for both subscales. Participants were asked to report on both IPA perpetration and victimization that had occurred in romantic relationships during the past year. Responses ranged from "this has never happened" to "more than 20 times" along with an option to indicate "not in the past year, but it did happen before." This last response was included as it is a standard response in the CTS2 and was coded with a score of "0." It was coded as "0" because this study was examining IPA acts within the past year only. The Physical Assault ($\alpha = .86$) and Psychological Aggression ($\alpha = .79$) subscales have demonstrated strong reliability in previous studies. Please see Appendix C for all the items in the Physical Assault and Psychological Aggression subscales.

The variable measuring total physical IPA acts was created by summing the items in the Physical Assault subscale for both witnessing interparental IPA and experiencing romantic IPA. The variable measuring total emotional IPA acts was created by summing the items in the Psychological Aggression subscale for both witnessing interparental IPA and experiencing romantic IPA. The items in the Physical Assault and Psychological Aggression subscales were summed in accordance with the authors' request when conducting psychometric analyses (Strauss et al., 1996).

Control Variables

Education

Participants were asked to indicate their highest level of education: bachelor's, master's, or a doctoral degree. This control variable was selected as previous research has examined the potential influence of education level (Dersch et al., 2006; Dudley et al., 2008) on therapists' responses to IPA cases, with some finding an association between the two (Dersch et al., 2006). The three categories for this variable were recoded into two categories, "bachelor's" and "grad school," in which master's and doctoral degree were combined into "grad school." The latter two categories were combined due to a small number of participants who selected "doctoral degree" for their highest level of education.

Years of Clinical Experience

Participants were asked to report the number of years they have provided therapeutic services to clients as an MFT. This control variable was selected as previous research has examined the potential influence of clinical experience on therapists' responses to IPA cases (Dersch et al., 2006; Dudley et al., 2008).

Dependent Variables

Recognizing IPA

Participants were asked to indicate whether or not the vignette they received classified as IPA (0 = "no," 1 = "yes"). Participants who selected "no" were coded as 0 for Identifying the Perpetrator(s) and for Future Risk of Harm. Said participants' responses were coded in this manner because if they did not recognize the IPA in their vignette, then they also failed to accurately identify the perpetrators and thus were unable to make a hypothesis about whether future harm could occur due to the IPA in Jacob and Sarah's relationship.

Identifying the Perpetrator(s)

The participants who recognized the IPA were asked to indicate the perpetrator(s) in the vignette they received. Participants had the option to select "Jacob," "Sarah," "both Jacob and

Sarah," and "I don't know." Their answers were coded as 0 = "incorrect" and 1 = "correct" based on whether the participant accurately identified the perpetrator(s). "I don't know" was considered an incorrect attempt at identifying the perpetrator(s) and was thus coded as 0 when selected by participants.

Future Risk of Harm

The participants who recognized the IPA were asked if they believed future harm would occur by specifying who they believed would be harmed. Participants had the option to select "no one," "Jacob," "Sarah," and "both Jacob and Sarah." "No one" was coded as 0 = "no," to indicate the participant did not believe future harm would occur. "Jacob," "Sarah," and "both Jacob and Sarah" were all coded as 1 = "yes," to indicate the participant believed future harm would occur. Participants who selected "Jacob," "Sarah," or "both Jacob and Sarah" were then asked to provide their definition of *harm* via an open-ended question to ensure content validity. The following qualitative coding procedure used existing phrases in the literature to describe different types of IPA and harm that could be a result of it.

Data Analysis

Logistic regression analyses were run to predict participants' responses to the dependent, categorical variables based on their responses to the independent, continuous variables (Field, 2018). Research question one was answered using a binomial logistic regression to examine whether previous IPA exposure and modality influenced participants' recognition of IPA in their given vignette. The modalities were dummy coded with the male unilateral modality serving as the referent category. Research question two was answered using a binomial logistic regression to examine whether previous IPA exposure and modality influenced participants' accurate identification of the perpetrator(s) in their given vignette. The selection choices ("Sarah," "Jacob," "Jacob and Sarah," or "I don't know") were coded into a "correct" or "incorrect" variable to indicate whether the participants identified the perpetrator(s) accurately. Research question three was answered using a binomial logistic regression to examine whether previous IPA exposure and modality influenced participants' belief that future harm would occur between

Sarah and Jacob. The selection responses ("no one," "Sarah," "Jacob," and "Jacob and Sarah") were coded into a "yes" or "no" variable.

Logistic regression analyses were also used to examine the influence of the control variables. Education level was included as a control variable to account for the possible influence that educational attainment might have had on participants' responses. Years of clinical experience was also included as a control variable to account for the possible influence that years of experience might have had on participants' responses.

Data screening procedures included the following. Descriptive analyses were run on all variables. All continuous variables—years of clinical experience, total physical acts of IPA, total psychological acts of IPA, and total professional IPA experiences—were tested for linearity of the logit and for multicollinearity. Leverage statistics were run for each binomial logistic regression to examine whether certain cases exerted undue influence on the model. Bivariate correlations were run to analyze the direct relationship between the continuous and dependent variables. Finally, chi-square cross tabulations were run to assess the relationship between the vignette type (i.e., male unilateral, bilateral, and female unilateral) and each dependent variable.

CHAPTER 4: RESULTS

Sample Characteristics

Forty-seven participants accessed the online survey. There was a total of 10 missing data cases, resulting in 37 remaining participants. Of the missing cases, one participant did not provide consent, two did not meet the inclusion criteria, and seven did not fully answer the questions necessary for data analysis. Thus, the completion rate was about 79%, with missing cases accounting for about 21% of the original sample size.

Descriptive Analyses

Demographic Variables

Twenty-eight participants identified as White (75.7%), six as African-American (16.2%), two as Hispanic/Latinx (5.4%), and one as Asian-American or Pacific Islander (2.7%). Twenty-eight participants identified their sex as female (75.7%), and nine participants as male (24.3%). Twenty-seven participants selected woman as their gender identity (73.0%), nine as a man (24.3%), and one as nonbinary (2.7%). Twenty-seven participants identified as heterosexual (73.0%), seven as bisexual (18.9%), two as lesbian (5.4%), and one as asexual (2.7%). Participants ranged in age from 22 to 49, with a mean of 29.68 and a standard deviation of 6.39. Twenty-one participants reported currently working toward licensure (56.8%), 11 held an associate's license (29.7%), and five were fully licensed (13.5%). Please see Tables 1-6 for a further breakdown of the demographic variables.

Table 1. Ethnicity (n = 37)

Ethnicity	Frequency	Percentage
Hispanic/Latinx	2	5.4%
African-American	6	16.2%
Asian-American or Pacific Islander	1	2.7%
White	28	75.7%
		100%

Table 2. Sex (*n* = 37)

Sex	Frequency	Percentage
Male	9	24.3%
Female	28	75.7%
		100%

Table 3. Gender Identity (*n* = 37)

Gender Identity	Frequency	Percentage
Man	9	24.3%
Woman	27	73.0%
Nonbinary	1	2.7%
		100%

Table 4. Sexual Orientation (*n* = 37)

Sexual Orientation	Frequency	Percentage
Lesbian	2	5.4%
Bisexual	7	18.9%
Heterosexual	27	73.0%
Asexual	1	2.7%
		100%

Table 5. Age (*n* = 37)

Age	Min	Max	Mean	Std. Deviation
Age	22	49	30	6.4

Table 6. Licensure Status (*n* = 37)

Licensure Status	Frequency	Percentage
No MFT License	21	56.8%
Associate MFT License	11	29.7%
Full MFT License	5	13.5%
		100%

Independent Variables

Modality was measured via three vignettes (Table 7). Twenty-two participants received the male unilateral vignette (59.5%), 11 received the bilateral vignette (29.7%), and four (10.8%) received the female unilateral vignette. Due to the small sample size, the extent to which the

vignettes could be randomized was limited, resulting in an uneven distribution. Also, several of the missing data cases were assigned vignette three, further reducing its frequency in this study.

