

# Intimate Partner and Family Abuse

**John Hamel, LCSW**, acquired both his BA in psychology (1986) and master's in social welfare (1988) from the University of California at Los Angeles and was licensed as an LCSW (LCS 15194) in November 1990. Since 1991, he has been director of John Hamel & Associates, with offices in Walnut Creek, Berkeley, and Greenbrae, California. Mr. Hamel and his associates provide a wide range of clinical, consultation, and training services. His areas of expertise are in the assessment and treatment of anger management and family violence, as well as substance abuse and codependency. Specialized clinical services include a substance-abuse relapse prevention group, family violence assessments (including specialized assessments in disputed child-custody cases), victim services and advocacy (including victim support groups), and treatment programs for angry and violent men, women, couples, parents, and teens. Although many of his clients are voluntary participants, many are referred from family court or child protective services or are mandated by the courts to participate in either a batterer treatment program or a parenting program.

Mr. Hamel has provided consultation and training for mental health professionals, batterer intervention providers, shelter workers and victim advocates, court mediators and evaluators, teachers, attorneys, and law enforcement and has spoken on family violence at a number of events, including the California Department of Social Services 10th Annual Family Strengths Training Institute, the 2006 Training Conference of the California Association of Family and Conciliation Courts, and the 2007 University of New Hampshire Family Violence Conference in Portsmouth, New Hampshire; he has presented regularly at the IVAT (formerly Family Violence & Sexual Assault Institute) International Conferences on Family Violence. Mr. Hamel is a pioneer in the development of the gender-inclusive approach to domestic violence, a newly emerging, empirically based model of research and treatment. His trainings have been praised both for their innovative look at theory and policy and for their abundance of practical, hands-on intervention tools. Mr. Hamel has also served as an expert court witness on the subject of family violence and has testified before the California legislature on domestic violence public policy.

His first book, *Gender-Inclusive Treatment of Intimate Partner Abuse: A Comprehensive Approach*, was published in 2005 by Springer Publishing. His second book, co-edited with Tonia Nicholls, PhD, is *Family Interventions in Domestic Violence: A Handbook of Gender-Inclusive Theory and Treatment* (2007) and includes contributions from the most respected experts in the field. Mr. Hamel is a founding member of the Family Violence Treatment and Education Association ([www.FAVTEA.com](http://www.FAVTEA.com)), as well as the National Family Violence Legislative Resource Center ([www.NFVLR.org](http://www.NFVLR.org)). He is married and lives with his wife, Judi, and their twins, Jacob and Aviva, in San Rafael, California.

# Intimate Partner and Family Abuse

*A Casebook of Gender-  
Inclusive Therapy*

**JOHN HAMEL, LCSW, Editor**

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*This book is dedicated to my wife, Judi, and my  
children, Jacob and Aviva.*

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## Contributors

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**Derek Ball, PhD**, is the senior therapist and director of the Hiebert Institute at Marriage and Family Counseling Service in Rock Island, Illinois. As a licensed marriage and family therapist, he has worked in the Prevention of Abuse program and has supervised interns on the prevention approach for over 10 years. He earned both his MA and PhD in marriage and family therapy at Purdue University. Dr. Ball has coauthored several book chapters, including chapters on the following topics: four predivorce marital typologies that aid in clinical assessment (with William Hiebert), couples facing divorce (with Peter Kivisto), and research in family therapy (with Doug Sprenkle). Dr. Ball also coauthored an article with Fred Piercy and Gary Bischof titled "Externalizing the Problem Through Cartoons: A Case Example."

**Lori Bloom** has been a licensed marriage and family therapist for 27 years. Along with her private practice, which includes facilitating stress-reduction workshops in the United States and abroad, she has been the director of the People's Alternatives to Violence (PAV), a court-certified anger management program, for 19 years. She works with both female and male offenders. She has studied strategic family therapy with Jay Haley and Cloe Madanes and has trained with and been a trainer for John Grinder in neurolinguistic programming. Lori has also worked with drug- and alcohol-addicted adults and teenagers as hospital psychodramatist and was the

substance abuse counselor/coordinator for the Mendocino County Health Department. She was also the director of a “court to community” program that transitioned children from foster care back to their parents. As a school counselor, Lori worked with children who came from violent homes. She also does family and divorce mediation. Lori believes that her work over the years has shown her that the one thing we all must learn to acknowledge is that fear and anger will come up in all of our lives. It is only when we can separate our true selves from the feelings of fear and the stories that we tell ourselves that keep the fear alive that we truly begin to live as compassionate and authentic human beings.

