# Domestic Violence Training Experiences and Needs Among Mental Health Professionals: Implications From a Statewide Survey

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## Abstract:

There is growing recognition of the interconnections between domestic violence and mental health, especially related to mental health concerns among those who have experienced domestic violence victimization. Despite high rates of mental health concerns among victims and survivors, many mental health professionals lack sufficient training to understand and address domestic violence in their clinical work. The North Carolina Governor's Crime Commission convened a task force to examine training experiences and needs among mental health professionals in the state. A statewide survey revealed that mental health professionals vary in their levels of training to address domestic violence. A key finding was that mental health professionals who had received any training in domestic violence reported engaging in more comprehensive assessment and intervention practices. Implications for future research, practice, and policy are discussed.

**Keywords:** domestic violence | intimate partner violence | mental health | professional training | trauma

## Article:

Domestic violence (DV), also referred to as intimate partner violence, describes “any form of physical, sexual, emotional, psychological, and/or verbal abuse between partners in . . . a current or former relationship” (Murray & Graves, 2013, p. 14). DV has long remained a critical public health issue. In 2010, the Centers for Disease Control and Prevention released the findings of the National Intimate Partner and Sexual Violence Survey, which showed that approximately one-third of women and one- fourth of men in the United States had experienced some form of intimate partner physical violence, sexual assault, or stalking at some point in their lives, and about one-half of both women and men had experienced intimate partner psychological aggression in their lives (Black et al., 2011).

DV victimization can contribute to significant consequences for adult victims and children who witness parental DV. These consequences may relate to physical injuries, impaired work and career functioning, financial losses, and mental health concerns. The latter of these issues—the mental health consequences of DV victimization—is increasingly recognized as a major concern for victims, survivors, child witnesses, and the professionals who work with them. However, many mental health professionals (MHPs) are undertrained to understand, assess, and intervene to address DV in their work with clients. The purpose of this study was to identify training needs and experiences related to DV among a statewide sample of MHPs. The next sections review existing research demonstrating the intersections between DV and mental health and the current state of training to address DV among MHPs.

## MENTAL HEALTH IMPLICATIONS OF DOMESTIC VIOLENCE

Rates of comorbidity of DV victimization and mental health symptoms are high (Helfrich, Fujiura, & Rutkowski-Kmitta, 2008; Mourad, Levendosky, Bogat, & von Eye, 2008; O'Campo et al., 2006). Mental health symptoms can be considered both a risk factor for and a potential consequence of DV victimization (Ehrensaft, 2008; U.S. Preventive Services Task Force, 2004). As a risk factor, mental health symptoms can increase risk by rendering a victim dependent on his or her partner (e.g., if they need financial support to be able to pay for psychotropic medications) or by impacting a victim's self-esteem and confidence in his or her ability to leave an abusive relationship.

Helfrich et al. (2008) examined rates of mental health symptoms among a sample of 75 women in DV shelters. The most commonly reported symptoms included sadness or anxiety (77%), major depression (51.4%), difficulty coping with daily stressors (39.2%), being confused and disoriented (37.8%), phobias/strong fears (35.1%), and anxiety (32.4%). Although this is a single study with a relatively small sample, it demonstrates the potentially high frequencies of mental health concerns in the aftermath of abuse. Helfrich et al. issued an important caution against the potential for MHPs to misdiagnose victims' and survivors' symptoms if they fail to consider the impact of trauma on mental health functioning. They wrote,

> It is imperative that IPV not be equated with mental illness but rather considered as a risk factor that, when identified, serves to initiate a series of informed responses and further exploration of each individual woman's presentation and service needs. (p. 450)

Additional research confirms the high prevalence of mental health disorders among those with recent and past experiences of DV, suggesting that mental health consequences may be felt for a long time following the abuse (Cavanaugh, Martins, Petras, & Campbell, 2013; Nathanson, Shorey, Tiron, & Rhatigan, 2012). Furthermore, there is growing recognition of the impact of trauma on survivors' mental health. Posttraumatic stress disorder (PTSD) may be one indicator of this trauma (Murray & Graves, 2013). However, the trauma associated with DV also may be linked with other symptoms, such as substance abuse and eating disorders (Substance Abuse and Mental Health Services Administration, 2014). In light of the significant overlaps among DV victimization and a range of mental health symptoms, best practices for MHPs support the need

for assessment and intervention to address the interconnections between DV and mental health symptoms (Murray & Graves, 2013).

Beyond the victims, mental health and DV also intersect regarding child witnesses and perpetrators. For example, children may experience trauma-related mental health symptoms as a result of witnessing abuse (Osofsky, 2003). In addition, mental health symptoms have been noted as part of the classification systems that have been developed to categorize different typologies of battering perpetrators (Holtzworth-Munroe & Stuart, 1994; Jacobson & Gottman, 1998). Therefore, it is important for MHPs to understand the dynamics and clinical guidelines related to DV because they may encounter any of these populations—victims, survivors, child witnesses, and/or perpetrators—in their clinical work.

## DOMESTIC VIOLENCE–RELATED TRAINING AMONG MENTAL HEALTH PROFESSIONALS

Despite the clear linkages between mental health and DV, many MHPs lack sufficient training to understand and address DV (Gauthier & Levendosky, 1996; Murray & Graves, 2013; Wingfield & Blocker, 1998). For example, a 2007 doctoral dissertation by Bozorg-Omid involved a survey of American Mental Health Counselors Association members and showed that about 80% of participants reported that they were inadequately trained to address family violence in their graduate training. More recent research by Karakurt, Dial, Korkow, Mansfield, and Banford (2013) adds further evidence to the limited training that MHPs receive. Karakurt and colleagues conducted a focus group with five marriage and family therapists (MFTs) to learn about their experiences related to working with clients impacted by DV. Their grounded theory data analysis process suggested that insufficient training related to DV was linked to the therapists lacking confidence in their ability to treat clients facing DV.

