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Experiences of Marriage and Family Therapists Working with Intimate Partner Violence

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Abstract

The purpose of our study was to explore the experiences of marriage and family therapists in working with violent couples. In particular, we focused on therapists' questions and feelings of competency pertaining to violence assessment and treatment, the difficulties they face during their practices, and the factors that affect their practice. Data for this study was collected via a focus group that lasted approximately an hour. The participants included five marriage and family therapists. A set of questions were used to explore experiences of therapists who were working with clients who are experiencing domestic violence. The research team recorded the answers to these questions as well as associated discussion. A grounded theory approach was used to analyze the data. Six themes were derived from the coded data: acknowledgment and reliance on systemic foundations, therapist factors, assessment, treatment considerations, sex of batterers, and training in Marriage and Family Therapy programs.

Keywords

Intimate partner violence; abuse; couple therapy; therapists experiences

INTRODUCTION

Intimate partner violence (IPV) has serious effects on human well-being, and prevention of IPV is an important public health concern. Statistics indicate that one in every four women will experience IPV at some point in their life time. Other statistics show that annually one and a half million women and 835000 men are physically or sexually abused by their intimate partners (Tjaden & Thoennes, 2000). Estimates also indicate that only half of IPV incidents are reported by the victims (Tjaden & Thoennes, 2000).

The cost of IPV to society is massive. There are not only more salient social costs of intimate partner abuse, such as criminal justice, legal interventions, shelter and advocacy services, and medical care for injured parties, but also more concealed effects in regard to emotional, relationship, and family functioning of victims and perpetrators (Murphy & Eckhardt, 2005). Therefore, for marriage and family therapists (MFTs) who are working with this population, it is crucial to develop an understanding of this social problem and potential difficulties therapists may have as they work with this issue . This understanding will allow us to recognize effective and safe treatment options. In this respect, the aim of this study was to explore the experiences of MFTs working with individuals and couples who suffer from IPV.

IPV contributes substantially to family instability, divorce, and homelessness. It is also significantly related to depression, substance abuse, and traumatic stress reactions for both the survivor and the abuser. More severe and frequent exposure to physical violence, including threats against life, use of weapons, sexual violence, and psychological abuse, has been shown to be related to the development of post traumatic stress disorder (PTSD) (Dutton, Green, Kaltman, Roesch, Zeffiro & Krause, 2006). Violence within the family also can have significant consequences for other family members who are not directly victimized. IPV has been associated with long lasting, intense, and negative emotional and behavioral influences on children who witness domestic violence (Jaffe & Sudderman, 1995). In particular, as compared to children who have not witnessed violence between their parents, children who have witnessed violence are more likely to assault their siblings and their parents, commit violent crimes outside the family, and assault their own intimate partners (Straus & Gelles, 1990).

IPV is associated with complex interactions among multiple variables and risk factors. Research on possible causes of IPV often focus on social-structural variables (e.g., age, gender, SES), cultural factors (e.g., social acceptance of violence, patriarchy), and interpersonal interaction patterns (e.g., marital conflict). Other research indicates that three of the strongest correlates for IPV are exposure to parental violence during childhood (Margolin, John, & Foo, 1998; Moffitt & Caspi, 1999), alcohol abuse (Flanzer, 1993; Coker, Smith, McKeown, & Melissa, 2000), and marital dissatisfaction (Byrn & Arias, 1997; Leonard & Senchak, 1993). Concerning therapeutic treatment of couples with occurrence of IPV, there are a number of issues that are of concern in determining how to best work with individuals and families who are affected by this problem. Recent findings on separate batterers' intervention programs indicated that these programs do not work as well as was expected. Although batterers' intervention programs for male offenders seem to be effective

in reducing physical violence for some men, there is lack of support that they are effective for all men under all circumstances. (Dobash, Dobash, Cavanagh, & Lewis, 1996; Edleson & Tolman, 1992). Furthermore, in contrast to widespread expectations, couples who experience IPV often still may want to remain together. Therefore, it is important to be able to improve the relationships and end the couple violence within the dyad.

Studies show that it is also important to understand distinctions between various types of violence when discerning the appropriateness and safety of working with both partners in a relationship. Johnson and Ferraro (2000) note the importance of making distinctions among types of violence, motives of perpetrators, the social locations of both partners, and the cultural contexts in which violence occurs. There is often a failure on the part of therapists to adequately recognize or screen for IPV in the clients they treat, and it is imperative that therapists do so (Heyman, Feldbau-Kohn, Ehrensaft, Langhinrichsen-Rohling, &, & O'Leary, 2001; Young, Barker-Collo, & Harrison, 2002).

