Screening for Physical Violence in Couple Therapy: Methodological, Practical, and Ethical Considerations

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Over two-thirds of clients in family therapy clinics engage in some form of physical violence against their partners within the year prior to the initiation of therapy. However, family therapists are aware of only a small proportion of these cases. The purpose of this article is to enhance the ability of family therapists to detect marital violence. We examine client and therapist reasons for why physical violence is not detected. We then review various methods to screen for the presence of physical violence, especially the Conflict Tactics Scales. Finally, indicators of life-threatening violence are presented to help family therapists detect cases that require immediate intervention to protect the partner whose life may be in danger.

Eighteen years after Martin (1976) criticized mental health professionals for not recognizing the high rate of physical abuse of women by male partners, the situation has not changed greatly, despite the fact that statistics on the extent of the problem have become part of the stock-in-trade of the field. These statistics show that a minimum of one out of every eight women is physically assaulted by her partner in a given year, and at least a third have been physically assaulted by a partner over the course of their relationship (Straus & Gelles, 1990). Studies of family therapy client populations show rates as high as 70% (O'Leary & Murphy, 1992).

Unawareness of Client Violence

Despite the wide dissemination of these statistics, studies at community mental health centers (Barnhill, Suires, & Gibson, 1982; Saunders, Kilpatrick, Resnick, & Tidwell, 1989) and inpatient facilities (Jacobson, Koehler, & Jones-Brown, 1987; Jacobson & Richardson, 1987) find that therapists and other service providers are aware of only a small proportion of their clients who are victims of physical assault. A preliminary report of a survey of mem-

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bers of the American Association of Marriage and Family Therapy (AAMFT) found that 60% did not consider family violence to be a significant clinical problem in their practice (Douglas & Mederos, 1992). Moreover, a survey of participants at an AAMFT convention found that 40% failed to recognize any evidence of wife assault in vignettes that contained clear indicators of violence (Hansen, Harway, & Cervantes, 1991). A study done in a family therapy clinic suggests that more than half of all cases involving physical violence are not detected during routine interviews (O’Leary, Vivian, & Malone, 1992).

The Cost of Undetected Violence

Unawareness of physical violence interferes with family therapy in several ways. When family therapists are not aware of the violence, they obviously cannot undertake the first and fundamental step of addressing the violence as a prerequisite of further treatment (Willbach, 1989). This must be the first step not only because violence is a criminal act and morally intolerable, but also because even “minor” violence, such as pushing and slapping, is a source of psychological distress regardless of what other problems are present in the family. A study of a nationally representative sample of couples found that physical violence is a risk factor for mental health problems such as psychosomatic symptoms, stress, and depression (Stets & Straus, 1990; Straus & Smith, 1990). The presence of physical violence is also an important indicator of a family context of intimidation, coercive power, and fear, which makes therapeutic change difficult. Physical violence, then, is inimical to therapy, to the quality of family life, and to the well-being of clients. Finally, even minor violence has the potential to escalate into more severe violence that poses a risk of serious injury (Feld & Straus, 1990). Consequently, therapists who are blind to the occurrence of violence, and those who underplay the seriousness of the violence, are not able to intervene to prevent life-threatening situations.

Family Therapy Approaches to Marital Violence

Knowing that physical violence is present in a relationship has important implications for the choice of treatment modality. In fact, there is considerable controversy about how family therapists should approach family violence. Critics of couple therapy argue that family therapy theories and interventions are ill-equipped to deal with issues of coercion and violence (Boograd, 1992); that abusive behaviors disappear in systemic formulations (Avis, 1992); and that couple therapy diffuses men’s responsibility for their actions by implying that women should be working on how to stop their victimization (Adams, 1988). Above all, critics argue that couple therapy can heighten the risk for women who are called upon to bring their partners’ violence into the open (Boograd, 1984; Kaufman, 1992). On the other hand, proponents of couple therapy claim that family violence can be effectively treated within the context of couple therapy (Geffner, Mantooth, Franks, & Rao, 1989; Geller & Wasserstrom, 1984; Guerney, Waldo, & Firestone, 1987; Lane & Russell, 1989; Neidig & Freedman, 1984). Although research is needed to help resolve this important debate, we should not wait for its resolution if we are to fulfill our obligations to insure the well-being and safety of those we serve. For this purpose, it is essential that violence in the lives of clients be effectively identified early on in the context of therapy.