Ben-Porat and Itzhaky (2011) argued that training is critical for MHPs who work to address DV, especially as a protective factor for preventing secondary traumatization and burnout. They surveyed 143 social workers in Israel who worked in DV shelters and agencies. Their findings highlighted the potential benefits of training. In comparing the 72% of social workers in their study who had received DV training with those who had not (28%), those who had been trained had a greater sense of competence and knowledge of tasks related to working with DV. However, contrary to their expectations, there were no differences between the groups in levels of preventing secondary traumatization or burnout. The researchers suggested that their findings support the need for comprehensive training in DV for MHPs in training programs.

Having policies that require professionals to receive DV training is one possible approach to increasing professionals' participation in such training. One study of social service workers (Payne, Carmody, Plichta, & Vandecar-Burdin, 2007) showed that program managers were 7 times more likely to report that at least one-fourth of their staff members had received training if they had DV training policies in place, compared to those without such policies. Some MHP credentialing boards do require DV training. However, this may be minimal, as in the case of the Florida Board of Clinical Social Work, Marriage & Family Therapy and Mental Health Counseling (2014), which requires a 2-hr DV training for licensure. Therefore, even when training is required and/or received, its duration, content, and quality may be minimal. In North

Carolina, where this study is situated, MHPs are not required to have any DV training for licensure. This study was conducted by a task force convened by the North Carolina Governor's Crime Commission to address in part current training and training needs of MHPs in the state.

## METHOD

A statewide survey of MHPs in North Carolina was conducted to identify their training needs related to DV. Beyond describing the participants' level of training and future needs, two other research questions were examined: (a) Are there differences in whether participants had received training in DV or trauma based on five key background variables: years in practice, professional affiliation, type of community (rural, urban/suburban, both), gender, and highest level of education? and (b) Do participants differ in their DV screening and intervention practices based on whether or not they had received any training related to DV? This survey was conducted by members of the DV and Mental Health Task Force, which was convened by the DV/Sexual Assault subcommittee of the North Carolina Governor's Crime Commission. The task force was chaired by the executive director of a DV service agency, and other members were representatives of state advocacy agencies, the Governor's Crime Commission, other service agencies, and universities. The task force was convened as part of a larger effort to identify strategies to build the capacity to effectively link MHPs with DV service providers in the state.

### Participants and Recruitment

We aimed to recruit a diverse sample that included MHPs representing the major professional disciplines in the state (i.e., MFTs, clinical social workers, professional counselors, and psychologists). Participants were recruited through snowball sampling and in partnership with state-level professional associations and licensure boards for MHPs. The administrators of each of the major licensure boards and professional associations for each of the earlier-listed categories of MHPs were contacted to request their assistance in distributing the invitation to participate in the survey to their members or licensees. Of the nine organizations and boards contacted, four (i.e., two licensure boards and two professional associations) did not provide any assistance, four (i.e., three professional associations and one licensure board) sent the notice to their membership lists, and one licensure board posted the website link to the survey on their webpage. In addition, members of the research team forwarded the invitation to participate to personal contacts of MHPs from all the major professional backgrounds. The invitation to participate included a request for participants to forward the invitation about the study to others who may be interested in and eligible to participate in the study. Given the diversity of recruitment methods used, it is not possible to determine an accurate response rate for this survey, and therefore, the final sample should be considered a convenience sample. The original sample included 200 survey respondents. However, 27 respondents did not complete the section of the survey on training needs and experiences, and these participants were dropped from the analyses. Thus, the final sample included 173 MHPs, and their background characteristics are described in the "Results" section.

### Survey Instrumentation and Study Procedures

The survey used for this study was developed by the task force members, who met for a series of meetings to develop and refine the survey. A pilot test of the survey with a small number (i.e., less than 10) of MHPs and students in MHP training programs was conducted to request feedback on the content, readability, and format of the survey. This feedback was used to finalize the survey prior to distributing it to MHPs for the final study. The survey had seven sections: (a) demographic questions, (b) professional background questions, (c) questions about participants' professional experiences related to DV, (d) a self-rating of their perceived competence to address DV-related client populations, (e) questions about participants' training experiences and needs related to DV, (f) an assessment of their DV-related screening and intervention practices, and (g) a section on their connections with DV agencies.

This study received institutional review board approval prior to data collection. Participants were required to read and agree to an informed consent document prior to completing the survey. The survey was hosted on Surveymonkey.com, and therefore, all data were collected electronically. Survey responses were anonymous, and there was no incentive or compensation for participants who completed the survey.

## RESULTS

Throughout this section, all percentages reported are for the 173 participants who completed the full survey, although a small number of participants skipped individual survey items. Therefore, where percentages add up to less than 100%, the remaining percentage is the missing responses for that item. For instances in which percentages add up to greater than 100%, participants were able to select more than one response for that particular item. Participants' demographic and professional background characteristics are summarized in Table 1.

As indicated in Table 1, the largest proportion of the sample was MFTs (41.6%), followed by clinical social workers (23.7%), psychologists (22.5%), and professional counselors (8.1%). We were unable to locate state-specific information about the number of professionals with each license in North Carolina. However, according to the U.S. Bureau of Labor Statistics' (2015) *Occupational Outlook Handbook*, in the United States in 2012, there were 145,100 clinical, counseling, and school psychologists; 128,400 mental health counselors; 114,200 mental health and substance abuse social workers; and 37,000 MFTs. Therefore, MFTs appear to have been overrepresented in the current sample based on the likely proportion of MHPs in the state.