IPA exposure was measured by both professional and personal experiences (Table 8). The total weighted number of professional IPA experiences ranged from 0 to 10, with a mean of 3.46 and a standard deviation of 2.83. Personal IPA experiences were measured by the CTS2 Physical Assault and Psychological Aggression subscales. The total number of physical acts of IPA ranged from 0 to 90, with a mean of 7.59 acts and a standard deviation of 19.93. The total number of emotional acts of IPA ranged from 0 to 275, with a mean of 78.46 acts and a standard deviation of 72.45. When measuring how often an incident occurred, especially adverse incidents, the data tend to be highly variable. This can be seen in both the wide range and large standard deviations of the total physical and emotional acts of IPA variables.

Table 7. Modality (n = 37)

Modality	Frequency	Percentage
Male Unilateral	22	59.5%
Female Unilateral	11	29.7%
Bilateral	4	10.8%
		100%

Table 8. IPA Exposures (n = 37)

IPA Exposures	Min	Max	Mean	Std. Deviation
Professional	0	10	3.46	2.83
Personal- Physical Acts	0	90	7.59	19.93
Personal- Emotional Acts	0	275	78.46	72.45

Control Variables

Participants were also asked to indicate their highest level of education (Table 9) and the number of years they have practiced as an MFT (Table 10). Twenty-five participants reported having a graduate degree, master's or doctoral (67.6%), and 12 participants reported having a bachelor's degree (32.4%). Thus, the latter 12 participants were enrolled in an MFT master's program at the time of the survey. Clinical experience ranged from less than one year to 24 years, with a mean of 3.41 years and a standard deviation of 4.44.

Table 9. Education (*n* = 37)

Education	Frequency	Percentage
Bachelor's Degree	12	32.4%
Graduate Degree	25	67.6%
		100%

Table 10. Clinical Experience (*n* = 37)

Clinical Experience	Min	Max	Mean	Std. Deviation
Clinical Experience	0	24	3.41	4.44

Dependent Variables

The majority of participants (34) recognized IPA (Table 11) in their given vignette (91.9%), leaving three participants who failed to recognize IPA (8.1%). Twenty-nine participants correctly identified the perpetrator in their given vignette (78.4%), and eight participants, including the three who did not recognize IPA, incorrectly identified the perpetrator (21.6%; Table 12). Thirty-three participants indicated that future harm could occur between Jacob and Sarah (89.2%), and four participants, including the three who did not recognize IPA, did not indicate future harm (10.8%; Table 13).

Table 11. Recognize IPA (*n* = 37)

Recognize IPA	Frequency	Percentage
No	3	8.1%
Yes	34	91.9%
		100%

Table 12. Identify Perpetrator(s) (*n* = 37)

Identify Perpetrator(s)	Frequency	Percentage
Incorrect	8	21.6%
Correct	29	78.4%
		100%

Table 13. Future Harm (n = 37)

Future Harm	Frequency	Percentage
No	4	10.8%
Yes	33	89.2%
		100%

Data Screening Procedures

All continuous variables were tested for potential violation of linearity of the logit and tested for multicollinearity. Linearity of the logit was not violated, and multicollinearity was not demonstrated for all continuous variables.

Cook's Distance, Leverage, and Standardized Residuals were calculated to examine whether certain cases exerted undue influence on the model. For all three binomial logistic regressions, similar cases were found to exert undue influence on the model. For all but one of these cases, further examination discovered that these participants differed in some manner from the average respondent. It is likely that the small sample size contributed to these cases exerting undue influence as even just one participant falling outside of the Standardized Residual (only 1.0% outside of plus or minus 2.58) was greater than 1.0% (i.e., 2.7%).

The bivariate correlation analysis revealed that the relationships among the dependent variables were positive and significant ($p < .01$). The positive relationships among the dependent variables follows due to the way they were coded; if a participant did not recognize IPA, then they received a value of 0 for the remaining two dependent variables. In that scenario, the participant would have also incorrectly identified the perpetrator(s) and not believed future harm would occur. Thus, the scores on the dependent variables were contingent upon one another. Additionally, the relationship between future harm and combined physical acts of IPA were negative and significant ($p < .05$). Please see Table 14 for the correlations.

The chi-square cross tabulations indicated no significant relationships between the vignette type and each dependent variable.

Table 14. Correlations

	Total Professional Experiences	Total Physical IPA Acts	Total Emotional IPA Acts	Recognize IPA	Identify Perpetrator	Future Harm
Clinical Experience	.050	.005	.224	-.064	-.013	-.008
Total Professional Experiences		-.119	-.092	.120	.039	.182
Total Physical IPA Acts			.287	.039	.113	-.330*
Total Emotional IPA Acts				.034	-.061	-.039
Recognize IPA					.566**	.853**
Identify Perpetrator						.451**

**. Correlation is significant at the .01 level (2-tailed).
*. Correlation is significant at the .05 level (2-tailed).

Instruments

Cronbach's alphas were calculated for the total acts of physical IPA variable and for the total acts of emotional IPA variable. Cronbach's alphas were calculated to remain consistent with Straus and colleagues' (1996) method of measuring internal reliability for the CTS2 Physical Assault and Psychological Aggression subscales. The total acts of physical IPA variable demonstrated good reliability ($\alpha = .82$). The total acts of emotional IPA variable demonstrated good reliability ($\alpha = .87$).

Hypothesis One

For Hypothesis One, a binomial logistic regression was run to examine the influence the independent variables, modality (1a) and previous IPA exposure (1b), had on the likelihood of MFTs recognizing IPA in their given vignette, the dependent variable. The control variables included education level and years of clinical experience. The binomial logistic regression model was not significant χ^2 (7) = 3.955, $p > .05$. The model accounted for 23.6% of the variance (Nagelkerke $R^2 = .236$). Thus, the model explained 23.6% of the variance in MFTs ability to

recognize IPA in their given vignette. Babbie (2016) supported the use of Nagelkerke R^2 in binomial logistic regressions instead of R^2. The amount of variance explained suggests that the small sample size contributed to the nonsignificant model, and, with more participants, the model might have been significant. The model accurately classified 91.9% (34) of the cases, incorrectly classifying the three cases who did not recognize the IPA in their vignette.

None of the independent or control variables were found to be significant (Table 15).

Table 15. Recognizing IPA Binomial Logistic Regression

	B	SE	Wald	*df*	*P*	Odds Ratio	95% CI for Odds Ratio	
							Lower	Upper
Clinical Experience	-.665	.482	1.904	1	.168	.514	.200	1.322
Education	-1.374	2.230	.380	1	.538	.253	.003	20.007
Professional IPA	.199	.328	.367	1	.545	1.220	.641	2.320
Total Physical IPA	.015	.050	.085	1	.770	1.015	.920	1.119
Total Emotional IPA	.011	.012	.827	1	.363	1.011	.987	1.036
Male Unilateral			.295	2	.863			
Bilateral	1.209	2.229	.295	1	.587	3.352	.042	264.406
Female Unilateral	30.573	13228.243	.000	1	.998	1.896E+13	.000	.
Constant	3.296	2.433	1.835	1	.176	27.003		

Hypothesis Two

For Hypothesis Two, a binomial logistic regression was run to examine the influence the independent variables, modality (2a) and previous IPA exposure (2b), had on the likelihood of MFTs correctly identifying the perpetrator(s) in their given vignette, the dependent variable. The control variables included education level and years of clinical experience. The binomial logistic regression model was not significant χ^2 (7) = 3.895, $p > .05$. The model accounted for 15.4% of the variance (Nagelkerke $R^2 = .154$). Thus, the model explained 15.4% of the variance in MFTs ability to correctly identify the perpetrator(s) in their given vignette. The amount of variance

explained suggests that the small sample size contributed to the nonsignificant model, and, with more participants, the model might have been significant. The model accurately classified 78.4% (29) of the cases, incorrectly classifying the eight cases who incorrectly identified the perpetrator(s) in their given vignette.

None of the independent or control variables were found to be significant (Table 16).