Considering the complexity of IPV, the purpose of this study was to understand the experiences of MFTs in working with violent couples. We thus focused on therapists' questions and feelings of competency pertaining to violence assessment and treatment, the difficulties they face during their practices, and how disparate opinions in the profession affect their practice.

METHOD

Sample

The sample for this study included five MFTs from an MFT training program in the southwest United States. The sample was comprised of four females and one male. All were Caucasian, and had a range of experience working in marriage and family therapy from less than one year to eight years. Experiences of participants in working with clients dealing with violence included working with clients who had been traumatized by violence, domestic violence agency and shelter work, juvenile justice center work, and domestic violence issues in private practice and in mental health settings. In the sample, there were two first year doctoral students, one first year master's student, one second year doctoral student, and one professor. For their prominent model of therapy, four therapists identified emotionally focused therapy (EFT) , and one identified as solution focused. For therapists who identified EFT as their prominent model of therapy, their experience with using EFT ranged from two to eight years , with an average of 4.5 years. The therapists had variable experience working with high risk situations in several placements and with several specific high risk issues.

Procedures

Data for this study were collected via a focus group. A focus group was chosen since group dynamics help in focusing and accessing difficult subjects (Robson, 2002). Group process also provides checks and balances on extreme views, as well as the extent of consistency of shared views (Robinson, 1999). Before data collection, IRB approval was received. All therapists from a large MFT training program were invited. Interested therapists attended the

focus group. Before the group interview began, consent forms describing the procedures and the project were distributed.

After obtaining participants' consent, the focus group began. The focus group was designed to explore the participants' experiences. A set of questions was used to explore the participants' experiences of working with clients from high risk populations, such as clients who are experiencing domestic violence. Difficulties and areas of strengths in the mental health field were explored. The focus group took approximately one hour.

The questions used during the focus group included: "What has changed for you since you started working with Intimate Partner Violence?", "What are the difficulties of working with IVP?", "What are the potential benefits of working with IVP?",. "How do you create change while working with IPV? What are the change mechanisms for these clients?", "From where you are now, can you think of any suggestions or changes that you would like to recommend for future MFTs IPV?", and "What is missing from your training that you think should be added regarding working with IPV?"

The process was audio-recorded and coded by two of the group participants. It was then transcribed, and the transcription was utilized in data analysis. These recordings did not include any identifying information. Once the focus group was completed, participants were compensated for their time and effort.

Data analysis

A grounded theory approach was utilized to identify concepts and themes that emerged from the data (Creswell, 2007). Coding was completed by two investigators. This helped to triangulate codes by comparing with each other (Miles & Huberman, 1994). These two investigators debated until they reached an agreement for all observations.

Data analyses began with the investigators independently reading the transcribed interviews. Open coding was completed to identify concepts. After completing the open coding, the investigators met to review and refine the open codes. During these meetings, categories concerning beliefs about relationships, violence, and therapy process were identified. These categories were then arranged into an axial coding process (Straus & Corbin, 1998). Axial coding is the process of identifying the relationships between concepts and categories that emerge in open coding (Corbin & Strauss, 2008).

Open and axial coding occurred interactively as follows. Investigators individually broke the data apart and identified concepts in the raw data. This was followed by a consolidation process in which the two investigators compared their codes against each other and debated. Once an agreement was reached, each investigator analyzed the broken data to put them back together by relating these concepts and categories (Corbin & Strauss, 2008), followed by a consolidation process. To identify key concepts that tied the categories together conceptually, we compared the final codes with existing family theories in a process similar to selective coding (Straus & Corbin, 1998). New concepts were identified and the conceptual connections between concepts were discussed repeatedly.

FINDINGS

Six themes were derived from the coded data that provide explanatory power for the overall content of the data collected. These themes are the following: (i) acknowledgment and reliance on systemic foundations, (ii) therapist factors, (iii) assessment, (iv) treatment considerations, (v) sex of batterers, and (vi) training in MFT programs. These themes are viewed as broad identifiers for the detailed information reviewed across the transcripts. Each theme provides the reader a glimpse into what participants in this study felt were elements they considered or were ones that arose in their work with violent couples. In the following, each theme is discussed in detail, and examples of content coded within each theme are provided.