The high rate of undetected violence and the extremely serious problems associated with not attending to violence suggest that family therapists need brief and valid methods of detecting violence. Obviously, nothing is more brief than directly asking clients about the occurrence of physical
violence. We will later discuss some reasons why asking about violence is not always that simple. For the moment, it is important to point out that, when it comes to detecting violence, the evidence shows that even therapists trained to assess family violence through interviews obtain considerably lower rates of physical violence than can be obtained through the use of brief, self-report measures (O'Leary & Murphy, 1992; Rhodes, 1992).

The aim of this article is to enhance family therapists' ability to identify the occurrence of physical violence in families. We will consider, first, the diverse ways in which the detection of violence is circumscribed by clients and family therapists. We will argue that emotional, cognitive, and clinical reasons act together to conceal reports of violence. We will then acquaint family therapists with brief and valid methods to screen for physical violence, especially by using the Conflict Tactics Scales or CTS (Straus, 1979, 1990). Finally, we will consider various indicators that can assist family therapists to evaluate the risk for life-threatening violence.

WHY MARITAL VIOLENCE IS NOT DETECTED

There are many reasons why physical violence is not detected by therapists, some of which have their locus in clients and some in therapists.

Client-Based Reasons

It may seem paradoxical that couples seeking relief from marital distress often fail to reveal physical violence. Part of the explanation is that violence toward spouses and partners is often woven into the fabric of intimate relationships (Straus, 1980) and hence is not perceived as something to reveal.

Perception of physical violence as trivial or tolerable: There are clients who believe that violence is tolerable provided it does not "go too far." They may not be aware of the negative impact violence has in the quality of their life and on their personal health, just as less than a generation ago few smokers were aware of the life-threatening risks associated with smoking. These clients regard occasional instances of slapping or shoving as only a minor problem that is not important enough to bring up in therapy (O'Leary & Murphy, 1992).

Violence as form of conflict resolution: Millions of people grow up witnessing violence between their parents (Jaffe & Wolfe, 1990; Straus, 1992). This experience validates the use of physical violence as a means of resolving conflicts in the family when other alternatives do not achieve the desired end. Clients who resort to violence under these circumstances are therefore unlikely to bring up the fact that physical assaults have occurred.

Narrow focus: On the one hand, there are clients who think that the violence is unrelated to the presenting problem. On the other hand, there are clients who see violent acts as merely symptomatic of other more fundamental problems. In either case, they narrowly focus on what they regard as "the real problem" and do not mention violence.

At the other end of the continuum from these "non-disclosing" clients, who misjudge the importance or seriousness of violence, are clients for whom violence is so threatening that they avoid mentioning it even to a therapist.

Making a good impression: When clients come to therapy, they often try to present a positive image of themselves, an image that would be consistent with how they present themselves in other social contexts. Thus, they are likely to present themselves as being good and loving, and not aggressive or destructive. In the service of self-enhancement and self-consistency, they minimize and often deny the occurrence of violence.
Shame and humiliation: Many clients find it more shameful to disclose violence than other problems. They prefer to keep private the occurrence of violence within their family. They may choose to conceal or minimize physical assaults in order to protect themselves or their loved ones from public condemnation and humiliation.

Fear and perceived risk of victimization: Some female victims of violence do not trust therapists with knowledge of their victimization for fear that their partner may learn about the disclosure and attack them, hurt the children, or take them away. Moreover, some clients with chronic histories of victimization are often demoralized and believe that “nothing is ever going to change,” while others hold onto the “positive illusion” that their partners will eventually come to their senses and bring the violence to an end. In either case, these clients fail to disclose the violence.

Love and concern for partner: One of the most profound paradoxes about family violence is that violence and love are often intertwined (Gelles & Straus, 1988; Goldner, Penn, Sheinberg, & Walker, 1990). Caught in a web of loyalties, emotional and economic dependency, desire to stay together, and genuine concern for their partners, many female victims are reluctant to disclose acts of violence in order to avoid both potential retribution against their partners and the threat of separation.

Therapist-Based Reasons

There are also reasons connected with the characteristics of therapy and therapists that interfere with obtaining information about violence.