Table 16. Correct Perpetrator Binomial Logistic Regression

	B	SE	Wald	*df*	*P*	Odds Ratio	95% CI for Odds Ratio	
							Lower	Upper
Clinical Experience	.006	.114	.003	1	.959	1.006	.804	1.258
Education	.304	1.093	.077	1	.781	1.355	.159	11.535
Professional IPA	.084	.163	.266	1	.606	1.088	.791	1.496
Total Physical IPA	.044	.061	.520	1	.471	1.045	.927	1.178
Total Emotional IPA	-.006	.006	.791	1	.374	.994	.982	1.007
Male Unilateral			1.602	2	.449			
Bilateral	1.606	1.305	1.156	1	.218	4.984	.386	64.278
Female Unilateral	-.040	1.465	.001	1	.978	.961	.054	16.963
Constant	.795	1.063	.559	1	.455	2.215		

Hypothesis Three

For Hypothesis Three, a binomial logistic regression was run to examine the influence the independent variables, modality (3a) and previous IPA exposure (3b), had on the likelihood of MFTs believing future harm would occur between Sarah and Jacob in their given vignette, the dependent variable. The control variables included education level and years of clinical experience. The binomial logistic regression model was not significant χ^2 (7) = 4.002, $p > .05$. The model accounted for 20.7% of the variance (Nagelkerke $R^2 = .207$). Thus, the model explained 20.7% of the variance in MFTs believing future harm would occur between Jacob and Sarah in their given vignette. The amount of variance explained suggests that the small sample

size contributed to the nonsignificant model, and, with more participants, the model might have been significant. The model accurately classified 91.9% (34) of the cases. The model accurately identified all cases that believed future harm would occur and one case that did not believe future harm would occur. The model incorrectly classified the remaining three cases who did not believe future harm would occur.

None of the independent or control variables were found to be significant (Table 17).

Table 17. Future Harm Binomial Logistic Regression

	B	SE	Wald	*df*	*P*	Odds Ratio	95% CI for Odds Ratio	
							Lower	Upper
Clinical Experience	-.050	.146	.117	1	.732	.951	.715	1.266
Education	-.563	1.575	.128	1	.721	.570	.026	12.476
Professional IPA	.238	.301	.624	1	.430	1.269	.703	2.290
Total Physical IPA	-.028	.023	1.441	1	.230	.973	.929	1.018
Total Emotional IPA	.002	.011	.040	1	.842	1.002	.982	1.023
Male Unilateral			.047	2	.977			
Bilateral	-.078	1.410	.003	1	.956	.925	.058	14.673
Female Unilateral	-.417	1.930	.047	1	.829	.659	.015	28.988
Constant	2.118	1.782	1.412	1	.235	8.312		

Harm Defined

Participants were provided with the following optional question, “If you selected that you believe future harm will occur between Sarah and Jacob, what do you define as harm?”. Four participants did not respond to this question, and one participant did not indicate a specific answer stating, “tough question.” Of the 32 remaining responses, 21 defined harm as including both physical and emotional aspects (65.6%), and 11 defined harm as including physical aspects only (34.4%). Although omitting emotional harm from one’s definition is concerning, as research has demonstrated that IPA can encompass both physical and emotional consequences

(Breiding et al., 2014; Ulloa & Hammett, 2016), it is possible that these participants might have interpreted the question as asking them to define the type of harm that occurred in the vignette. This can be seen in some participants providing a general definition of harm and then one specific to the vignette in the same response along with specifying in their response that their definition is based on the type of harm in the vignette. Thus, definitions with just physical aggression would logically follow, as the case example only encompassed a physical IPA incident. Due to this, it is not possible to determine whether participants omitted emotional harm because they do not view it as a potential type of harm that could result from IPA versus they omitted emotional harm only because they interpreted the question as to describe the IPA in the vignette.

Another common theme was participants considering emotional, psychological, verbal, and mental aggression/harm to be separate concepts rather than the same—what this paper refers to as *emotional* IPA. This is not surprising in the sense that these terms are often used interchangeably to describe one concept (Breiding et al., 2014; World Health Organization, 2012). However, confusion in this area might result in an incohesive understanding of the different types of IPA. Among these participants, all reported personal IPA experiences, but the majority reported little to no professional IPA experiences. It could be that formal education or training on IPA leads to the teaching of specific definitions, thereby clarifying the different forms for individuals. This type of clarification might not occur during personal IPA exposures.

CHAPTER 5: DISCUSSION

Since the 1990s, studies have examined how therapists conceptualize and treat couples who are experiencing IPA. Several themes arose from those studies, including concerns regarding therapists' ability to recognize IPA when it is occurring, ability to accurately identify who is perpetrating the IPA, and ability to conduct adequate risk assessments in IPA cases. The purpose of this study was to further replicate these themes by analyzing how the modality of IPA and previous IPA exposure impact MFTs' recognition of IPA, identification of perpetrator(s), and assessment of risk. This was implemented through random assignment of one of three vignettes, all of which described the same act of physical IPA with varying IPA modalities.

Hypothesis One

Hypothesis One was not supported by the results of its respective binomial logistic regression. Significant relationships were not found between modality and recognition of IPA nor between previous IPA exposure and recognition of IPA. However, despite the lack of significant findings, other results demonstrated an encouraging improvement in MFTs ability to recognize IPA in couple's cases. Descriptive analyses indicate that 91.9% of participants recognized the IPA occurring in their vignette, demonstrating marked improvement compared to around 60% in Hansen and colleagues (1991) and 58% in Dersch and colleagues (2006). The 91.9% IPA recognition rate also reflects the improvement seen in Blasko and colleagues' (2007) finding that 99.7% of the sample strongly agreed that the given case example accurately encompassed physical abuse. It also reflects the improvement seen in Dudley and colleagues' (2008) finding that 78% of the sample recognized IPA in their given case example.

This increased ability to recognize IPA is even more encouraging due to the ambiguous nature of the IPA incident. This study's IPA incident included a physical act that could either result in injury or not, and it was not made clear to the participants whether an injury had occurred, which were details that participants were provided in Blasko and colleagues' study (2007). The author's intention was to describe a more ambiguous IPA incident compared to Blasko and colleagues (2007) to further force participants to rely on their preconceived notions

of IPA. Thus, the descriptive analyses suggest that the participants' current views of IPA might have influenced their decision making in a positive manner.

Finally, the resulting model from the binomial logistic regression accounted for 23.6% of the variance in MFTs' ability to recognize the IPA in their given vignette. Therefore, this suggests the lack of significant findings might be attributed to the small sample size rather than the lack of any significant relationships between modality and IPA recognition and previous IPA exposure and IPA recognition.

Hypothesis Two

Hypothesis Two was not supported by the results of its respective binomial logistic regression. Significant relationships were not found between modality and correct perpetrator identification nor between previous IPA exposure and correct perpetrator identification. Despite lack of significant findings, descriptive analyses demonstrate that the majority of sample (78.4%) correctly identified the perpetrator(s) in their given vignette, leaving eight participants (21.6%) who answered incorrectly. Of these eight participants, three were not presented with this question because they failed to recognize IPA in their vignette. The five remaining selected the bilateral modality, or "Jacob and Sarah" as the perpetrators, when their vignette encompassed only one perpetrator (four with male unilateral; one with female unilateral). The bilateral selection for those with the male unilateral vignettes does not appear to reflect research that shows therapists are more likely to lean toward viewing IPA as typically a male perpetrator and a female victim (Karakurt et al., 2013), especially when it is a heterosexual couple (Blasko et al., 2007). Thus, it would be assumed that reading a case example with a male perpetrator and a female victim would further affirm that narrative and lead to choosing "Jacob" as the only perpetrator. The bilateral selection from the participant with the female unilateral vignette might reflect previous research demonstrating how women's perpetration is often missed or minimized (Allen & Bradley, 2018; Karakurt et al., 2013). In this case, Sarah's physical aggression might have been minimized by displacing blame onto Jacob as well. However, most of these participants' responses to the open-ended question asking for their definition of harm might explain their incorrect identification of the perpetrator. Four out of five described harm as including both physical and emotional harm. Thus, they might have interpreted the argument

indicated in the vignette as emotional IPA, which could account for them stating that bilateral IPA had occurred.