Acknowledgement and Reliance on Systemic Foundations

The first theme identified in the review of the transcripts was an acknowledgement of and reliance on systemic foundations to assist the clinician in conceptualization and treatment of high-risk clients. As participants reflected on their experiences with violent couples, a common thread manifested that appeared to be agreed on by a majority of the participants. This common thread was that family systems theory acted as a secure base for the therapists, as something to go back to when overwhelmed by the complexity of the clinical work before them. Often mentioned was that treatment of couples with IPV necessitated an understanding of the dynamics present in the system that created the partner violence.

Similarly, participants highlighted the benefits of cycle work with high-risk clients. Cycle work refers to the identification of the defeating pattern of interaction within a couple that is repetitive and negatively reinforcing. In the context of cycle work, based on systemic patterns, therapists discussed the importance of identifying triggers, primary and secondary emotions, and “inter” and “intra”-personal elements at play. As therapists considered the best ways of gathering this information, individually or as a couple, they were challenged to consider the ways their systemic background influenced the process. One participant stated:

> When you are working with an individual it's kind of anti-ethical sometimes to what we believe when we are asking one person to create change in the whole system that is stuck, and so I think you increase the likelihood that whole systemic change will occur the more you include people beyond an individual in the room.

As the conversation progressed, and grew in depth, it was obvious that participants felt safety and security in being trained systemically, but at the same time expressed uncertainty about the utilization of systemic foundations paired with maintaining safety for the couple. Participants overall seemed to pose the question: “I know that systemic treatment will get me further faster, but will seeing them together increase risk of violence?” They expressed that at times safety took precedence, and when couples were separated due to safety concerns, the implementation of systemic interventions and treatment became more complex.

The participants highlighted that their intense training in work with couple systems was another foundation that served them advantageously. One participant stated:

> I've heard fellow psychology students say that they really want couples treatment classes, and we have that so we are kind of already half-way there in the efforts to being comfortable working with couples experiencing violence.

Though the participants acknowledged less knowledge about the treatment of violence, they reported a great confidence in working with couples in general. This strength of understanding about couple processes allows a shorter leap into the transition to treating violence in dyadic systems.

Therapist Factors

Codes placed under the “therapist factors” theme related to therapists’ intrapersonal characteristics or processes that manifested in their work with high-risk couples. These factors ranged from those that were intrinsically difficult for therapists, to basic issues about which the therapists were uncertain. Some examples include difficulty managing the therapist's own anxiety in session, fear of increasing violence, dismissing one time incidents, and feeling burdened about keeping people safe. A participant remarked:

> I always have this lingering gut fear that while what we are doing is helpful in session, I don't know how its going to be taken at home and I don't know if somebody might get hurt. So that anxiety I think is the hardest part, like a constant re-evaluation of everything and a constant fear for their safety.

In sum, there was a great deal of uncertainty and worry, however both of these seemed to be moderated by experience and involvement of other entities (e.g.,. law enforcement). One participant stated:

> I feel like as I've practiced longer and as I feel more comfortable just as a therapist overall, I feel more comfortable talking about it (violence), and having it on the table rather than something that I'm scared to address.

Some participants mentioned that their fear and anxiety about how to handle issues of violence would lead them to avoid assessment of violence and downplay its severity in order to inhibit the associated anxieties. One comment was as follows:

> Sometimes out of just wanting to maintain a joining relationship I would protect him from feeling like we were accusing him or protect him from feeling like he's the bad guy in the situation and so I just wouldn't even go there and would try to discuss other relational issues instead.

Assessment

Issues related to assessment encompassed an important part of the content shared by participants. Assessment, as a code, refers to discussions about therapists’ perceptions of violence based on the information they obtained about the frequency and severity of violent interactions. In addition, what the therapist did with this information and how this led to reassessment in the future was also a consideration. While all coded categories were integrated with aspects of other codes, assessment overall appeared to have the greatest impact on the other five areas. After assessment of violence, the therapist either had a male or female batterer, or both. After assessment of the processes and cycles at play within the

couple's dynamics, the therapist then relied on their systemic foundations to determine the best treatment to provide. Finally, elements of training were integrated in the ways therapists implemented assessment processes, how they handled results of their assessment, and how they maintained their own emotional state.