Not asking: Probably the most important reason for the loss of this vital information is not asking (Brekke, 1987; Douglas, 1991). Some of the reasons affecting clients’ disclosure of violence also affect therapists’ capacity and willingness to inquire about physical violence. Therapists who “trivialize” a slap, “narrowly focus” on what they define as the root problem, and perceive physical violence “as a form of conflict resolution” are likely not to ask about it or, at least, focus on it as an important aspect of treatment. Also, therapists who perceive themselves as all-knowing, all-loving, neutral participants in the process of change may not want to risk introducing images of violence and destruction because it may make them appear challenging, intrusive, or one-sided to their clients.

Obviously, a therapist’s decision to ask about violence is not dependent on just his or her psychology and how he or she processes information; it is also a matter of personal values and clinical proclivity for particular procedures. Bograd (1992) points out that assumptions about “the goodness of our clients, their capacity for change, and the possibility of healing and forgiveness in human relationships” (p. 246) may prevent many family therapists from acknowledging the violence and destruction often present in clients’ lives. Therapists who do not recognize in every person a capacity to harm and dominate others, and who do not see their role as one of taking an active stance in preventing such abuses, are not likely to make inquiry about violence a priority.

In terms of clinical practice, Efran, Lukens, and Luken (1990) point out that some family therapists seem to shy away from inquiring about possibly pertinent but potentially troublesome topics not presented by clients because they believe that this curtails the prompt resolution of presenting complaints. Other therapists adhere to lessons learned during their training, such as: “Do not impose your agenda. If the issue is important enough for the client, it will come out.” This, however, is often not the case when violence is involved. As previously noted, the evidence shows that many clients do not “come out” unless there is direct inquiry about
violent behaviors (Jacobson et al., 1987; O’Leary et al., 1992).

In addition to the considerations raised above, there are technical ways in which therapists increase the odds against detection of physical violence in couple relationships.

*Inappropriate language:* For many clients, there is a great difference between having “pushed” their spouse and having been “violent.” The latter description is potentially an affront to the client’s self-concept and sense of self-worth, and for that reason it may not be perceived as applying to someone who “only shoved her.” Thus, although some therapists may regard using the term “violence” as more professional than “pushing” or “shoving,” only those clients who recognize their behavior as “violent” and who can tolerate defining themselves as such will respond, at least initially (Stordeur & Stille, 1989).

*Who is asked:* Violence may not be revealed unless both partners are asked specifically. Men in treatment for wife assault have been found to report less violence than their partners report for them (Browning & Dutton, 1986). Men in couple therapy have been found to report less severe acts of wife assault when compared to their partners’ reports of victimization (Lehr, 1988). Nevertheless, women as well as men often fail to disclose the physical assaults unless specifically asked. Consequently, another reason for questioning both partners is that it reveals incidents that do not come to light when only one partner is questioned (Straus, 1990; Szinovacz, 1983).

*The context in which the inquiry takes place:* Traditional couple therapy interviews have been noted to hinder family therapists’ capacity to detect wife assault (Cook & Frantz-Cook, 1984). Conjoint assessments of violence also seem to generate less reporting of violence than separately obtained self-reports, especially from women (Cantos, Neidig, & O’Leary, 1990).

**MEASURES OF PHYSICAL VIOLENCE**

Given the obstacles listed above, there is a need for procedures that will increase the probability of obtaining this vital information. Several instruments have been developed to measure physical violence in couple relationships.

*The Index of Spouse Abuse (ISA)* was developed by Hudson and McIntosh (1981) to measure both physical and nonphysical abuse. The ISA consists of 30 items, three of which ask directly about acts of physical violence (punches me with the fist; beats me so badly I must seek medical help; slaps me around my face and head). One refers to sexual coercion that is not necessarily physical (My partner makes me perform sex acts that I do not enjoy). The remaining seven items in the physical abuse subscale appear to measure physical intimidation and domination (for example, my partner frightens me; acts like he would like to kill me). Although the ISA provides useful information concerning the psychological maltreatment of women, the scale offers limited information about specific acts of physical violence. It also mixes physical violence with other forms of maltreatment. Thus, a partner could have a high score on the “violence” subscale without ever having been physically assaulted. In addition, the ISA contains no items on the minor forms of physical violence and, therefore, does not detect what is the most frequently occurring kind of physical violence among partners.

*The Wife Abuse Inventory (WAI)*, developed by Lewis (1983, 1985), was designed to identify abused women or women at risk of being abused by their spouses. The scale asks women to rate their partners and themselves on a number of “family management matters.” As Saunders (1992) points out, only two of these items measure physical violence; the rest focus not
on abusive behaviors but on the causes and consequences of abuse. Thus, the WAI appears to measure the risk of abuse rather than detecting whether violence has occurred or is occurring (Sedlak, 1988).