In addition, it is possible that these incorrect participants might have been thinking systemically or operating from the systemic notion that both partners mutually contribute to cycles of interaction (Hecker et al., 2015). In previous studies examining therapists' conceptualizations of IPA, some therapists have reported that they would focus on couple dynamics when presented with IPA couples' case examples (Dudley et al., 2008; Hansen et al., 1991). This focus might be more appropriate in bilateral cases that reflect SCV because this typology often entails poor conflict resolution and anger management skills within the couple (Kelly & Johnson, 2008) and can be more often treated within couple's therapy (Stith et al., 2012). However, in cases that entail unilateral IPA, which was true for the incorrect participants in this study, approaching IPA in the context of both partners mutually contributing to the interaction cycle might prove to be detrimental. Previous research has shown that a unilateral modality is more often reflective of IT, a typology in which there is a clear power differential between the perpetrator and the victim, with the perpetrator exerting the control in the relationship (Johnson & Leone, 2005). This might suggest, then, that MFTs must consider power differentials in tandem with their systemic orientation because in some cases not all partners have equal power over relational dynamics (McGeorge et al., 2015).

Even though five participants incorrectly identified the perpetrator, it is encouraging that for 80% of them their conceptualization process was attuned to both potential physical and emotional IPA acts. Their heightened awareness for the potentiality of physical and emotional harm aligns with research showing that when one IPA type is present (physical), it is likely that another type is occurring as well (emotional; Hamby & Sugarman, 1999). Thus, they might be more likely to identify emotional IPA perpetration in future cases. However, the incorrect identification might also simply represent misclassification. This study's IPA incident was designed not to include indicators of emotional IPA, and it did so by only describing the verbal exchange between Jacob and Sarah as *arguing* with no signs of verbal aggression or controlling behaviors (Breiding et al., 2014). This misclassification could cause harm going forward if these participants label a partner as a perpetrator if they are not actually perpetrating aggression.

Finally, the resulting model from the binomial logistic regression accounted for 15.4% of the variance in MFTs' ability to accurately identify the perpetrator(s) in their given vignette.

Thus, the lack of significant findings might be due to the small sample size instead of an actual lack of significance between modality and perpetrator identification and previous IPA exposure and perpetrator identification.

Hypothesis Three

Hypothesis Three was not supported by the results of its respective binomial logistic regression. Significant relationships were not found between modality and future harm nor between previous IPA exposure and future harm. Despite the lack of significant findings, descriptive analyses showed that 89.2% of participants (n = 33) indicated that future harm was a possibility in their given vignette. This finding suggests MFTs might now hold a heightened awareness for the potentiality of harm in IPA couple's cases. For example, 50% of participants in Hansen and colleagues' (1991) and in Harway and Hansen's (1993) studies did not see prompt safety measures as a necessity in a vignette depicting an actual severe physical IPA case where the victim was later killed by the intimate partner. Participants in this study were not presented with severe physical aggression in their vignette. Thus, despite the fact that there was not a clear indication of injury, the vast majority of participants still recognized that harm could be a potential outcome. Also, Dersch and colleagues (2006) found that only 46% of those who recognized IPA would have addressed it in some manner. However, direct comparisons cannot be made because not all the previous studies used the same vignette type and because the previous studies were assessing for intervention use, not just assessing potential harm overall as in this study.

Additionally, of the four participants who did not indicate the potential for future harm, three did not recognize the IPA in their vignette, automatically skipping them past the future harm question. Thus, only one participant held the belief that future harm would not transpire between Jacob and Sarah. This suggests that MFTs' risk assessments have become more attuned to IPA during the past few decades, despite the modality of IPA with which they are presented. Recognizing the potential for harm despite the modality aligns with research demonstrating that all three modalities can lead to injury (Jacobson & Gottman, 1998; Johnson & Leone, 2005; Madsen et al., 2012), as the recognition among participants crossed all modalities in this study. This might be a sign that MFTs are not neglecting risk assessment, regardless of the IPA with

which they are confronted. If that is the case, ensuring safety and treatment quality will be enhanced as well in future IPA couple's cases for these MFTs.

Also, about 64.7% of participants (excluding the three participants who did not recognize IPA) indicated that both Jacob and Sarah could be victims of harm in the future. This is noteworthy as it aligns with research demonstrating that experiencing IPA, whether as the perpetrator or victim, increases the likelihood of perpetration and victimization in the future (Simmons et al., 2018). Therefore, even if the participants received a unilateral vignette, a perpetrator could continue perpetrating and a victim could begin perpetrating, increasing the risk of harm for both partners. Also, the majority of participants who responded to the open-ended question defined harm resulting from IPA as encompassing both physical and emotional harm (64.7%; excluding the three participants who did not recognize IPA). This is encouraging as multiple forms of IPA exist with multiple types of potential harm that accompany them (Breiding et al., 2014). Overall, if therapists are aware of the potential for both partners to be victims and the different types of IPA, it logically follows that they would be more likely to accurately assess the risk for harm in IPA couple's cases.

Furthermore, the bivariate correlation analysis indicated that physical IPA experiences were negatively related to future harm. The negative relationship between future harm and combined physical acts of IPA could be related to the frequency of physical acts of IPA. Physical acts were not as commonly reported compared to emotional acts, with multiple participants scoring 0 on the Physical Assault subscales. Thus, it could be that in their experience physical IPA is not a common occurrence, possibly increasing the likelihood of believing that future harm would not transpire between Jacob and Sarah. Additionally, depending on the severity of the physical aggression experienced by the participants who reported this type of exposure, the act of throwing a cell phone might not register as an incident that could result in harm. In other words, it is possible participants who might have experienced more severe forms of physical aggression might be less likely to consider throwing a cell phone at one's partner as harmful.

Finally, the resulting model from the binomial logistic regression accounted for 20.7% of the variance in MFTs' indication that future harm could occur. Thus, the lack of significant findings might be due the small sample size instead of an actual lack of significance between modality and indication of future harm and between previous IPA exposure and indication of future harm.

Theoretical Support

Descriptive analyses showed that IPA exposures were common among the participants, both professional and personal. Professional exposures ranged from 0 to 10 with a mean of 3.46, and 34 participants had a score greater than "0" for this variable (91.9%). This finding supports previous research demonstrating that MFTs have experienced professional IPA exposures (Dersch et al., 2006). Total acts of emotional IPA ranged from 0 to 275 with a mean of 78.46, and 34 participants had a score greater than "0" for this variable (91.9%). Total acts of physical IPA ranged from 0 to 90 with a mean of 7.59, and 16 participants had a score greater than "0" for this variable (43.2%). These results support previous research that has found IPA exposures can occur in romantic relationships and in witnessing interparental violence in general (Bradel et al., 2019; Costa et al., 2015; Cui et al., 2013; Fritz et al., 2012; Holmes, 2013) and specifically among MFTs (Dersch et al., 2006) as well. These results also indicate that exposure to emotional acts of IPA were much more common than exposure to physical acts of IPA. From a SLT perspective, participants might have learned from these past experiences the indicators of IPA, people who could perpetrate IPA, and the harm that could result from IPA. Therefore, although not found to be significant, these exposures might have assisted the participants with recognizing IPA, identifying the perpetrator(s), and assessing for risk when presented with an IPA scenario. In SLT, this is called observational learning, or when individuals internalize the messages they receive from others to guide them in similar, future situations (Newman & Newman, 2015). Integrating self-of-the-therapist, what participants learned from their past IPA exposures, then, influenced their conceptualization of the IPA in the vignette they received (Aponte, 1985; Winter & Aponte, 1987).

Clinical Implications

Although this study did not have significant findings, important implications exist for therapists to carefully consider. First, therapists must be paying attention to signs of IPA in all couples' cases. Although this might seem like common sense, IPA in couples' cases is still being missed, which was the case for about 8.1% of participants in this sample. The significant improvement in recognition of IPA seen in this study compared to previous studies is not something to dismiss, but until it reaches 100% recognition, couples experiencing IPA will

continue to be overlooked. As seen in the study's design, participants who did not recognize the IPA in their given vignette were not asked to identify the perpetrators nor indicate the potential for future harm. This was done intentionally to represent what occurs in real life. Without recognition, therapists will be unaware of the modality, and whatever assessment conducted and treatment plan created will not be adequate. Thus, recognition is an essential first step and not one to be taken for granted.