Most participants (*n* 5 100, 57.8%) indicated that they work primarily with a private organization, and 67 (38.7%) work primarily in public agencies. Most (*n* 5 107, 61.8%) of the organizations for which participants worked receive their primary funding from client fees, private insurance, and government subsidized care. Other funding sources included government grants (*n* 5 16, 9.2%), contracts with corporations and grants from private organizations (each with *n* 5 4, 2.3%), and donations (*n* 5 1, 0.6%). Participants indicated the types of organizations in which they work, and their responses included private practice, schools and universities, hospitals, behavioral health/community mental health agencies, family service agencies, hospice, residential facilities, managed care organizations/local management entities, prisons, military settings, and government agencies. Eighty participants (46.2%) reported that they serve urban/suburban communities, 49 (28.3%) serve rural communities, and 41 (23.7%) reported

serving both rural and urban/ suburban communities. Overall, participants represented diverse work settings and types of organizations.

**TABLE 1. Participants' Demographic and Professional Background Characteristics**

| Skill | Frequency | % |
|---|---|---|
| Participants' ages (years) | | |
| 18–24 | 4 | 2.3 |
| 25–34 | 46 | 26.6 |
| 35–44 | 36 | 20.8 |
| 45–54 | 24 | 13.9 |
| 55–64 | 51 | 29.5 |
| 65+ | 7 | 4.0 |
| Participants' gender | | |
| Female | 129 | 74.6 |
| Male | 40 | 23.1 |
| Participants' race/ethnicity | | |
| White | 152 | 87.9 |
| Black/African American | 11 | 6.4 |
| Asian | 2 | 1.2 |
| Native American/American Indian | 1 | 0.6 |
| Hispanic/Latino/Latina | 1 | 0.6 |
| Other | 2 | 1.2 |
| Participants' highest level of education | | |
| Master's degree | 127 | 73.4 |
| Doctoral degree | 37 | 21.4 |
| Bachelor's degree | 2 | 1.2 |
| Amount of time since completing highest level of education | | |
| Less than 1 year | 9 | 5.2 |
| 1–5 years | 41 | 23.7 |
| 6–10 years | 37 | 21.4 |
| 11–15 years | 28 | 16.2 |
| 16–20 years | 21 | 12.1 |
| 21+ years | 34 | 19.7 |
| Professional qualifications | | |
| MHPs with an active license | 146 | 84.4 |
| MHPs with a provisional license | 22 | 12.7 |
| Master's-level students in an MHP training program | 5 | 2.9 |

*(Continued)*

**TABLE 1. Participants' Demographic and Professional Background Characteristics *(Continued)***

| Skill | Frequency | % |
|---|---|---|
| Participants' years of experience working as an MHP | | |
| Less than 1 year | 6 | 3.5 |
| 1–5 years | 29 | 16.8 |
| 6–10 years | 38 | 22.0 |
| 11–15 years | 30 | 17.3 |
| 16–20 years | 20 | 11.6 |
| 21+ years | 50 | 28.9 |
| Participants' primary professional affiliations | | |
| Marriage and family therapists | 72 | 41.6 |
| Clinical social workers | 41 | 23.7 |
| Psychologists | 39 | 22.5 |
| Professional counselors | 14 | 8.1 |
| Substance abuse specialists | 2 | 1.2 |
| Advocates | 1 | 0.6 |
| Psychiatrists | 1 | 0.6 |
| Other | 3 | 1.7 |
| Mental health skills currently practiced by participants | | |
| Therapy for adults | 125 | 72.3 |
| Family counseling | 115 | 66.5 |
| Therapy for children | 105 | 60.7 |
| Couple therapy | 86 | 49.7 |
| Parent education | 75 | 43.4 |
| Anger management/counseling | 71 | 41.0 |
| Psychological evaluations | 50 | 28.9 |
| Group counseling | 44 | 25.4 |
| Substance abuse counseling | 43 | 24.9 |
| Coaching | 11 | 6.4 |
| Batterer intervention | 10 | 5.8 |
| Intensive in-home therapy | 9 | 5.2 |
| Mediation | 8 | 4.6 |
| Home/custody studies | 3 | 1.7 |
| None of the above | 11 | 6.4 |

*Note*. MHP = mental health professional.

## Professional Experience Related to Domestic Violence

Only five (2.9%) participants reported that they do not provide any services to clients who are victims of abuse or DV. Participants reported the percentages of their adult caseloads that they estimated have been victims of DV as follows: none (*n* 5 8, 4.6%), 1%–25% (*n* 5 85, 49.1%), 26%–50% (*n* 5 34, 19.7%), 51%–75% (*n* 5 21, 12.1%), and 76%–100% (*n* 5 5, 2.9%). Seventeen (9.8%) respondents indicated that they never work with adult clients. Regarding the estimated percentage of their child caseloads (ages 0 through 17 years) who had witnessed DV, participants' responses were as follows: none (*n* 5 15, 8.7%), 1%–25% (*n* 5 45, 26.0%), 26%–50% (*n* 5 38, 22.0%), 51%–75% (*n* 5 27,

15.6%), 76%–100% (*n* 5 13, 7.5%). Thirty-three (19.1%) participants reported that they do not work with children.

Participants selected up to three mental health symptoms that they see most commonly among clients experiencing trauma and/or DV. The symptoms indicated most frequently were depression (*n* 5 128, 74.0%), anxiety (*n* 5 126, 72.8%), PTSD (*n* 5 104, 60.1%), and substance abuse (*n* 5 43, 24.9%). The less common symptoms were complex PTSD (*n* 5 26, 15.0%), self-harm/self-cutting (*n* 5 20, 11.6%), suicidal tendencies (*n* 5 12, 6.9%), borderline personality disorder (*n* 5 11, 6.4%), acute traumatic stress (*n* 5 8, 4.6%), bipolar disorder (*n* 5 6, 3.5%), eating disorders (*n* 5 5, 2.9%), dissociative disorder (*n* 5 6, 3.5%), psychotic symptoms (*n* 5 1, 0.6%), and schizophrenia (*n* 5 0, 0%). Only 58 (33.5%) participants reported that their organizations had posters and materials about DV posted. Most (*n* 5 104, 60.1%), however, reported that their organizations had implemented a workplace safety plan. Ninety-seven (56.1%) participants indicated that their workplace safety plan addresses violence, although only 60 (34.7%) reported that their workplace safety plan incorporates a plan of action regarding DV.