**Ellen L. Bowen** began her master’s degree in social work at the University of Iowa and completed it at San Diego State University in 1979. She has over 34 years of clinical experience—initially in private, nonprofit settings and the last 23 years in private practice in Santa Rosa, California. She is a past board member and fellow in the California Society for Clinical Social Work. Ten years ago she cofounded Non-Violent Alternatives (NOVA), a certified domestic violence treatment program. Through NOVA, she facilitates groups for male and female domestic violence offenders. She also coteaches a continuing education class for therapists titled “Understanding and Treating Intimate Partner Abuse.” She is in the process of writing a book tentatively titled *Domestic Violence Treatment for Abusive Women: A Step-by-Step Approach*.

**Wendy Bunston** is a senior social worker, has a master’s degree in family therapy, and has undertaken further postgraduate studies in organizational development. She is manager of the national award-winning Community Group Program (CGP) and Addressing Family Violence Programs (AFVP) within Melbourne, Australia’s Royal Children’s Hospital Mental Health Service (RCH MHS). She has specialized in working with children, adolescents, and families considered at high risk and within the areas of sexual violence and family violence. She has published work in the area of child protection, childhood trauma, child/adolescent sex-offending, and group work. Most recently she has coauthored *The Therapeutic Use of Games in Group Work* and coedited the book *Addressing Family Violence Programs: Group Work Interventions for Infants, Children and Their Families*. Wendy has codeveloped specialist group-work programs for children and their parents affected by family violence called PARKAS, as well as the Peek a Boo Club, for infants and mothers.

**Tom Caplan** received his MSW from McGill University and an MA in counseling psychology from the Adler School of Professional Psychology. He is an adjunct professor at the McGill University School of Social Work and director and supervisor of the McGill Domestic Violence Clinic. He is a designated expert in domestic violence for the Quebec court system. Tom is on the editorial board of *Social Work With Groups* and is a certified marriage and family therapist and supervisor (A.A.M.F.T.). He has published many articles on therapeutic techniques, the treatment of domestic violence, and the comorbidity of substance abuse and domestic violence. His

recently published book is *Needs ABC: A Needs Acquisition and Behavior Change Model for Group Work and Other Psychotherapies* (2007).

**Mirna E. Carranza** works as an assistant professor at the School of Social Work, McMaster University. She is a social worker and a registered marriage and family therapist. She is a clinical member of AAMFT and a member of AFTA. Her experience includes working with individuals, couples, and families within a clinical setting and the development of community initiatives aiming at social change regarding the social inclusion of disadvantaged populations such as women and children, particularly looking at the intersection of gender, race, ethnicity, and sexual orientation. Her theoretical standpoint is a liberationist perspective with strong commitment to social justice and human rights issues.

**Karen Cohen** has been a licensed marriage and family therapist since 1987. She is certified in chemical dependency counseling as well as in the use of cognitive behavioral therapy and group psychotherapy. From 1999 to the present, she has presented workshops and trainings on intergenerational, multicultural multiple-family group therapy. Since 1988, Karen has supervised graduate practicum students and registered California marriage and family therapy interns. She has been an adjunct professor at Mount Saint Mary's College graduate programs in marriage and family therapy and at the University of La Verne. Karen previously served as clinical program director for Santa Anita Family Services' Pathways Program, an outpatient drug and alcohol treatment in Monrovia, California, from 1985 to 2002. She has also served as clinical director of counseling services for Project SISTER, a counseling program for male and female adults and adolescent survivors of rape trauma and childhood sexual molestation and their families in Pomona, California.

**Kimberly Flemke, PhD**, is an assistant professor at Drexel University in the graduate programs of couple and family therapy. She is a trained couple and family therapist and clinically works at Council for Relationships in Philadelphia, where she evaluates and treats women with rage and trauma. Dr. Flemke previously worked as a forensic family therapist in a Philadelphia prison, frequently treating incarcerated women on past issues of rage, violence, and trauma. She also worked as a BIS treatment provider for Bucks County Adult Probation and Parole Department for women arrested for domestic violence. Dr. Flemke's primary research interest is in understanding women's use of violence and rage in their intimate relationships, having recently completed a study of incarcerated women's experiences of rage toward their intimate partners. She has published and presented on her findings both nationally and locally.