The majority of participants in this study did accurately identify the perpetrator(s) in their given vignette (78.4%). However, that still leaves 21.6% who incorrectly classified them, with 7.6% of that rate encompassing the three participants who were skipped past this question because they did not identify IPA in the vignette. Although we discussed previously the potential benefits of those who misclassified due to possibly interpreting the argument as emotional abuse, these participants were still incorrect. When the perpetrator/victim type is inaccurately identified, then the modality is inherently misidentified as well. This is extremely problematic as different modalities are related to different IPA typologies. The typology drastically changes the nature of the IPA on multiple levels, including the underlying factors contributing to the aggression, who is perpetrating the aggression, and the aggression frequency and severity (Johnson & Ferraro, 2000; Johnson & Leone, 2005). For example, a unilateral IPA couple's case is more suggestive of IT, which is typically more dangerous than bilateral IPA seen in SCV, due to the increased frequency and severity of physical aggression (Anderson, 2008; Johnson & Leone, 2005). Altogether, failure to correctly identify the perpetrator, or modality, will likely lead to failure in assessing the context of the IPA. Without a complete understanding of the context, treatment cannot be tailored to the unique needs of the couple. For example, immediate safety measures for victims of IT (Jacobson & Gottman, 1998), and conflict resolution training for SCV couples (Kelly & Johnson, 2008).

It logically follows that if IPA recognition is necessary for classifying the modality, and if correctly classifying the modality is essential for understanding the context behind the IPA, then adequate risk assessments relies on both. Although it is encouraging that 89.2% of the participants in this study acknowledged future harm as a possibility, the rate must be 100% to fully reflect the research that demonstrates harm is always possible in IPA cases (Jacobson & Gottman, 1998; Johnson & Leone, 2005; Madsen et al., 2012). The extent of the harm largely varies on the typology (Anderson, 2008; Johnson & Leone, 2005; Swan et al., 2008), but IPA,

even what appears to be minor acts of IPA, can always escalate (Cui et al., 2013). Overall, MFTs cannot afford to miss IPA, incorrectly classify perpetrator(s), or conduct inadequate risk assessment due to the prevalence of couples seeking treatment who have a history of IPA (Greene & Bogo, 2003) and the detrimental consequences that can follow (Breiding et al., 2014; Gehring & Vaske, 2017; Simmons et al., 2018; Ulloa & Hammett, 2016).

Suggestions

Acknowledging the potential consequences of IPA and taking into account therapists' history of struggles with assessing and treating IPA warrants suggestions on how to be an effective therapist in this area. Integrating SLT and self-of-the-therapist research, the author foremost recommends that therapists reflect on their past IPA exposures, or lack thereof, to examine how they influence their conceptualization of IPA (Kissil et al., 2018). This in itself is an arduous task as internalized preconceptions of IPA can occur outside of our awareness as learning transpires regardless of whether the individual is engaging in said behavior (Newman & Newman, 2015). Although this requires immense personal work, the therapist is not alone in their examination. In fact, AAMFT's Code of Ethics requires MFTs to seek assistance for matters that might negatively impact their clinical work (2015; 3.3). Thus, because therapists' unconscious biases will affect their clinical work (Aponte, 1985), it is MFTs' ethical responsibility to ensure biases surrounding IPA are not hindering their ability to recognize it, identify perpetrator(s), and assess for risk. This assistance could potentially include supervision or peer consultation. Another suggestion includes continuing to educate oneself about IPA, whether that encompasses enrolling in courses or trainings, reading current literature, or participating in other professional opportunities that exposes individuals to IPA (Dersch et al., 2006). The open-ended responses in this study suggested that those with more professional exposures better understood the types of IPA. Remaining educated on IPA also reflects MFTs' ethical duty to maintain competency in clinical areas (AAMFT; 2015; 3.1). Overall, previous research supports that following these suggestions can enhance the assessment and treatment of IPA.

Limitations

When interpreting the results from this study, they must be considered along with the following limitations. The primary limitation of this study was its small sample size. The low response rate may be attributed to several factors. First, data were collected during a global pandemic, potentially detracting from eligible participants' desire or ability to take the time to participate in the study. Additionally, the sensitive nature of the study may have deterred other eligible participants as well. Although the study advertisement did not inform eligible participants that they would have to report on their own IPA experiences, the topic of IPA itself may have been triggering or off-putting for some people, possibly influenced by using the term "relational violence" when describing the purpose of the study. Using the term "aggression" instead may have come off as less threatening, potentially encouraging more participation. These factors are hypothesized to have exerted great influence on the low response rate because of the numerous locations in which the survey was distributed, as described in the Methods section.

Due to a small sample size, the findings might not be representative of MFTs as a group. Additionally, the small sample size reduced the opportunity for randomization of the vignettes, leading to 59.5% of the participants receiving the male unilateral vignette. Without an even distribution of vignettes, the ability to draw sound comparisons between the three modalities and the dependent variables was limited. Furthermore, the combination of large standard deviations and a small sample size contributed to the difficulty of finding significant results. Along with the variability that occurs when asking participants to report the number of incidents of a given event, a small sample size exacerbated this issue as more participants might have led to a better depiction of the average amount of different IPA exposures among MFTs. A better depiction of the average amount of different IPA exposures among MFTs might have led to more accurate examination between previous IPA exposure and the dependent variables. Also, the standard error for each binomial logistic regression model and previous research's replicated concerns with IPA recognition, perpetrator identification, and risk assessment among therapists lend further support to the small sample size being the primary source of insignificant findings. However, it could also be that therapists have improved in all three areas since the 1990s, a progression that was seen in Dudley and colleagues' study (2008).

Due to the sensitive nature of questions surrounding personal IPA experiences, social desirability bias might have influenced the data as well (Fowler, 2015). For example, participants

might have been less likely to report instances in which they perpetuated IPA due to concerns regarding how they would be perceived by others. Additionally, a selection effect might have transpired among the two missing data cases that were removed due to dropping out of the survey after answering the demographic variables. For these two cases, they were shown their randomized vignette before exiting out of the survey, with one receiving the bilateral vignette, and the second receiving the female unilateral vignette. It is possible these participants chose to leave the survey because their vignette did not describe an IPA incident that matches popular opinion in public and professional spheres, or male unilateral IPA (Armenti & Babcock, 2016; Barocas et al., 2016). Therefore, they might not have recognized such an incident and felt they would be unable to proceed in the survey. A selection effect might have also occurred if eligible participants chose not to take the survey because they had experienced IPA in some manner.

Additionally, this study might include several instances of question design error (Fowler, 2015). First, the author did not gather information regarding the varying levels of commitment that accompanied the different professional IPA exposures. Without assessing factors such as the length of time and the intensity of the exposure, the author had to base the weighted scores on educated hypotheses instead of concrete data. Therefore, not all participants' weighted scores might be accurate to the actual degree of professional exposure they experienced. Second, how the author asked for participants' definitions of harm might represent a limitation. The question could have been more specific regarding the author's intent to gather definitions of harm that could result from IPA in general, not just defining the IPA demonstrated in the vignette. With more specificity, it might have clarified whether or not the participants who defined harm as physical only did so because they interpreted the question as asking for a definition of harm in the vignette. If that was the case, there might have been more responses that encompassed both physical and emotional harm. Third, a potential design error regarding the question asking for years of clinical experience might have combined with the small sample size to contribute to its nonsignificant relationship with the dependent variables. When comparing participants' education level with their reported years of clinical experience, it appeared that some of those who had graduated from either a master's or doctoral program were not counting the clinical experience they received while in school. The question could have been more specific by adding a description informing participants to count the number of clinically active years while in school

as well. This might have resulted in a more accurate depiction of the sample's total years of clinical experience.

Fourth, a question design error might have occurred when developing the future harm variable, or the variable meant to analyze risk assessment. As mentioned in the discussion section, direct comparisons could not be made between this study and previous studies regarding therapists' relative improvement with risk assessment because of design differences. For replication purposes, it might have benefited the study to match the same design as previous studies. Further, due to the manner in which the variable measuring risk assessment was coded, participants who did not recognize IPA in their vignette were considered to not have conducted an IPA risk assessment. However, this may not be accurate in all cases, as some therapists might have still assessed for future IPA due to the conflict presented in the vignette.