The Severity of Violence Against Women Scales (SVAWS): Marshall (1992) developed this 49-item instrument to assess the severity of violence perpetrated by men on women. Factor analysis of ratings made by college students and community women yielded nine factors (symbolic violence, mild threats, moderate threats, serious threats, minor violence, mild violence, moderate violence, sexual violence, and serious violence). There is presently no information on the validity and reliability of the SVAWS, but it is potentially useful to researchers and clinicians.

The Relationship Conflict Inventory (RCI) was developed by Arthur Bodin (1992) as part of the efforts of the Task Force on Diagnosis and Classification of the Family Psychology Division of the American Psychological Association. The instrument is informed by the interactional communication research conducted at the Mental Research Institute in Palo Alto (Bodin, 1993, personal communication). The RCI consists of 114 items measuring levels of verbal and physical conflict among couples in treatment. The four items on physical violence are designed to measure three levels of violence. Given the clinical and theoretical basis of the RCI, it should be of particular interest to systemic family therapists addressing wife assault in their practice. However, in the RCI, respondents are not asked to identify the perpetrator of the violence directly. In addition, the psychometric properties of the RCI remain unknown.

The Conflict Tactics Scales (CTS)

The CTS (Straus, 1979, 1990) is the most widely used technique for detecting marital violence. It has been used in three studies of nationally representative samples of U.S. couples, thus making available detailed normative tables by age and gender (Kaufman, Jasinski, & Aldarondo, in press; Straus & Gelles, 1990; Straus, Gelles, & Steinmetz, 1980). It has also been used in about one hundred other studies, including longitudinal studies of marital violence (O'Leary, Barling, Arias, & Rosenbaum, 1989), clinical studies of violent men (Saunders, 1987), studies of battered women in shelters (Giles-Sims, 1983), and several marital therapy studies (for example, Lehr, 1988; O'Leary et al., 1992). A test manual with over 200 references to the CTS, along with documentation of validity and reliability is available (Straus, 1989).

In addition to the availability of normative tables, the CTS offers several advantages over the above-mentioned instruments, which make it suitable to the practical needs of family therapists and other mental health professionals. First, the CTS takes only a few minutes to administer, either within an interview or as a self-administered questionnaire. Thus, it can be added to standard intake procedures with relative ease (see Lehr, 1988, and O'Leary et al., 1992, for examples). Second, the CTS targets specific behavior and thus minimizes the possibility that respondents must first recognize their behavior as violent in order to respond. Third, the CTS can be completed by both one partner or by each partner separately. When the CTS is completed by each partner, a "double description" (Bateson, 1979) is generated, which provides therapists with a quick glance at the difference in the partners' reports of the violence. Fourth, the CTS is a brief means not only of identifying the occurrence of violence, but also of evaluating the severity and chronicity of that violence. Thus, therapists are able to know whether acts of physical violence occurred prior to treatment as
well as how many times they occurred over the course of the specified target date (for example, the past month, past year).

Factor analyses by several investigators using diverse populations have consistently resulted in a factor structure consisting of a reasoning factor, a verbal aggression factor, and either a single violence factor or two violence factors, the second measuring life-threatening attacks with knife or gun (Straus, 1990). There is a large body of evidence indicating reliability and validity of the CTS (summarized in Straus, 1990). As in the case of all widely used instruments, the CTS has been the focus of critical review (see Straus, 1990). The most frequent criticism is that the violence scale measures only the frequency and severity of physical attacks and does not indicate the extent of injury, if any, resulting from those attacks. Despite these and other limitations, a review of family assessment instruments by Grotevant and Carlson (1989, p. 297) concludes that the CTS “is constructed in such a way as to encourage accurate reporting. The Verbal Aggression and Violence scales ... have shown good internal consistency, and substantial evidence has supported the construct validity of the instrument.” Given the above considerations, the remainder of this article gives primary attention to the CTS.

The scale is comprised of 19 items on tactics used in marital conflicts. The items are presented on a continuum from nonviolent to severely violent tactics. The introduction to the CTS asks subjects to think of situations when they had a disagreement or were angry with their partners, and to indicate how often they engaged in each of the acts included in the CTS in a given time period, such as the previous 12 months or the previous month. The CTS does not measure either the issues over which there may be disagreement, such as money, children, sex, and so on, or the extent of such disagreements. Indeed, there may have been conflicts over a number of issues. There could also be hostility, anger, and violence without reference to a specific substantive conflict.