**Perceived Competence to Address Domestic Violence–Related Client Populations**

On a scale from 1 (*not at all competent*) to 4 (*extremely competent*), participants rated their perceived competence level in working with various DV-related populations (Table 2).

**Training Experiences and Needs Related to Domestic Violence**

Most participants (*n* 5 136, 78.6%) reported that they had ever received any training pertaining to DV, whereas 37 participants (21.4%) had never received such training. Among those who had received any training, 59 (34.1%) received their most recent training on the topic in the last 2 years, 43 participants (24.9%) received the training between 2 and 5 years ago, and 34 (19.7%) had their most recent trainings more than 5 years ago. Among the 59 participants who received training on DV in the past 2 years, the amount of training received in that time was as follows: 8 hr or less (*n* 5 35, 20.2%), 9–16 hr (*n* 5 12, 6.9%), 17–24 hr (*n* 5 5, 2.9%), 25–32 hr (*n* 5 2, 1.2%), 33–40 hr (*n* 5 2, 1.2%), and more than 40 hr (*n* 5 3, 1.7%).

**TABLE 2. Participants' Perceived Competence in Working with Domestic Violence–Related Client Populations**

| Population | *M* | *SD* |
|---|---|---|
| Female adult victims | 3.37 | 0.75 |
| People of varying economic backgrounds | 3.32 | 0.69 |
| Child abuse victim | 3.08 | 0.88 |
| Child witness of domestic violence | 3.05 | 0.93 |
| Intimate partner sexual abuse | 2.98 | 0.90 |
| Male adult victims | 2.96 | 0.86 |
| Teen dating violence | 2.93 | 0.81 |
| People of other ethnic backgrounds | 2.91 | 0.75 |
| Sibling violence | 2.90 | 0.86 |
| Same-sex partner violence | 2.78 | 0.88 |
| Elder abuse | 2.61 | 0.86 |
| Male adult offenders | 2.46 | 1.05 |
| People with intellectual or developmental disabilities | 2.44 | 0.93 |
| Female adult offenders | 2.39 | 0.99 |
| Immigrant populations | 2.23 | 0.82 |

The vast majority of participants (*n* 5 164, 94.8%) reported that they had ever received any training pertaining to clients who had experienced trauma, whereas 9 participants (5.2%) had never received trauma-related training. Among those who had received training, 122 (70.5%) received their most recent training on the topic in the last 2 years, 29 participants (16.8%) received the training between 2 and 5 years ago, and 10 (5.8%) had their most recent trainings more than 5 years ago. Among the participants who had received training on trauma in the past 2 years, the amount of training received in that time was as follows: 8 hr or less (*n* 5 35, 20.2%), 9–16 hr (*n* 5 35, 20.2%), 17–24 hr (*n* 5 17, 9.8%), 25–32 hr (*n* 5 18, 10.4%), 33–40 hr (*n* 5 6, 3.5%), and more than 40 hr (*n* 5 13, 7.5%).

Participants responded to an open-ended question that asked them to list any evidence-based practice approaches in which they had been trained. The responses that were listed by more than one participant were as follows: cognitive-behavior therapy (CBT; *n* 5 49); trauma-focused CBT (*n* 5 37); motivational interviewing (*n* 5 17); eye movement desensitization and reprocessing (EMDR; *n* 5 14); emotion-focused therapy (*n* 5 8); dialectical behavior therapy (*n* 5 6); prolonged exposure/exposure therapy/desensitization (*n* 5 5); cognitive processing therapy, Seeking Safety, and solution-focused therapy (each with *n* 5 4); multisystemic therapy and trauma-informed care (each with *n* 5 3); and relaxation training, hypnosis, Seven Challenges, acceptance and commitment therapy, PREPARE and ENRICH, Suicide ASIST, and cognitive therapy (all of which had *n* 5 2). Another 42 approaches (e.g., yoga for trauma and the trauma resiliency model) were listed by only one participant each.

Participants indicated what topics related to DV and trauma are incorporated into staff orientation at their agencies. Sixty-six (38.2%) participants marked this question as "not applicable." Among those providing responses, the topics covered were as follows: confidentiality policies (*n* 5 84, 48.6%), procedures for responding to disclosures (*n* 5 64, 37.0%), workplace safety policies (*n* 5 64, 37.0%), assessment (*n* 5 58, 33.5%), basic DV dynamics (*n* 5 50, 28.9%), and social values regarding violence against women (*n* 5 24, 13.9%). Forty-one (23.7%) participants reported that any type of cross-training activities (i.e., staff of each program are trained by staff of other programs or in other issues) take place between their organizations and DV organizations. Among those reporting cross- training activities, 22 (12.7%) participants reported that these are not regularly scheduled, 13 (7.5%) reported that they occur annually, 3 (1.7%) reported they occur quarterly, and 2 (1.2%) reported monthly activities.