Finally, another limitation of this study might be the fact that a physical act of IPA could be considered an emotional act of IPA simultaneously. Thus, this study's attempt to separate physical IPA from emotional IPA in the vignettes might not have been complete.

Future Directions

The goal of this study was to contribute to the literature by replicating previous studies that have found modality (Blasko et al., 2007; Karakurt et al., 2013) and previous IPA exposure (Dersch et al., 2006) to be associated with MFTs' conceptualization of IPA cases. Conceptualization of IPA was broken down into three components based on what has been examined in previous research, including IPA recognition (Dersch et al., 2006; Hansen et al., 1991), perpetrator identification (Blasko et al., 2007), and risk assessment (Dudley, 2008; Harway & Hansen, 1993). Future studies can contribute to the literature by utilizing case examples that expand beyond severe, male unilateral IPA case examples to examine female unilateral and bilateral cases in both opposite-sex and same-sex couples. Replication with all three modalities would allow for direct comparison along with assessing the similarities and differences between opposite-sex and same-sex couples experiencing IPA.

Additionally, replication with the different types of potential contributing factors to IPA case conceptualization would address a much-needed gap in the literature. Very little is known about not only how MFTs view IPA couples' cases but also why MFTs view IPA couples' cases the way they do. Modality and previous IPA exposure might be an effective place to start as

some research has been conducted on these factors already. Future research should continue to include both professional and personal experiences of IPA when examining exposure as well. Studies on the general population demonstrate high rates of IPA, but there is a dearth of knowledge on the extent to which therapists have been exposed to IPA in their lives. It may also be beneficial for future research to separate witnessing interparental aggression and experiencing IPA in romantic relationships. Further, making these variables dichotomous (they experienced it, or they did not experience it) could potentially allow for researchers to see if one personal exposure exerts a greater influence than the other in terms of IPA case conceptualization.

Also, future research should work toward consistency when examining different components of case conceptualization. To get an accurate depiction of how therapists think about IPA in their clinical work, studies must use similar operational definitions. Without reproducible measures, researchers would not be able to draw sound comparisons and interpretations. This does not mean future studies should not explore unexamined areas; it means replication is key to establish any type of coherent findings.

Finally, future research should analyze IPA typologies as well. When solely analyzing modalities, studies miss the context, or the why, behind the aggression. Without understanding the why, therapists are not adequately informed to make decisions about treatment. Previous research indicates how typologies vary in both motivation, underlying factors contributing to perpetrating aggression, the type of aggression, and aggression frequency and severity. All are key pieces of information necessary for efficacious treatment that prioritizes safety and is tailored to each unique IPA case. The IPA typology might also trigger different internalized biases therapists hold. Although case conceptualization should be different based on the typology, therapists might have distinct preconceptions that could either benefit or hinder their clinical work.

Conclusion

Previous research has found relationships between IPA modality and previous IPA exposure and IPA case conceptualization and has examined case conceptualization in the context of recognition, perpetrator identification, and risk assessment. Although no significant relationships were found in this study, descriptive analyses indicated the majority of the sample recognized IPA, correctly identified the perpetrator(s), and acknowledged the potential for future

harm in their given vignettes. Although these are encouraging findings, until the rates are 100%, couples experiencing IPA will go overlooked in therapy. As a result, these couples face severe consequences that could be eliminated or at least diminished with IPA-informed treatment. To achieve this, therapists should self-reflect on their own previous IPA exposures and how they might be influencing their view of IPA and how that might transfer into their clinical work. Therapists should also continue to educate themselves as formal training might dispel potential misconceptions and fill gaps in knowledge. Completing this self-of-the-therapist work and maintaining competency will serve therapists and the couples experiencing IPA who seek their services.

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APPENDIX A. SURVEY ADVERTISEMENT

Hello, my name is Lara Hoss, and I am a Marriage and Family Therapy graduate student at Purdue University Northwest. I am reaching out to other MFTs to gather participants for my thesis study. MFT masters and doctoral students who are currently seeing clients are eligible to participate as well. If you are interested, please see the study's description below. Thank you for your time.

Marriage and Family Therapists' Perceptions of Intimate Partner Aggression in Couples' Cases. (IRB #2020-746)

This is a survey about Marriage and Family Therapists' thoughts on cases where couples are experiencing relational violence. If you are currently practicing as a Marriage and Family Therapist and are interested in participating in this study, follow the survey link below. It will take about 10 to 15 minutes to complete the survey. After you complete the survey, you will have the option to enter in a drawing to receive one of three $20 Amazon gift cards. Your responses will not be connected to your drawing entry. Thank you for considering participating in this study. If you are willing, please share this survey with other currently practicing Marriage and Family Therapists you know. If you have any questions, please reach out to the Principal Investigator of this project, Dr. Anne B. Edwards, Associate Professor of Human Development and Family Studies at Purdue University Northwest via email at [abedward@pnw.edu] or phone at 219-989-8439.

https://purdue.ca1.qualtrics.com/jfe/form/SV_3mHyCdHYBwMqL77

APPENDIX B. SURVEY

Start of Block: Block 3

Q37

Key Information

Please take time to review this information carefully. This is a research study. Your participation in this study is voluntary which means that you may choose not to participate at any time without penalty or loss of benefits to which you are otherwise entitled. You may ask questions to the researchers about the study whenever you would like. If you decide to take part in the study, you will be asked to sign this form, be sure you understand what you will do and any possible risks or benefits.

This study aims to better understand how Marriage and Family Therapists (MFTs) work with couples who are experiencing relational violence. Data will be collected until approximately October 2020 or until the needed number of participants has been met.

What is the purpose of this study?

You are being asked to participate in this survey because you meet the following selection criteria: clinically practicing as an MFT at the time of the survey. This includes MFT masters and doctoral students who are seeing clients, graduated MFTs working toward licensure, or graduated MFTs who have an associates or full license. We would like to enroll 200 people in this study.

What will I do if I choose to be in this study?

You will take an online survey, which can be completed on your cellphone, tablet, laptop, desktop computer, or other smart device. You can take this survey at any location you choose to do so.

This survey is experimental, and you will be given one case study to provide comments on.

How long will I be in the study?

It will take approximately ten minutes to complete this survey.

What are the possible risks or discomforts?

You may experience some discomfort when answering questions about relational violence. You can choose not to answer any question at any time. If you do experience feelings of discomfort, the following are resources that can connect you with trained professionals:

- https://www.aamft.org/Directories/Find_a_Therapist.aspx
- https://www.psychologytoday.com/us/therapists

Breach of confidentiality is always a risk with data, but we will take precautions to minimize this risk as described in the confidentiality section.

Are there any potential benefits?

You will not directly benefit from this study, but you may indirectly benefit from furthering the MFT field's knowledge of the treatment of relational violence.

Will I receive payment or other incentive?

If you complete this survey, you will be eligible to win one of three Amazon Gift Cards. Each Amazon Gift Card will be worth $20. The odds of winning a gift card will be approximately 5 out of 200. If you would like to be eligible for a gift card, please click on the link that will appear at the end of the survey. You will enter your email address here. By having a separate link for the contact information, your email will not be attached to your survey responses.

Are there costs to me for participation?

There are no anticipated costs to participate in this research.

This section provides more information about the study

Will information about me and my participation be kept confidential?

The project's research records may be reviewed by the study sponsor/funding agency, Food and Drug Administration (if FDA regulated), US DHHS Office for Human Research Protections, and by departments at Purdue University responsible for regulatory and research oversight.

There is no personally identifying information on this survey; all responses will remain anonymous and will be used only in combination with the responses of other participants in this and related studies. IP addresses will not be linked to your responses.

Only the research team will have access to your responses. Your responses will be stored via an encrypted flash drive that is password protected. The flash drive will be stored in a locked cabinet that is behind three key card access only doors. Only approved personnel have access to the key card necessary to enter through the three doors. The locked cabinet is located at Purdue Northwest University.

Your responses will be stored for a maximum of three years after publication of any articles related to this study. After this time period, the data set will be disposed of via the complete

deletion of the data and destruction of the hard drive.

What are my rights if I take part in this study?