Violence Scale: Nine of the items concern physical assault against a partner. These are items K: Threw something at the partner; L: Pushed, grabbed, or shoved; M: Slapped; N: Kicked, bit, or hit with a fist; O: Hit or tried to hit with something; P: Beat up the partner; Q: Choked the partner; R: Threatened with knife or gun; and S: Used a knife or gun.

The violent acts included in the CTS can be combined to form different indexes useful to clinicians. First, they can be used to obtain an “overall” measure of violence indicating the number of times clients used any of the violent acts included in the CTS during the referent period (for example, past year, past month). The Overall Violence Index then is a measure of chronicity, regardless of severity. The scores can range from zero (no violent incidents) to more than 150 incidents during a given period of time. The Overall Violence Index can also be used to evaluate changes in the chronicity of violence over the course of therapy.

The Overall Violence Index does not distinguish between couples who experience a dangerous and sometimes life-threatening assault from those who engaged in the “ordinary violence” of married life in the U.S., such as slapping, shoving, and plate throwing. This issue is particularly important for family therapists dealing with wife assault because both clinical formulations and intervention procedures may be different in severely violent cases. Two procedures can be used to take severity into account: the Minor and the Severe Violence Indexes, and the Violence Level Typology. These have proved useful for the analyses of couples in the National Family Violence Surveys and other studies.
Minor And Severe Violence Scales: Early in the development of the CTS, the need to distinguish between severe and minor violence was recognized. It was operationalized by identifying items K, L, and M as “minor violence,” and items N through S as “severe violence” because they were judged as posing a greater risk of causing an injury that requires medical treatment, such as head trauma. The Minor Violence Scale is the sum of the frequency of occurrence of items K, L, and M; the Severe Violence Scale is the sum of the frequency of occurrence of items N through S.

Violence Level Types: A shortcoming of the Minor Violence Scale is that it is confounded with use of severe violence because a spouse who kicks or punches is also likely to slap or throw things at his or her partner. The Violence Level Types permit identifying couples whose violence is expressed only in minor assaults. It is created by classifying couples on the basis of the most severe level of violence that occurred during the year, namely: None, Minor Violence Only (items K, L, or M, but no severe violence), and Severe Violence (any occurrence of items N through S).

Couple Violence Types: Other classifications of potential use to family therapists are possible by combining reports on the violence of both partners. This can be done even when only one partner completes the CTS because the CTS asks the subject to indicate both what he or she has done and what the partner has done (see Appendix 1). More accurate data, however, are likely if both partners complete the CTS. A basic classification is whether neither partner is violent, one partner is violent (man only, woman only), or both partners are engaged in violence. It is also possible to further refine the classification of couples by including the occurrence and severity of violence for both partners. This classification was used by Stets and Straus (1990) and yields eight possible groups: men minor violence only; woman minor violence only; both partners minor violence; men severe violence and woman minor violence; men minor violence and woman severe violence; men severe violence and woman not violent; women severe violence and men not violent; both partners severe violence.

Detecting Life-Threatening Violence (LTV)

Data on the partners of battered women in shelters (Giles-Sims, 1983), on abusers who have been murdered by their victim (Browne, 1987), and on court-mandated abusers (Gondolf, 1988b; Saunders, 1987) suggest that the CTS distinction between severe and minor violence is not adequate to identify the extreme and often life-threatening level of violence that characterize these men. How do we detect cases where our clients are likely to be seriously injured or killed? This is a difficult question, the answer to which can only be hinted at here. A thorough discussion of this issue from a clinical perspective would have to take into account the severity of the violence, type of situations where assaults occur, physical and psychological consequences of these acts, personality disorders, individual resources to deal with stressful events, and the victim’s resources to assure her safety, as well as a careful examination of case studies. However, such a broad-ranging discussion is beyond the scope of this article. At the risk of oversimplifying the complexity of this process, we summarize characteristics associated with such extreme violence.

It is difficult to find an appropriate term for such dangerous violence. The analogy of “clinical violence” to “clinical depression” is not satisfactory because it can be construed as trivializing the seriousness of the “minor” violence detected by the CTS, and suggesting that minor levels of violence do not warrant urgent intervention. On the contrary, even the most minor violence between spouses, such as an occasional slap or shove, cannot be ignored, any
more than we can ignore minor violence when it occurs between strangers. Since a distinguishing characteristic of this extreme level of violence is the risk of serious bodily harm or death, we will identify it as "Life-Threatening Violence" or LTV.