***Differences in Whether Participants Had Received Training Based on Key Background Variables.*** One-way analyses of variance (ANOVAs) were completed to determine whether there were differences in whether participants had received training in DV or trauma based on five key background variables. Because MFTs were overrepresented in the sample, differences based on professional affiliation were examined in two ways: comparing all categories separately and collapsing the participants into two groups (i.e., MFTs and all others). No statistically significant differences were found in DV training based on the following variables: years in practice, $F(5, 167) = 2.024$, $p = .08$; professional affiliation: for all categories: $F(7, 165) = 0.873$, $p = .53$; comparing MFTs to all other affiliations: $F(1, 171) = 1.631$, $p = .20$; type of community (rural, urban/suburban, both), $F(2, 167) = 0.535$, $p = .59$; gender, $F(1, 167) = 0.011$, $p = .92$; and highest level of education, $F(3, 165) = 0.263$, $p = .85$. Likewise, there were no statistically significant differences found for trauma training based on the same variables: years in practice, $F(5, 167) = 0.868$, $p = .50$; professional affiliation, $F(7, 165) = 0.421$, $p = .89$; type of community (rural, urban/suburban, both), $F(2, 167) = 0.149$, $p = .86$; gender, $F(1, 167) = 0.824$, $p = .37$; and highest level of education, $F(3, 165) = 0.095$, $p = .96$.

## Domestic Violence Screening and Intervention Practices

Participants were asked how they assess for DV and trauma (Table 3). Participants also were asked to indicate their common practices when they know or suspect DV is present. For both, participants could indicate as many of the possible responses that applied.

**TABLE 3. Screening Practices Currently Practiced by Participants**

| Screening or Intervention Practice | Frequency | % |
|---|---|---|
| Screening practices | | |
| I universally screen all clients for other types of trauma experiences. | 111 | 64.2 |
| I screen for trauma symptoms (such as PTSD). | 98 | 56.6 |
| I universally screen all clients for DV as part of my own protocol. | 93 | 53.8 |
| I screen for DV only when suspected DV is occurring. | 41 | 23.7 |
| My agency has protocols in place for universal screening so that I screen all clients for DV. | 37 | 21.4 |
| I screen for intimate partner sexual abuse. | 35 | 20.2 |
| I screen for other types of trauma only when suspected. | 24 | 13.9 |
| Intervention practices | | |
| I inquire about how abuse has impacted clients psychologically (e.g., emotional effects, feelings about life in general). | 154 | 89.0 |
| I inquire about the safety of clients' children. | 151 | 87.3 |
| I inquire about the timing of when the trauma occurred (i.e., childhood, adulthood, or both). | 147 | 85.0 |
| I provide information about DV resources. | 145 | 83.8 |
| I report to DSS when children are in homes where DV is present. | 143 | 82.7 |
| I document any signs/observations of abuse within clients' mental health records. | 142 | 82.1 |
| I conduct a safety risk or lethality assessment. | 141 | 81.5 |
| I develop a safety plan. | 139 | 80.3 |
| I inquire about how abuse has impacted their children. | 134 | 77.5 |
| I inquire about how abuse has impacted physical health (e.g., injuries, hospitalization, pregnancy complications). | 131 | 75.7 |
| I inquire whether they have experienced DV with other partners. | 121 | 69.9 |
| I connect my client with DV-specific programs. | 121 | 69.9 |

*Note*. Participants could indicate all skills that applied, so the total is greater than 100%. PTSD = posttraumatic stress disorder; DV = domestic violence; DSS = Department of Social Services.

To consolidate participants' responses to these items, we combined the seven screening practice items into a single score by summing participants' responses to these seven items. Thus, their scores could range from 0 to 7, with their score representing the number of screening practices in which they indicated they engaged. Likewise, the 12 intervention practice items were combined into a single score by summing participants' responses to these 12 items. Participants' intervention practices combined scores could therefore range from 0 to 12. For the screening combined score, the observed range was from 0 to 7, with a mean of 2.54 (*SD* 5 1.34). For the interventions combined score, the observed range was from 0 to 12, with a mean of 9.65 (*SD* 5 3.03). Thus, overall, the sample endorsed a relatively lower number of screening items than they did for the intervention items, as reflected in the means for each combined score.

***Differences in Screening Practices Based on Whether the Mental Health Professional Had Received Any Domestic Violence Training.*** Using one-way ANOVAs, we examined whether

participants' combined screening practices scores differed based on whether they had received training related to DV. The results revealed a statistically significant difference in participants' combined screening score based on training ($F$ 5 3.932, $p$ 5 0.49). The mean combined screening score for participants who had received any training related to DV was 2.71 (*SD* 5 1.35), and the mean for participants who had never received any training related to DV was 1.89 (*SD* 5 1.08). Therefore, participants who had received any training related to DV reported engaging a statistically significant higher number of screening practices than those who have never received such training.

**TABLE 4. Differences in Domestic Violence Screening Practices Based on Whether Participants Had Received Any Training Related to Domestic Violence**

| Screening Practice | Pearson Chi-Square Value | *df* | *p* |
|---|---|---|---|
| I universally screen all clients for DV as part of my own protocol. | 8.610 | 1 | .005* |
| I screen for DV only when suspected violence is occurring. | 1.985 | 1 | .191 |
| I screen for intimate partner sexual abuse. | 6.410 | 1 | .010* |
| I universally screen all clients for other types of trauma experiences. | 1.122 | 1 | .335 |
| I screen for other types of trauma only when suspected. | 1.003 | 1 | .298 |
| I screen for trauma symptoms (such as PTSD). | 8.869 | 1 | .005* |
| My agency has protocols in place for universal screening so that I screen all clients for DV. | 4.936 | 1 | .025* |

*Note.* *df* = degrees of freedom; DV = domestic violence; PTSD = posttraumatic stress disorder.
*$p < .05$ (two-tailed).

To further examine the impact of training on specific screening practices, chi-square tests were used to examine whether participants differed in their DV screening practices based on whether or not they had received any training related to DV. Thus, two groups (i.e., those who had ever received training and those who had not) were compared in their responses to whether they engage in each screening practice. Four statistically significant differences emerged, as indicated in Table 4.