You do not have to participate in this research project. If you agree to participate, you may withdraw your participation at any time without penalty. If you decide to withdraw your participation, please exit out of the survey tab. There are no penalties or withdrawal of benefits if you choose not to complete the survey. However, you will not be eligible to win one of the $20 Amazon gift cards if you do not complete the survey.

You can choose not to answer any question. There are some questions that you must select a response in order to proceed. For those questions, you will have the option to select "I prefer not to say" if you do not want to answer the question.

Who can I contact if I have questions about the study?

If you have questions, comments, or concerns about this research project, you can talk to one of the researchers. Please contact Dr. Anne Edwards at abedward@pnw.edu or at (219) 989-8439, who is the first point of contact for this study. You may also contact Lara Hoss at hoss@pnw.edu. To report anonymously via Purdue's Hotline see www.purdue.edu/hotline

If you have questions about your rights while taking part in the study or have concerns about the treatment of research participants, please call the Human Research Protection Program at (765) 494-5942, email (irb@purdue.edu) or write to:

Human Research Protection Program - Purdue University
Ernest C. Young Hall, Room 1032
155 S. Grant St.
West Lafayette, IN 47907-2114

Documentation of Informed Consent

I have had the opportunity to read this consent form and have the research study explained. I have had the opportunity to ask questions about the research study, and my questions have been answered. I am prepared to participate in the research study described above. I will be offered a copy of this consent form after I sign it.

O Yes, I consent (1)

O No, I do NOT consent (2)

Skip To: End of Survey If Key Information Please take time to review this information carefully. This is a research study.... = No, I do NOT consent

Q1 Are you currently treating clients as a Marriage and Family Therapist (MFT)?

O Yes (1)

O No (2)

O I prefer not to say (8)

Skip To: End of Survey If Are you currently treating clients as a Marriage and Family Therapist (MFT)? = No

Skip To: End of Survey If Are you currently treating clients as a Marriage and Family Therapist (MFT)? = I prefer not to say

Q32 What is your licensure status?

O No MFT license (1)

O Associate MFT License (2)

O Full MFT license (3)

O Associate or full MFT license with another license (4)

_____

Q2 How many years of clinical experience do you have as an MFT?

_____

Q12 What is your highest level education?

O Bachelors degree (2)

O Masters degree (3)

O Doctoral degree (4)

Q3 What is your ethnicity?

O Hispanic/Latinx (1)

O African-American (2)

O Asian-American or Pacific Islander (3)

O American-Indian/Native American (4)

O White (5)

O Other (6) _____

Q4 What is your age?

_____

Q5 What sex were you assigned at birth?

O Male (1)

O Female (2)

O Intersex (3)

Q6 What is your gender identity?

O Man (1)

O Woman (2)

O Nonbinary (3)

O Trans woman (4)

O Trans man (5)

Q7 What is your sexual orientation?

O Gay (1)

O Lesbian (2)

O Bisexual (3)

O Heterosexual (4)

O Asexual (5)

O Pansexual (6)

O Currently exploring (7)

O Other (8) _____

End of Block: Block 3

Start of Block: Block 1

Q20 Please read the following case example.

You just had an intake with Jacob and Sarah who are seeking couple's therapy. During the couple portion of the intake, they disclosed an incident that occurred a couple weeks ago. In the incident, both partners were returning home from work around the same time. After settling in from work, both partners became angry that the other partner had not cleaned the apartment before he/she had left for work. At this point, they began arguing, and sometime during the course of the argument, Jacob threw his cell phone at Sarah, hitting her in the arm. The argument ended there, and both partners went to separate rooms in the apartment.

Q28 Please read the following case example.

You just had an intake with Jacob and Sarah who are seeking couples' therapy. During the couple portion of the intake, they disclosed an incident that occurred a couple weeks ago. In the incident, both partners were returning home from work around the same time. After settling in from work, both became angry that the other partner had not cleaned the apartment before he/she had left for work. At this point, they began arguing, and sometime during the argument, they threw their cellphones at one another, with both hitting one another in the arm. The argument ended there, and both partners went to separate rooms in the apartment.

Q29 Please read the following case example.

You just had an intake with Jacob and Sarah who are seeking couples' therapy. During the couple portion of the intake, they disclosed an incident that occurred a couple weeks ago. In the incident, both partners were returning home from work around the same time. After settling in from work, both became angry that the other partner had not cleaned the apartment before he/she had left for work. At this point, they began arguing, and sometime during the course of the argument, Sarah threw her cell phone at Jacob, hitting him in the arm. The argument ended there, and both partners went to separate rooms in the apartment.

End of Block: Block 1

Start of Block: Block 4

Q23 Does the case example encompass relational violence?

O Yes (1)

O No (2)

O I don't know (5)

O I prefer not to say (3)

Skip To: Q30 If Does the case example encompass relational violence? = No

Skip To: Q30 If Does the case example encompass relational violence? = I prefer not to say

Skip To: Q30 If Does the case example encompass relational violence? = I don't know

Q35 Please select who perpetrated the relational violence.

O Jacob (1)

O Sarah (2)

O Both Jacob and Sarah (3)

O I prefer not to say (4)

Skip To: Q30 If Please select who perpetrated the relational violence. = I prefer not to say

Q27 If you believe future harm could occur between Sarah and Jacob, who do you believe will be harmed?

O Jacob (1)

O Sarah (2)

O Both Sarah and Jacob (3)

O No one (5)

O I prefer not to say (6)

Skip To: Q30 If If you believe future harm could occur between Sarah and Jacob, who do you believe will be harmed? = No one
Skip To: Q30 If If you believe future harm could occur between Sarah and Jacob, who do you believe will be harmed? = I prefer not to say

Q31 If you selected that you believe future harm will occur between Sarah and Jacob, what do you define as harm?

_____

Page Break

Q30 Please select if you witnessed any of the following between your parents or guardians. Select all that apply.

- [ ] Male parent/guardian perpetrating aggression toward a female parent/guardian (1)
- [ ] Aggression being perpetrated by both the male and female parents/guardians (2)
- [ ] Female parent/guardian perpetrating aggression toward a male parent/guardian (3)
- [ ] Aggression between same-sex parents/guardians (4)
- [ ] I prefer not to say (5)
- [ ] None of these apply (6)

End of Block: Block 4

Start of Block: Default Question Block

Page Break

Q11 No matter how well a couple gets along, there are times when they disagree, get annoyed with the other person, want different things from each other, or just have spats or fights because they are in a bad mood, are tired, or for some other reason. Couples also have many different ways of trying to settle their differences. This is a list of things that might happen when you have differences. Please select how many times you did each of these things in the past year, and how many times your partner did them in the past year. If you or your partner did not do one of these things in the past year, but it happened before that, please select "not in the past year, but it did happen before."

Please do not report any of the following acts that occurred during consensual, sexual interactions.

	Once (1)	Twice (2)	3-5 times (3)	6-10 times (4)	11-20 times (5)	More than 20 times (6)	Not in the past year, but it did happen before (7)	This has never happened (8)	I prefer not to say (9)
Threw something that could hurt my partner (1)	O	O	O	O	O	O	O	O	O
My partner did this to me (2)	O	O	O	O	O	O	O	O	O

I twisted my partner's arm or hair (3)	O	O	O	O	O	O	O	O	O
My partner did this to me (4)	O	O	O	O	O	O	O	O	O
I pushed or shoved my partner (5)	O	O	O	O	O	O	O	O	O
My partner did this to me (6)	O	O	O	O	O	O	O	O	O
I grabbed my partner (7)	O	O	O	O	O	O	O	O	O
My partner did this to me (8)	O	O	O	O	O	O	O	O	O

I used a knife or gun on my partner (9)	O	O	O	O	O	O	O	O	O
My partner did this to me (10)	O	O	O	O	O	O	O	O	O
I punched or hit my partner with something that could hurt (11)	O	O	O	O	O	O	O	O	O
My partner did this to me (12)	O	O	O	O	O	O	O	O	O
I choked my partner (13)	O	O	O	O	O	O	O	O	O
My partner did this to me (14)	O	O	O	O	O	O	O	O	O

I slammed my partner against a wall (15)	O	O	O	O	O	O	O	O	O
My partner did this to me (16)	O	O	O	O	O	O	O	O	O
I beat up my partner (17)	O	O	O	O	O	O	O	O	O
My partner did this to me (18)	O	O	O	O	O	O	O	O	O
I burned or scalded my partner on purpose (19)	O	O	O	O	O	O	O	O	O
My partner did this to me (20)	O	O	O	O	O	O	O	O	O
I kicked my	O	O	O	O	O	O	O	O	O

partner (21)									
My partner did this to me (22)	O	O	O	O	O	O	O	O	O

Page Break

Q12 No matter how well a couple gets along, there are times when they disagree, get annoyed with the other person, want different things from each other, or just have spats or fights because they are in a bad mood, are tired, or for some other reason. Couples also have many different ways of trying to settle their differences. This is a list of things that might happen when you have differences. Please select how many times you did each of these things in the past year, and how many times your partner did them in the past year. If you or your partner did not do one of these things in the past year, but it happened before that, please select "not in the past year, but it did happen before."