Appendix 2 summarizes characteristics found to be associated with Life-Threatening Violence. This information was obtained from clinical studies of extreme marital violence, including studies of abusers murdered by their victims (Browne, 1987), partners of battered women in shelters (Giles-Sims, 1983; Okun, 1986), court-referred male offenders (Gondolf, 1988b; Hamberger & Hastings, 1986; Saunders, 1987), and convicted homicide offenders (Goetting, 1989, 1991).

When physical violence is found through the CTS (or any other measure), the possibility of LTV or abuse should be thoroughly investigated. Obviously, if use of a weapon is indicated in the CTS, LTV is present. The use of a knife or a gun by itself, however, is not sufficient to identify many cases of LTV because it is only one of many indicators and, therefore, will fail to detect cases where these weapons are not a concern. Thus, we suggest that therapists use the presence of two or more of the factors in Appendix 2 to alert themselves to the possibility that the situation may be life threatening.

It is important to keep in mind that the prediction of homicides and potentially lethal violence always results in a high number of "false positive" cases. The high false positive rate is inevitable because these are relatively rare events (Sedlak, 1988; Straus et al., 1980). Thus, the presence of two or more of the factors in Appendix 2 does not necessarily mean that LTV is present. It means that the situation must be monitored and that the possibility of LTV should be specifically addressed with clients. Moreover, the therapist should be prepared to deal with that possibility, including taking steps to assure the safety of the partner whose life may be in danger.

CONCLUSIONS

Despite increased awareness of the prominent role of physical violence in couple relationships, most incidents of violence are not detected through the usual interviews. Over two-thirds of the couples in marriage and family therapy clinics engage in some form of marital violence in the year prior to seeking therapy (Lehr, 1988; O'Leary et al., 1992). Most of this violence, such as slapping and pushing, could be considered minor in the sense of having a low probability of causing an injury that needs medical attention (Stets & Straus, 1990). However, the evidence shows that a proportion of these cases can escalate to severe acts of violence (Feld & Straus, 1990). Also, physical violence has negative effects on the mental and physical health of victims. Consequently, the detection and cessation of violence, regardless of whether it is minor or severe, is extremely important, not only to permit more effective treatment of other problems in the family, but also to prevent mental health problems, severe injuries, and death.

Brief self-report measures of marital violence, such as the Conflict Tactics Scales, greatly improve the family therapists' capacity to detect violence (O'Leary et al., 1992). The CTS, however, is not a substitute for comprehensive interview assessment of physical violence and the victimization of women (Dutton, 1992; O'Leary & Murphy, 1992; Saunders, 1992; Stuart & Campbell, 1989; Tolman, 1992). Thus, in-depth assessments must follow whenever physical assaults are detected through these scales.

Couple and family therapists can play an important role in the detection and prevention of physical violence in the family, particularly violence against women. They come into contact with many couples moti-
vated to improve their relationships, and for whom the presence of physical violence may have not yet become scripted in their relationships (Aldarondo, 1992). Presumably, these clients would be receptive to efforts to help them eliminate violence in their relationships and to modify their behaviors accordingly. The early detection of physical violence in such cases could prevent the development of the “traumatic bonding” (Dutton, 1988) that holds many couples together in a “cycle of violence” (Walker, 1979, 1984).

Taking an active stance in the prevention and detection of violence in family therapy necessitates an evaluation of the reasons why so much violence goes undetected. We discussed some of the reasons in this article in an attempt to heighten therapists' sensitivity to violence. The task that faces family therapy at this point, however, cannot be solved by sensitivity alone. Family therapists must face the problem of physical assaults between partners with the same rigor and imagination that characterize their treatment of other destructive conditions such as anorexia, drug abuse, and alcoholism. Intake procedures and family assessments need to reflect the family therapist’s privileged position to hear what historically has been unheard-of. Family therapists need to recognize the potential contribution that standardized instruments can make to their practice (Boughner, Hayes, Bubenzer, & West, 1994). Integrating the systematic and pragmatic use of standardized instruments to detect violence with the intuitive and experience-based inquiry characteristic of good family therapy is one way to respond more adequately to the high rate of physical violence in U.S. families. It is also a way to help family therapists fulfill their obligations to attend to the safety and well-being of their clients.