Across the statistically significant findings regarding screening differences based on DV training, those who had been trained demonstrated more thorough assessment practices. For participants who had been trained in DV, 81 (59.6%) reported universal screening for DV among all clients, whereas 55 (40.4%) did not do universal screening. In contrast, 12 (32.4%) participants without training reported doing universal screening for DV, and 25 (67.6%) did not. Among the participants with DV training, 33 (24.3%) indicated that they screen for intimate partner sexual abuse, and 103 (75.7%) said they do not. For those with no such training, only 2 (5.4%) reported that they screen for intimate partner sexual abuse, and 35 (94.6%) reported that they do not. Among the participants who received DV training, 85 (62.5%) indicated that they screen for trauma symptoms such as PTSD, and 51 (37.5%) indicated that they did not. In contrast, among those who had not received DV training, 13 (35.1%) reported screening for trauma symptoms, and 24 (64.9%) said they did not. Finally, 34 (25.0%) participants with DV training reported that their agencies have protocols for universal screening in place, and 102 (75.0%) did not. This

compared to 3 (8.1%) participants with DV training with agency protocols for universal screening, and 34 (9.9%) without such protocols.

Additional analyses were conducted to determine whether five key background variables (i.e., years working as a mental health professional; professional affiliation, comparing MFTs with all other affiliations, gender, type of community, and highest level of education) interacted with whether participants had received training in DV to impact their screening practices. For these analyses, given the number of specific items, only the combined scores were used. Two-way ANOVAs were used for these analyses, and no statistically significant differences were found for the interactions between whether participants had received DV training and the following variables: years working as a mental health professional ($F$ 5 6.33, $df$ 5 5, $p$ 5 .675), professional affiliation ($F$ 5 0.724, $df$ 5 1, $p$ 5 .396), type of community ($F$ 5 5.23, $df$ 5 2, $p$ 5 .594), gender ($F$ 5 0.453, $df$ 5 1, $p$ 5 .502), and highest level of education ($F$ 5 1.739, $df$ 5 2, $p$ 5 .179).

***Differences in Intervention Practices Based on Whether the Mental Health Professional Had Received Any Domestic Violence Training.*** Again, we used one-way ANOVAs to examine whether participants' combined intervention practices scores differed based on whether they had received training related to DV. The results revealed a statistically significant difference in participants' combined intervention scores based on training ($F$ 5 6.995, $p$ 5 .009). The mean combined intervention practices score for participants who had received any training related to DV was 10.13 ($SD$ 5 2.73), and the mean for participants who had never received any training related to DV was 7.89 ($SD$ 5 3.454). Therefore, participants who had received any training related to DV reported engaging a statistically significant higher number of intervention practices than those who have never received such training.

As with the screening practices, we used chi-square tests to examine whether participants differed in their DV intervention practices based on whether or not they had received any training related to DV. Thus, two groups (i.e., those who had ever received training and those who had not) were compared in their responses to whether they engage in each intervention practice. Seven statistically significant differences emerged (Table 5).

**TABLE 5. Differences in Domestic Violence Intervention Practices Based on Whether Participants Had Received Any Training Related to Domestic Violence**

| Intervention Practice | Pearson Chi-Square Value | *df* | *p* |
|---|---|---|---|
| I conduct a safety risk or lethality assessment. | 3.939 | 1 | .057 |
| I develop a safety plan. | 9.856 | 1 | .004* |
| I provide information about DV resources. | 20.581 | 1 | .000* |
| I inquire about the safety of clients' children. | 16.483 | 1 | .000* |
| I report to DSS when children are in homes where DV is present. | 1.601 | 1 | .224 |
| I document any signs/observations of abuse within clients' mental health records. | 6.740 | 1 | .015* |
| I inquire about how abuse has impacted physical health (e.g., injuries, hospitalization, pregnancy complications). | 6.772 | 1 | .016* |
| I inquire about how abuse has impacted clients. | 3.032 | 1 | .133 |
| I inquire about how abuse has impacted their children. | 14.762 | 1 | .000* |
| I inquire about the timing of when the trauma occurred (i.e., childhood, adulthood, both). | 0.052 | 1 | .799 |
| I inquire whether they have experienced DV with other partners. | 10.151 | 1 | .002* |
| I connect my client with DV-specific programs. | 2.460 | 1 | .156 |

*Note.* *df* = degrees of freedom; DV = domestic violence; DSS = Department of Social Services.
*$p < .05$ (two-tailed).

Table 6 presents the frequencies and percentages for each of the statistically significant findings for these analyses. Similar to the findings regarding screening and training, for all of the statistically significant findings, participants who reported training in DV demonstrated higher rates of using comprehensive, DV-specific interventions.

As described earlier for the screening practices, additional analyses were conducted to determine whether the five background variables interacted with whether participants had received training in DV to impact their intervention practices, based on their combined scores. The results of the two-way ANOVAs revealed that there were no statistically significant differences for the interactions between whether participants had received DV training and the following variables: years working as a mental health professional ($F$ 5 1.186, $df$ 5 5, $p$ 5 .318), type of community ($F$ 5 0.227, $df$ 5 2, $p$ 5 .797), and gender ($F$ 5 0.098, $df$ 5 1, $p$ 5 .755). However, there was a statistically significant difference based on the interaction between DV training and professional affiliation ($F$ 5 4.330, $df$ 5 1, $p$ 5 .039). MFTs who had received training related to DV had the highest combined intervention score ($M$ 5 10.37), followed by non-MFTs who had received DV training ($M$ 5 9.93), MFTs who had never received DV training ($M$ 5 9.75), and non-MFTs who had never received DV training ($M$ 5 7.00). In addition, there was a statistically significant difference based on the interaction between DV training and highest level of education ($F$ 5 5.423, $df$ 5 2, $p$ 5 .005). Because there were only two participants with a bachelor's degree and only three participants indicating some other degree, only the means for participants with master's and doctoral degrees will be reported. The highest means on the interventions combined scores were found among participants with participants with doctoral degrees who had received DV training ($M$ 5 10.24), followed by participants with master's degrees who had received DV

training (*M* 5 9.98), participants with master's degrees who had not received DV training (*M* 5 8.59), and participants with doctoral degrees without any prior DV training (*M* 5 6.13).