**Bo Gunnehill** has worked for almost 20 years in Sweden as a social worker, family therapist, and couples counselor and most recently also as a family therapy supervisor. He has previously worked in the field of child and adolescent psychiatry, as well as in the field of adult psychiatry, and has maintained a private practice.

Currently, he provides clinical services to troubled families in Helsingborg, in partnership with Martin Söderquist and three other therapists. His articles, all published in Swedish, include “Focus På Familjen, nr 4, 2004” (Universitetsforlaget, Oslo) and “Handledning-ett kreativt samspel.”

**K. Kerstin Gutierrez, PhD**, is a licensed clinical psychologist in private practice in San Ramon, California. She provides psychotherapy and psychological assessment services to adults, children, and families and specializes in co-parenting counseling, mediation, parent–child reunification, and other services related to helping families cope with separation and divorce. She also is a member of the Contra Costa Collaborative Practice Group, providing mental health services within a collaborative team approach to families going through divorce. She worked for several years as a mediator for both the Alameda and Contra Costa County superior courts, where she also taught the high-conflict parenting program. She has taught graduate-level courses on child, adolescent, and adult development and has given presentations abroad and in California on mediation, co-parenting counseling, and report writing for the court and has published articles on the impact on children of domestic violence and on the transmission of violent coping from parent to child.

**Alison Heru** is a graduate of Glasgow University Medical School in Scotland and has completed psychiatric residencies in Edinburgh, Scotland, and Brown University in Providence, Rhode Island. Dr. Heru is an associate professor in the Department of Medicine at National Jewish Medical and Research Center and in the Department of Psychiatry at the University of Colorado at Denver and Health Sciences Center. Dr. Heru is a member of the family committee of the Group for the Advancement of Psychiatry and the American Psychiatric Association. She is the secretary and treasurer of the Association of Family Psychiatrists. Dr. Heru has published articles on family psychiatry and coauthored a book titled *Working With Families of Psychiatric Inpatients*. She has conducted and published research on caregiver burden in chronic mental illness, gender differences in supervision, and intimate partner violence. Most recently she has conducted pilot research in couples therapy where one partner has major depression and where there is comorbid intimate partner violence. The case described in this book is an example from this study.

**William J. Hiebert, DMin**, is the executive director of marriage and family counseling service in Rock Island, IL. Dr. Hiebert has worked with previolent families for 40 years, is a licensed marriage and family therapist, and was instrumental in forming the Prevention of Abuse program in 1989. He earned his STM from Andover Newton Theological School and a DMin in marriage and family therapy from the Graduate Theological Foundation. Dr. Hiebert has coauthored two books: *Dynamic Assessment in Couple Therapy* (with Robert Stahmann and Joseph Gillespie) and *Premarital and Remarital Counseling* (with Robert Stahmann). He recently published a book chapter titled “Four Predivorce Marital Typologies That Aid in Clinical Assessment” (with Derek Ball).

**Jodi Klugman-Rabb** is a marriage and family therapist working in private practice in San Rafael, California. Jodi received her master's degree in counseling psychology from Dominican University and initially interned with the San Rafael Police Department's Youth Services Bureau, meeting with families of first-offender juveniles. Later she went on to become the anger management program manager for a local nonprofit agency specializing in multifamily groups for adolescents with anger problems and probation cases. Jodi uses the 7 years of expertise in the field of anger management to work in the unique multifamily format and tailor treatment programs for juvenile or adult probation and child protective services clients. Along with appearing as a guest lecturer at Sonoma State University, Jodi has also appeared on local cable programming, *Recovery Station*, to discuss the effects of anger and violence in conjunction with substance abuse. Please visit [www.jkrabb.com](http://www.jkrabb.com) for a more complete explanation of her specialties and contact information.

**Catherine Lieb, LCSW**, is a graduate of Santa Clara University and earned her master's in social work at California State University, Sacramento. Her foundation in family therapy began at an Asilomar training by David Freeman, DSW, in multigenerational family therapy to heal emotional pain. For many years she has worked with families who have histories of child abuse and want to heal and change their family's aggressive patterns. She is certified as a Gestalt therapist with the Sierra Institute for Contemporary Gestalt Therapy, where she has served as adjunct faculty and on the advisory council. She currently works as a psychotherapist for Veterans Affairs.