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APPENDIX 1

The Conflict Tactics Scales, Couple Form RC*

No matter how well couples get along, there are times when they disagree, get annoyed with the other person, or just have spats or fights because they're in a bad mood or tired, or for some other reason. They also use many different ways of trying to settle their differences. I'm going to read some things that you and your (spouse/partner) might do when you have an argument. I would like you to tell me how many times (Once, Twice, 3–5 times, 6–10 times, 11–20 times, or more than 20 times) in the past 12 months you (READ ITEM)

<table>
<thead>
<tr>
<th>Respondent</th>
<th>Spouse</th>
<th>If &quot;Never&quot; for both: Has it Ever happened?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 = Once</td>
<td>1 = Once</td>
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<tr>
<td>2 = Twice</td>
<td>2 = Twice</td>
<td></td>
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<tr>
<td>4 = 3–5 Times</td>
<td>4 = 3–5 Times</td>
<td></td>
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<tr>
<td>8 = 6–10 Times</td>
<td>8 = 6–10 Times</td>
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<tr>
<td>15 = 11–20 Times</td>
<td>15 = 11–20 Times</td>
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<tr>
<td>25 = More than 20</td>
<td>25 = More than 20</td>
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<tr>
<td>0 = Never (don't read)</td>
<td>0 = Never (don't read)</td>
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<tr>
<td>A. Discussed an issue calmly</td>
<td>1 2 4 8 15 25 0</td>
<td>1 2 4 8 15 25 0</td>
</tr>
<tr>
<td>B. Got information to back up your/his/her side of things</td>
<td>1 2 4 8 15 25 0</td>
<td>1 2 4 8 15 25 0</td>
</tr>
<tr>
<td>C. Brought or tried to bring in someone to help settle things</td>
<td>1 2 4 8 15 25 0</td>
<td>1 2 4 8 15 25 0</td>
</tr>
<tr>
<td>D. Insulted or swore at him/her/you</td>
<td>1 2 4 8 15 25 0</td>
<td>1 2 4 8 15 25 0</td>
</tr>
<tr>
<td>E. Sulked or refused to talk about an issue</td>
<td>1 2 4 8 15 25 0</td>
<td>1 2 4 8 15 25 0</td>
</tr>
<tr>
<td>F. Stomped out of the room or house or yard</td>
<td>1 2 4 8 15 25 0</td>
<td>1 2 4 8 15 25 0</td>
</tr>
<tr>
<td>G. Cried</td>
<td>1 2 4 8 15 25 0</td>
<td>1 2 4 8 15 25 0</td>
</tr>
<tr>
<td>H. Did or said something to spite him/her/you</td>
<td>1 2 4 8 15 25 0</td>
<td>1 2 4 8 15 25 0</td>
</tr>
<tr>
<td>I. Threatened to hit or throw something at him/her/you</td>
<td>1 2 4 8 15 25 0</td>
<td>1 2 4 8 15 25 0</td>
</tr>
<tr>
<td>J. Threw or smashed or hit or kicked something</td>
<td>1 2 4 8 15 25 0</td>
<td>1 2 4 8 15 25 0</td>
</tr>
<tr>
<td>K. Threw something at him/her/you</td>
<td>1 2 4 8 15 25 0</td>
<td>1 2 4 8 15 25 0</td>
</tr>
<tr>
<td>L. Pushed, grabbed, or shoved him/her/you</td>
<td>1 2 4 8 15 25 0</td>
<td>1 2 4 8 15 25 0</td>
</tr>
<tr>
<td>M. Slapped him/her/you</td>
<td>1 2 4 8 15 25 0</td>
<td>1 2 4 8 15 25 0</td>
</tr>
<tr>
<td>N. Kicked, hit, or hit him/her/you with a fist</td>
<td>1 2 4 8 15 25 0</td>
<td>1 2 4 8 15 25 0</td>
</tr>
<tr>
<td>O. Hit or tried to hit him/her/you with something</td>
<td>1 2 4 8 15 25 0</td>
<td>1 2 4 8 15 25 0</td>
</tr>
<tr>
<td>P. Beat him/her/you up</td>
<td>1 2 4 8 15 25 0</td>
<td>1 2 4 8 15 25 0</td>
</tr>
<tr>
<td>Q. Choked him/her/you</td>
<td>1 2 4 8 15 25 0</td>
<td>1 2 4 8 15 25 0</td>
</tr>
<tr>
<td>R. Threatened him/her/you with a knife or gun</td>
<td>1 2 4 8 15 25 0</td>
<td>1 2 4 8 15 25 0</td>
</tr>
<tr>
<td>S. Used a knife or fired a gun</td>
<td>1 2 4 8 15 25 0</td>
<td>1 2 4 8 15 25 0</td>
</tr>
</tbody>
</table>