The discussion about assessment centered around frequency, severity, and intensity. Participants reported specifically that frequency of episodes of violence weighed heavily on their clinical decision-making. They admitted that they treated the case differently when there had been multiple episodes of violence versus one episode, though added that they knew this was likely a poor decision. A related comment was as follows:

> It's hard because I think we dupe ourselves. If somebody only had two violent episodes a year versus somebody who had forty, we might talk less about the two only to find out that that the intensity of the two was greater than the intensity of the 40 combined.

Additionally, participants stated that they often determined severity based on involvement of substance abuse in violence. As a result, it seems it was often easy to be convinced that violence would not occur as long as there was no substance abuse. Where severity seemed to encapsulate how far things went, intensity was considered by the therapists as more of the internal process or the levels of rage that occurred. An assessment that rage or an antisocial personality disorder was the underlying cause of violence appeared to lead to more certainty that a different aspect of intervention was required for treatment.

Treatment Considerations

Participants in this study frequently identified ways in which they considered how treatment would be implemented with a couple experiencing violence. In some places what manifested was the therapist's struggle between doing what traditionally had been done for liability purposes (safety plans, non-violence contracts, etc.) and what they naturally felt would best fit the couple. Second, the therapists appeared to determine treatment focuses based on the pattern of violence that occurs. If only one violent episode had occurred in an isolated situation, they appeared to focus treatment elsewhere. However, if violence was frequent and severe, they tailored treatment more around intervention and prevention of episodes of violence. The participants also gave consideration to how intense treatment would be for a given couple based on their pattern of violence. The process of knowing which couples could receive the more intense style of therapy was an important treatment consideration.

More specific to interventions, therapists paid attention to the importance of ground rules in session. Two participants discussed the importance of iterating to couples that what is said and done in session, a safe place, cannot be used for harm at home, a potentially unsafe place. The therapists also discussed asking couples to have no discussion about the things discussed in therapy except in the therapy room. Some therapists found it helpful to engage in cycle work with the couple in order to establish a more process focus of treatment. A belief that treatment at the process level instigated the most change was evident. One participant stated:

> I'm always inclined to pretty early on determine the cycle that's happening between them and then add in substance abuse and violence to identify extreme patterns of the cycle at play.

Additionally, the participants discussed the inclusion of EFT. One participant spoke of experiencing in the session the emotions that are present in violence as it happens so that new experiences and responses of the emotion can be attempted without the violence. Another participant discussed uncovering the raw feelings that have been overshadowed by violence to allow opportunities for connection in a non-violent way. One participant discussed taking the couple to a vulnerable place where each is asked to express themselves in ways they have not before. The therapists emphasized the delicate balance this emotion-focused work requires to prevent escalation outside of treatment sessions.

Sex of Batterers

The first theme identified from the transcripts was the therapists' biases towards male batterers versus female batterers. The researchers noticed that throughout the focus group there were ideas supporting the notion that female batterers were less serious, less dangerous, and more justified than male batterers. The participants felt that they were more familiar with the research and had more confidence in treatment and clinical experiences when working with male perpetrators. They also felt less empathy and concern for the male victims, and stated that they empathize better with female victims due to the lack of context in which females use violence. One member of the group mentioned that:

> Statistically I know there's a pattern and I know that there's a common role or a common stereotype of a person. I know that primarily men are the perpetrators. It's harder for me to see women as a perpetrator, because I do not read a lot of evidence for that."

The participants mentioned the importance of being aware of their own anxieties while working with each population. Some biases that were expressed included downplaying situations and struggling with the seriousness of the violence when women were the batterers. Finally, the participants expressed concern about the assessment for males and how it differs from female assessment.

Training in MFT Programs

The last re-occurring theme was training. Participants expressed concern about lack of confidence in safety planning, lack of trust in the liability of interventions with trainees, lack of clinical experience, lack of course materials, and the lack of training in the ability to know what to do next after the initial assessment is completed for violence in couples. The participants deliberated on the problems that they feel were occurring in training programs with regard to working with domestic violence. Some group members felt that supervisors needed to be more assertive with their trainees, provide more exposure, and create clear treatment plans with high-risk couples. One participant stated:

> We are on the cutting edge of learning how to treat partners that are violent. We need to be taking some risks, trying to see more couples together.