Please do not report any of the following acts that occurred during consensual, sexual interactions.

	Once (1)	Twice (2)	3-5 times (3)	6-10 times (4)	11-20 times (5)	More than 20 times (6)	Not in the past year, but it did happen before (7)	This has never happened (8)	I prefer not to say (9)
I insulted or swore at my partner (1)	O	O	O	O	O	O	O	O	O
My partner did this to me (2)	O	O	O	O	O	O	O	O	O
I shouted or yelled at my partner (3)	O	O	O	O	O	O	O	O	O
My partner did this to me (4)	O	O	O	O	O	O	O	O	O

I stomped out of the house or yard during a disagreement (5)	O	O	O	O	O	O	O	O	O
My partner did this to me (6)	O	O	O	O	O	O	O	O	O
I said something to spite my partner (7)	O	O	O	O	O	O	O	O	O
My partner did this to me (8)	O	O	O	O	O	O	O	O	O
I called my partner fat or ugly (9)	O	O	O	O	O	O	O	O	O
My partner did this to me (10)	O	O	O	O	O	O	O	O	O
I destroyed something belonging to my partner (11)	O	O	O	O	O	O	O	O	O
My partner did this to me (12)	O	O	O	O	O	O	O	O	O

I accused my partner of being a lousy lover (13)	O	O	O	O	O	O	O	O	O
My partner did this to me (14)	O	O	O	O	O	O	O	O	O
I threatened to hit or throw something at my partner (15)	O	O	O	O	O	O	O	O	O
My partner did this to me (16)	O	O	O	O	O	O	O	O	O

Page Break

Q9 No matter how well parents or guardians get along, there are times when they disagree, get annoyed with the other person, want different things from each other, or just have spats or fights because they are in a bad mood, are tired, or for some other reason. Parents or guardians also have many different ways of trying to settle their differences. This is a list of things that might happen when parents or guardians have differences. Please select how many times you witnessed your parents or guardians doing these things. If you have never witnessed these acts, select "I never witnessed this."

	Once (1)	Twice (2)	3-5 times (3)	6-10 times (4)	11-20 times (5)	More than 20 times (6)	I never witnessed this (7)	I prefer not to say (8)
Threw something that could hurt the other parent or guardian (1)	O	O	O	O	O	O	O	O
Twisted the other parent or guardian's arm of hair (2)	O	O	O	O	O	O	O	O
Pushed or shoved the other parent or guardian (3)	O	O	O	O	O	O	O	O

Grabbed the other parent or guardian (4)	O	O	O	O	O	O	O	O
Slapped the other parent or guardian (5)	O	O	O	O	O	O	O	O
Use a knife or gun on the other parent or guardian (6)	O	O	O	O	O	O	O	O
Punched or hit the other parent or guardian with something that could hurt (7)	O	O	O	O	O	O	O	O
Choked the other parent or guardian (8)	O	O	O	O	O	O	O	O

Slammed the other parent or guardian against a wall (9)	O	O	O	O	O	O	O	O
Beat up the other parent or guardian (10)	O	O	O	O	O	O	O	O
Burned or scalded the other parent or guardian on purpose (11)	O	O	O	O	O	O	O	O
Kicked the other parent or guardian (12)	O	O	O	O	O	O	O	O

Page Break

Q10 No matter how well parents or guardians get along, there are times when they disagree, get annoyed with the other person, want different things from each other, or just have spats or fights because they are in a bad mood, are tired, or for some other reason. Parents or guardians also have many different ways of trying to settle their differences. This is a list of things that might happen when parents or guardians have differences. Please select how many times you witnessed your parents or guardians doing these things. If you have never witnessed these acts, select "I never witnessed this."

	Once (1)	Twice (2)	3-5 times (3)	6-10 times (4)	11-20 times (5)	More than 20 times (6)	I never witnessed this (7)	I prefer not to say (8)
Insulted or swore at the other parent or guardian (1)	O	O	O	O	O	O	O	O
Shouted or yelled at the other parent or guardian (2)	O	O	O	O	O	O	O	O
Stomped out of the room or house during a disagreement (3)	O	O	O	O	O	O	O	O
Said something to spite the other parent	O	O	O	O	O	O	O	O

or guardian (4)								
Called the other parent or guardian fat or ugly (5)	O	O	O	O	O	O	O	O
Destroyed something belonging to the other parent or guardian (6)	O	O	O	O	O	O	O	O
Threatened to hit or throw something at the other parent guardian (7)	O	O	O	O	O	O	O	O

Page Break

Q13 Select all that apply.

- [ ] I attended a university course with domestic violence (DV), intimate partner violence (IPV), or intimate partner aggression (IPA) included in the curriculum (1)
- [ ] I attended a university course dedicated to DV, IPV, or IPA (2)
- [ ] I attended a DV, IPV, or IPA training (3)
- [ ] I held a position in which I worked with perpetrators or survivors of DV, IPV, or IPA (4)
- [ ] None of these apply to me (8)
- [ ] I prefer not to say (9)

Page Break

Q39

If you would like to enter into the drawing to win one of five $20 Amazon gift cards, please click on the following link. If you do not want to enter into the drawing, select "No."

O https://purdue.ca1.qualtrics.com/jfe/form/SV_0iw3msfceJzFzDv (1)

O No (2)

Page Break

End of Block: Default Question Block

APPENDIX C. REVISED CONFLICT TACTICS SCALE

Intimate Partner Aggression in the Family-of-Origin

Physical Assault Subscale

Threw something that could hurt the other parent

Twisted the other parent's arm or hair

Pushed or shoved the other parent

Grabbed the other parent

Slapped the other parent

Used knife or gun on the other parent

Punched or hit the other parent with something that could hurt

Choked the other parent

Slammed the other parent against a wall

Beat up the other parent

Burned or scalded the other parent on purpose

Kicked the other parent

Psychological Aggression Subscale

Insulted or swore at the other parent

Shouted or yelled at the other parent

Stomped out of the room or house or yard during a disagreement

Said something to spite the other parent

Called the other parent fat or ugly

Destroyed something belonging to the other parent

Accused the other parent of being a lousy lover

Threatened to hit or throw something at the other parent

Intimate Partner Aggression in Past Romantic Relationships

Physical Assault Subscale

I threw something that could hurt my partner

My partner did this to me

I twisted my partner's arm or hair

My partner did this to me

I pushed or shoved my partner

My partner did this to me

I grabbed my partner

My partner did this to me

I slapped my partner

My partner did this to me

I used knife or gun on my partner

My partner did this to me

I punched or hit my partner with something that could hurt

My partner did this to me

I choked my partner

My partner did this to me

I slammed my partner against a wall

My partner did this to me

I beat up my partner

My partner did this to me

I burned or scalded my partner on purpose

My partner did this to me

I kicked my partner

My partner did this to me

Psychological Aggression Subscale

I insulted or swore at my partner

My partner did this to me

I shouted or yelled at my partner

My partner did this to me

I stomped out of the room or house or yard during a disagreement

My partner did this to me

I said something to spite my partner

My partner did this to me

I called my partner fat or ugly

My partner did this to me

I destroyed something belonging to my partner

My partner did this to me

I accused my partner of being a lousy lover

My partner did this to me

I threatened to hit or throw something at my partner

My partner did this to me