*The actual form has two columns (on the right) for recording scores, and can be found in the Conflict Tactics Scales Manual (Straus, 1989). The Manual also contains Spanish translations.
## APPENDIX 2

**Factors Associated with Life-Threatening Violence**

<table>
<thead>
<tr>
<th>Category</th>
<th>Reference(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>High frequency of violence (e.g., two or more acts of violence in a period of 12 months)</td>
<td>Bowker (1983); Browne (1987); Eisenberg &amp; Micklow (1977); Fagan, Stewart, &amp; Hansen (1983); Giles-Sims (1983); Gondolf (1988a,b); Roy (1977)</td>
</tr>
<tr>
<td>Alcohol abuse</td>
<td>Bowker (1983); Browne (1987); Eisenberg &amp; Micklow (1977); Fagan et al. (1983); Giles-Sims (1983); Goetting (1989); Gondolf (1988a,b); Okun (1986); Saunders (1987); Sonkin, Martin, &amp; Walker (1985); Tolman &amp; Bennett (1990)</td>
</tr>
<tr>
<td>Drug abuse</td>
<td>Browne (1987); Gondolf (1988a,b); Roy (1977)</td>
</tr>
<tr>
<td>Dependency, jealousy</td>
<td>Bowker (1983); Dobash &amp; Dobash (1979); Giles-Sims (1983); Hilberman &amp; Munson (1978); Saunders (1987); Sonkin et al. (1985); Tolman &amp; Bennett (1990); Walker (1979)</td>
</tr>
<tr>
<td>Caused physical injuries to partner</td>
<td>Browne (1987); Fagan et al. (1983); Gondolf (1988a,b)</td>
</tr>
<tr>
<td>Arrest history, or is violent outside as well as inside the home</td>
<td>Browne (1987); Fagan et al. (1983); Gayford (1975); Goetting (1989); Gondolf (1988a,b); Okun (1986); Sonkin et al. (1985)</td>
</tr>
<tr>
<td>Raped or forced partner to have sexual intercourse</td>
<td>Bowker (1983); Browne (1987); Gondolf (1988a,b); Hilberman &amp; Munson (1978); Walker (1979)</td>
</tr>
<tr>
<td>Physical violence in family of origin, or severely abused in childhood</td>
<td>Browne (1987); Fagan et al. (1983); Giles-Sims (1983); Gondolf (1988a,b); Okun (1986); Saunders (1987); Shupe, Stacey, &amp; Hazelwood (1987); Sonkin et al. (1985); Tolman &amp; Bennett (1990)</td>
</tr>
<tr>
<td>Possession or use of weapons*</td>
<td>Dobash &amp; Dobash (1979); Giles-Sims (1983); Goetting (1989); Gondolf (1988a,b); Sonkin et al. (1985)</td>
</tr>
<tr>
<td>Threatening to hit and/or kill partner</td>
<td>Bowker (1983); Browne (1987); Eisenberg &amp; Micklow (1977); Giles-Sims (1983); Gondolf (1988a,b); Sonkin et al. (1985)</td>
</tr>
<tr>
<td>Killed or abused pets</td>
<td>Blackman (1989); Bowker (1983); Gondolf (1988a,b); Netting &amp; Freedman (1984)</td>
</tr>
<tr>
<td>Possessive/dominating/coercive control</td>
<td>Giles-Sims (1983); Sonkin et al. (1985); Walker (1979)</td>
</tr>
<tr>
<td>Psychological maltreatment, verbal abuse</td>
<td>Bowker (1983); Gondolf (1988a,b); Tolman (1992)</td>
</tr>
<tr>
<td>Sociopathic/narcissistic</td>
<td>Gondolf (1988a,b); Hamberger &amp; Hastings (1986)</td>
</tr>
</tbody>
</table>

*The importance of this item should not be minimized, even for clients in rural areas where weapon possession is widespread, or in households where weapons are kept as collection items. Research on the effect of weapons shows that the presence of firearms increases the chances that someone will be killed during an emotional outburst (Herikowitz, 1993).