The participants mentioned that the MFT field is very new and that we are "just starting to uncover the whole spectrum of all the different types of things that go on." Some participants thus felt that there are many grey areas and that many practitioners have very little experience in treating clients with disparate presenting problems. The therapists also felt that training therapists in self of the therapist work was key in working with domestic violence populations. One participant stated:

> Because I think personal anxiety and personal attributes of being a therapist play a big role in this and with EFT you have to be emotionally prepared and capable of being able to go into that crucible with these couples.

Overall, the participants were concerned with the lack of experience and training that the new field has to offer thus far. They expressed hope that changes in the risk of assessing couples can help create more experienced therapists in the field.

DISCUSSION

Whether MFTs are aware of it or not, high rates of partner violence suggest that clinicians are regularly working with violent individuals. Often , working with high risk populations, particularly those with IPV, can be anxiety provoking. Motivated by these considerations, this study aimed to explore the experiences of MFTs in working with violent couples, their feelings of competency pertaining to violence assessment and treatment, the difficulties they face during their practices, and how the distinct opinions in the profession affect their practice. Six themes emerged from the data: sex of batterers, acknowledgment and reliance on systemic foundations, therapist factors, assessment, treatment considerations, and training in MFT programs.

The treatment of IPV in conjoint marital therapy is a controversial issue in the mental health professions. Given the general preference of MFTs to work with multiple partners in a relational system, there is a growing need to understand the dynamics and risk factors commonly associated with IPV, its affects on human well-being, and the possibilities and appropriate bounds for conjoint therapy.

Family Systems theory is the foundational bedrock for training in MFT. This conceptual framework leads to ideas reflective of considering functioning and pathology on a systemic level rather than an individual level, which allow a primary focus on the family as a whole. Similarly, key concepts like circularity and homeostasis provide a clinician with an understanding about the processes that occur between people, rather than just within them. This theoretical view provides a different perspective on IPV than those traditionally applied. However, some might argue that an individual focus is necessary when there is an obvious perpetrator. Willbach (1989) discusses the systemic notion of neutrality and the difficulty of maintaining this stance when individual responsibility for violent behavior is necessary. Similarly, Lamb (1991) identifies that systemic application can be interpreted as implicating the victim as a contributor to the couple violence. The complexity of being a systemic therapist with IPV obviously has yet to be accommodated smoothly.

A difficulty that seemed to emerge in the dialogues between participants was that the therapists struggled regarding whether to treat violence as an indicator of larger systemic problems, or to treat violence itself. One could argue that a focus on overall systemic pathological processes could indirectly reduce violence, rather than the common approach of targeting violence first. Particularly in a training setting, therapists would not risk treatment that did not begin with a focus on violence and safety planning. It appears that, for the sake of liability, therapists could not explore the possibilities of varying systemic treatment styles with violent couples.

Ideally, in MFT programs there would be less of an alarmist view that occurs whenever violence is present in a case. At the mention of the word, the default approach of safety planning, contracting about safety commitments, and seeing the couple separately seems to happen every single time. Novice therapists would benefit from discussing each case individually to determine the possibilities for conjoint treatment, and hypothesizing about systemic level contributors to the manifestation of violence.

It is also important for therapists to differentiate and assess different forms of IPV, including intimate terrorism, violent resistance, common or situational couple violence, and mutual violent control (Johnson, 2008). Conjoint therapy may be appropriate in some situations, even if caution is advised, while it could be dangerous in others (Bograd & Mederos, 1999). While traditional approaches to working with those affected by IPV have encouraged abused partners to leave the relationship and for each partner to receive separate therapy, many studies show that a significant number of partners stay together, with rates varying depending on the form of abuse considered. Even in couples where violence is severe enough that a partner chooses to find a battered women's shelter, the battered partner often chooses to return to the relationship. Several studies suggest the following return rates: a) 33% of women returned to the relationship after receiving treatment at a shelter (Johnson, Crowley, & Sigler, 1992); b) 24% to 33% of women returned to the relationship after receiving treatment at a shelter (Gondolf, 1988); and c) 33% of community IPV victims preferred to stay with their current partners (Herbert, Silver, & Ellard, 1991).