**Connections with Domestic Violence Agencies**

Participants indicated an estimated average number of referrals that they receive per month from DV agencies: none (*n* 5 125, 72.3%), 1–2 (*n* 5 34, 19.7%), 3–4 (*n* 5 6, 3.5%), and providers. Among the participants, 63 (36.4%) strongly agreed and 103 (59.5%) agreed with the statement, "I know how to access available DV services if needed." Only 7 (4.0%) respondents disagreed with this statement. Most participants (*n* 5 125, 72.3%) reported that their work setting has procedures in place for determining appropriate referrals to DV service providers. However, participants' responses varied in response to whether they viewed the process of referring clients to DV service providers as working well, with 26 (15.0%) participants strongly agreeing and 74 (42.8%) agreeing with this statement and 44 (25.4%) disagreeing and 10 (5.8%) strongly disagreeing.

**TABLE 6. Differences in Frequencies and Percentages in Domestic Violence Intervention Practices Based on Whether Participants Had Received Any Training Related to Domestic Violence**

| Intervention Practice Yes/No | DV Training Received? Yes *n* (%) | No *n* (%) |
|---|---|---|
| I develop a safety plan. | | |
| Yes | 116 (85.3) | 23 (62.2) |
| No | 20 (14.7) | 14 (37.8) |
| I provide information about DV resources. | | |
| Yes | 123 (90.4) | 22 (59.5) |
| No | 13 (9.6) | 15 (40.5) |
| I inquire about the safety of clients' children. | | |
| Yes | 126 (92.6) | 25 (67.6) |
| No | 10 (7.4) | 12 (32.4) |
| I document any signs/observations of abuse within clients' mental health records. | | |
| Yes | 117 (86.0) | 25 (67.6) |
| No | 19 (14.0) | 12 (32.4) |
| I inquire about how abuse has impacted physical health (e.g., injuries, hospitalization, pregnancy complications). | | |
| Yes | 109 (80.1) | 22 (59.5) |
| No | 27 (19.9) | 15 (40.5) |
| I inquire about how abuse has impacted their children. | | |
| Yes | 114 (83.8) | 20 (54.0) |
| No | 22 (16.2) | 17 (45.9) |
| I inquire whether they have experienced DV with other partners. | | |
| Yes | 103 (75.7) | 18 (48.6) |
| No | 33 (24.3) | 19 (51.4) |

*Note.* One hundred thirty-six participants reported that they had received any form of domestic violence (DV) training, and 37 reported that they did not.

5 or more ($n$ = 7, 4.0%). Likewise, they reported the estimated number of clients they refer to DV service providers each month: none ($n$ = 87, 50.3%), 1–2 ($n$ = 69, 39.9%), 3–4 ($n$ = 9, 5.2%), and 5 or more ($n$ = 7, 4.0%). Participants were asked to rate, on a scale from 1 (*not well at all*) to 6 (*extremely well*), how well their organization, as a whole, collaborates with DV service providers. Their responses ranged from 1 to 6, with a mean of 3.73 ($SD$ = 1.69), indicating a moderate level of positive collaboration with DV service

## DISCUSSION

This study's findings support previous studies (Helfrich et al., 2008; Mourad et al., 2008; O'Campo et al., 2006) that demonstrate the links between DV victimization and mental health. More than one-third (34.7%) of the MHPs in this study reported that at least one- quarter of their adult caseloads have been victims of DV, and nearly half (45.1%) of the participants reported that at least one-quarter of their child caseloads had witnessed DV. Similar to previous research (Helfrich et al., 2008), the MHPs in this study indicated that the most common symptoms among their clients impacted by trauma and DV were depression, anxiety, PTSD, and substance abuse. However, the settings in which MHPs work may be limited in their capacity to serve clients impacted by DV, with only about one-third of participants reporting that their agencies have

materials about DV posted in their agencies. Likewise, only about one-third of participants reported that their agencies have workplace safety plans that address DV. Participants also varied in the DV-related client populations they viewed themselves to be competent to serve. They rated themselves as most competent to serve female adult victims, people of varying economic backgrounds, child abuse victims, and child witnesses of DV, but they viewed themselves to be least competent to serve immigrant populations, female adult offenders, people with intellectual or developmental disabilities, and male adult offenders.

As with other literature (Gauthier & Levendosky, 1996; Murray & Graves, 2013; Wingfield & Blocker, 1998), this study demonstrates that many MHPs lack adequate training on the topic of DV. More than one-fifth (21.4%) of participants had never received any training related to DV. Even when training is received, its duration and recency may vary. For example, only about one-third (34.1%) of the sample had received any training within the past 2 years, and about one-fifth (20.2%) of the sample had received 8 hr or less of training on DV in the past 2 years. It appears that MHPs are more likely to receive training on trauma in general, with 94.8% of participants reporting some training. However, the lack of training specific to DV suggests that many MHPs may be unprepared or underprepared to address the unique safety and mental health considerations associated with DV. The lack of differences in whether participants had been trained based on professional and demographic variables suggests that a lack of training on DV is common, and it may be that the burden for receiving this training falls on individual professionals rather than it being required as part of professional training programs.

One of the most important findings for this study relates to the differences that emerged between those who had received DV and those who had not in terms of their typical screening and assessment practices. These findings will be important to replicate in future research, especially because most of the current sample reported having received some DV training. It is notable that receiving any training in DV was linked to MHPs engaging in more comprehensive and thorough assessment and intervention practices. For the most part, these differences based on training were not impacted by the background characteristics that were studied (i.e., years working as a MHP, professional affiliation, gender, type of community, and highest level of education), although there was some evidence that professional affiliation and education level may impact MHPs' intervention practices related to DV. In general, participants reporting any level of training were more likely to do all of the following: (a) universally screen clients for DV, (b) screen for intimate partner sexual abuse, (c) screen for trauma symptoms, (d) work in agencies that have policies for universal screening of all clients for DV, (e) develop safety plans, (f) provide information about DV resources, (g) inquire about the safety of clients' children, (h) document any signs of abuse in clients' mental health records, (i) inquire about how abuse impacts clients' physical health, (j) inquire about how abuse impacts clients' children, and (k) inquire whether clients experienced DV with other partners. Each of the earlier mentioned practices is important for MHPs to be able to accurately identify and safely and effectively provide services to clients who have experienced DV victimization (Murray & Graves, 2013).

Finally, this study's findings support the need for ongoing efforts to promote positive collaborations and partnerships between DV and mental health service agencies. Overall, participants rated their organizations' collaborations with DV service agencies as working moderately well, although there were participants at each end of the spectrum from reporting that

these collaborations work extremely well to not well at all. These dynamics likely vary from community to community, and therefore, MHPs should consider whether and how collaborations in their area can be strengthened, especially in the process of referring clients between agencies because participants in this study varied in how well they viewed that process.

**Statement of Limitations**

As an anonymous survey research study, this study resulted in self-reported data, and therefore, we were unable to verify participants' responses with any objective or behavioral data (e.g., transcripts or other documentation of training received, observations of their actual clinical assessment and intervention practices). The convenience sample is another important limitation, and it is not possible to determine the extent to which the findings with this sample would generalize to other samples of MHPs. In particular, MFTs were the most represented group in this sample. Training among different disciplines can vary, especially because each discipline has its own set of training program accreditation standards and professional licensure standards. Although the sample included a diverse group on many variables, the racial/ethnic diversity also was limited. Furthermore, future research is needed to further examine whether and how certain demographic and professional background characteristics may impact the connections between training and practice related to domestic violence. A third limitation is that participants were drawn from only one state, and therefore, public policies and practice systems in that state could differ from those influences in other states. In North Carolina, there are no set requirements for MHPs to receive training in DV. An additional limitation was that the survey asked limited information about the type of training that MHPs had received related to DV. Training content and formats can vary widely. Therefore, it would be useful in future research to account more fully for the nature of training that MHPs receive related to DV.

**Implications for Research, Policy, and Practice**

The findings of this study suggest several important directions for future research. First, additional information is needed about the type, content, format, and duration of training that will most effectively equip MHPs to provide clinical services to clients impacted by DV. Second, researchers can continue to identify the critical mental health issues that MHPs will encounter when working with clients impacted by DV as well as to develop and evaluate effective interventions to address those concerns. For example, in this study, the most common symptoms that MHPs reported included depression, anxiety, and PTSD. Researchers can study the extent to which existing interventions to address these concerns are applicable to survivors of DV. Third, in light of the findings related to the interconnections between DV and mental health service organizations, researchers can study effective processes for better linking these services as well as for ensuring that other collaborative organizations (e.g., law enforcement and court systems) are equipped to help survivors connect with a full range of services to meet their unique needs. Finally, researchers can study additional strategies for helping MHPs to become more competent to serve the unique needs of specific client populations, such as immigrants and offenders.

The analysis strategy used in this study was designed to address the research questions that guided the work of the task force that conducted this research. Therefore, the research questions were designed to be both methodologically sound and relevant to the practice- focused needs of

the task force. Additional analyses, especially a multivariate regression analysis, could have provided a different statistical approach to analyzing the data gathered in this study. As such, future research on this topic would benefit from the expanded use of multivariate analyses, especially involving multivariate regression analyses can help to account for the potentially overlapping variance in the variables under study. Therefore, additional research is needed to further explore the various intersecting influences on how MHPs make choices about their clinical work with clients impacted by DV.

The finding that MHPs reporting any level of training on DV report that they engage in more comprehensive assessment and intervention services supports the value of policies that require training on DV (Payne et al., 2007). These policies may occur at many levels, including agency policies, mental health training program requirements and accreditation standards, and even licensure standards. Where such policies are created, they should ensure that training is of a sufficient quality and duration to cover critical topics, such as basic information about the dynamics and safety risks associated with DV, effective assessment strategies and intervention approaches, and steps that MHPs can take to support clients in navigating legal processes and accessing community resources to provide them with additional support.

Until such policies exist, a critical implication of this study for MHPs is a need to individually seek out training to ensure that they are competent to provide appropriate services to clients impacted by DV. MHPs may not immediately view the connections between their work settings and the issue of DV. However, MHPs in virtually every work setting are likely to encounter clients whose lives have been touched by DV. For example, children in school settings may be witnessing DV in their homes, college students seeking help in university counseling centers may experience dating violence, and clients in virtually any setting may have a history of past abuse or even current abuse. Therefore, greater actions should be taken to promote MHPs' competence in working with clients impacted by DV. This includes increased attention to the topic in graduate training programs, more comprehensive ongoing training as part of individual MHPs' continuing education endeavors, enhanced cross-training activities between DV and mental health service agencies, and organizational policies that promote high-quality training and effective assessment and intervention practices to meet the needs of clients impacted by DV.

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