The theme of therapist factors is one that captured, in several ways, the fear that therapists have about working with violent couples. Although there is a growing body of evidence to suggest that working with violent couples can be safe and effective (McCollum & Stith, 2008), clinicians still feel uncertain about the effect of the treatment offered. Therapists are primarily concerned for their clients' safety when working with violent couples, and are concerned about provoking violent interactions at home. There is a longstanding body of literature that critiques conjoint treatment of violent couples as unsafe and even dangerous. Previous literature indicates that violent episodes have occurred after conjoint sessions (Adams, 1988). Other researchers conclude that systemic approaches implicate women over men, or neutralize men's responsibility for violence that occurs (Bograd, 1992). Stith and McCollum (2008) argue that these critiques are based on an oversimplification of systemic understanding, and that clinicians also need to be sensitive to what type of violence is present. Johnson (1995) delineated that there are types of violence that must be differentiated in treatment consideration, namely *intimate terrorism*, and *situational violence.* Johnson also offers considerable information and protocol for decision making

around conjoint treatment in each case. In order for therapists to address their own anxiety about treating violent couples, an understanding of the type of violence and best care practices must be considered from an informed point of view. We need to further emphasize the delineation in types of violence in training programs and familiarize students with what the standard of care is given the situation.

Female batterers was another theme that emerged from the data. Female batterers can be defined as women who perpetrate intimate partner violence. Research indicates that women are just as likely to perpetrate violence in relationships as men (Weston, Temple, & Marshall, 2005; Abel, 2001; Steinmetz, 1980). Although women admit violence more often, their acts are found to be less severe forms of aggression and result in less physical harm (Ridley & Feldman, 2003; Weston, Temple, & Marshall, 2005). Past studies also show that women use violence in response to male violence as a means of self-defense as opposed to chronic battering behaviors (Abel, 2001; Kernsmith, 2005). Kernsmith (2005) also mentions that in the moment where women act out aggressively, they report to have felt hurt, scared, weak, and powerless.

Characteristics of female batterers who are seen as extreme batterers are more frequent and severe in comparison to other female batterers. These women are shown to be in relationships with twice as much unilateral verbal aggression, less constructive communication, more mutual conflict avoidance, and less conflict resolution than those that are less violent (Ridley & Feldman, 2003). Many women perpetrators report role identity loss and confusion and self-devaluation. The women who act in response to their partners' antagonism fail to see themselves as victims and view themselves as in a "one-down" position (Schroffel, 2004). Women's retaliation may be their way of trying to gain a "one-up" position when in conflict. So why is there more research showing that men are more likely to perpetrate than women? It is believed that since men perpetrate more frequently and severely, women's assaults are easier to be minimized or rationalized than men's. Other possible reasons include lack of data on female batterers, selective inattention by media and researchers, men's lack of acknowledgment of being abused, and women making their victimization more visible (Schroffel, 2004; Steinmetz, 1980).

IPV is a crucial issue that negatively influences individual, couple and family well being. Given the high prevalence of IPV , its consequences on family systems, and increasing rates of clients visiting MFTs due to intimate partner issues, it is vital that future MFTs are prepared for the challenges associated with this work and to receive adequate training. Our study indicated that many MFTs are feeling challenged in developing safety plans, lack of confidence in the liability of interventions with trainees, lack of clinical experience, lack of course materials, and the lack of training in the ability to know what to do next after the initial assessment is completed. Avis (1992) suggests that a course on treating IPV in families should be part of the curriculum in MFT training program. Such a course can explore issues of power, dominance and coercion, different forms of IPV, different treatment models, effective multi-method approaches, and co-morbid issues such as substance abuse, depression, and post-traumatic stress disorder (PTSD).

Many therapists are also concerned about their lack of experience. To this end, supervision sessions can be strengthened with case examples and suggestions for various situations that involve violence with a view to strengthening the confidence of the therapist. Finally, many therapists are concerned about their own fear and anxiety in working with intimate partner violence. In this respect, self of the therapist work can be integrated with violence training to help therapists in training explore their own feelings about IPV.

The findings of this study should be considered in the light of its limitations. The sample size of this study was small. Therefore, findings cannot be generalized to all MFTs. Future research could focus on a larger number of MFTs s from diverse locations with a wider range of experiences for more comprehensive understanding of the issue. Including the experiences of couples and individuals who are receiving treatment for IPV would provide further information regarding how these treatments are received by the clients. Large sample size with a diverse group of therapists working at different clinical settings might produce a much wider array of findings.

In conclusion, this study aimed to provide the Marriage and Family Therapy field with additional knowledge that will contribute to the professional awareness of the field. The results of this study can also benefit MFT programs to the extent that this research and future research on this topic can make MFT programs practice more effectively.

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