**Michael Mesmer, MFT**, has been a licensed marriage and family therapist since 2000 and a certified grief counselor since 1995. Michael has over 30 years of experience in empowering groups, having led inner-city teens on survival courses and in street theater classes; men, women, and children in drumming circles and support groups; and children and therapists in theater improvisation. Michael is also the cofounder and codirector of Building Better Families, Inc. ([www.bbfmarin.com](http://www.bbfmarin.com)), which provides weekly groups aimed at reducing anger and ending family violence for men, women, and teens in Marin County and surrounding communities. He also maintains a private practice in San Rafael, California, where he treats adults, couples, families, teens, and children in individual, couples, and family therapy. Michael can be reached at 415-601-7497; PO Box 2711, San Rafael, CA 94912; or [mjm@therapyalternatives.org](mailto:mjm@therapyalternatives.org). His Web site is at [www.therapyalternatives.org](http://www.therapyalternatives.org).

**Darlene Pratt, MFT**, graduated from San Diego State University with an MS degree in counseling and family therapy in May 1992 and obtained her LMFT license (MFC 36349) in February 2000. She has worked with John Hamel & Associates since 1994. A certified domestic violence counselor and an approved batterer intervention program provider in Contra Costa and Alameda counties, Ms. Pratt facilitates anger management and batterer intervention groups for both male and female offenders. She facilitates the teen anger management group, as well as the 26- to 52-week high-conflict family violence program, and provides counseling and

psychotherapy to high-conflict families, including child victims of family violence. For many years, she has also conducted specialized family violence assessments on behalf of the family court in Contra Costa County. Ms. Pratt has spoken on the subject of family violence at numerous events, including the 2002 ACAD Training Conference and the Family Violence Treatment and Education Association 2003 Training Conference, and before the California Association of Marriage and Family Therapists. Recently, her article on high-conflict family-violence parent programs was included in the anthology *Family Interventions in Domestic Violence* (2007), edited by J. Hamel and T. Nicholls. In addition to her work in family violence, Ms. Pratt has expertise in the field of sexual addiction. She is also trained in EMDR.

**Martin Söderquist** is a licensed psychologist and family therapist, with a private clinical practice in Helsingborg, located in the south of Sweden. For the past 18 years, he has worked in the field of child and adolescent psychiatry and with drug and alcohol addicts. He has been a therapist, supervisor, and project head in several treatment and research projects focused on addicts and their families, sexually abused children and their parents, and obese children and their parents and has conducted assessment with families referred from child protection services. Over the years, Martin has provided training and supervision in family therapy and, in particular, solution-focused brief therapy. He has published several articles and five books in Swedish and several articles in English. His Web site is [www.martin-utbildning.nu](http://www.martin-utbildning.nu).

**Arlene Vetere and Jan Cooper** are codirectors of Reading Safer Families—an assessment and therapeutic service for both victims and perpetrators of violence in the family. They have published extensively about their work, and in 2005 they published the book *Domestic Violence and Family Safety: Working Systemically With Family Violence*. They are both UKCP-registered family therapists. Jan is also a trained social worker and has her own independent practice. Arlene is an academic and clinical psychologist, based at the University of Surrey, UK.

**Laura Dreuth Zeman** is licensed as a clinical social worker in Tennessee and is a tenured associate professor in social work and women's studies at Southern Illinois University, Carbondale. She earned a bachelor's degree in sociology emphasizing women's studies at Indiana University in Bloomington and later earned an MSW from the Jane Addams College of Social Work at the University of Illinois at Chicago, with a concentration in mental health. She earned a PhD from Vanderbilt University, Peabody College of Education and Human Development, in policy development and program evaluation. She completed her 2 years of post-master's clinical training at an acute and residential treatment psychiatric facility in Nashville, Tennessee. Her practice incorporated recovery and psychotherapeutic care for individuals and families recovering from sexual assault, mental illness, and substance abuse. Her research seeks to enhance consumer self-determination and well-being through improved understanding and policy across school, hospital, and community care settings.

## Foreword

The publication of this casebook represents an achievement of extraordinary scope in which John Hamel brings gender-neutral treatment of domestic violence out of the closet. This book provides readers with the opportunity to learn how experienced therapists are actually using a systemic perspective in responding to domestic violence. To provide understanding of how innovative this book is, I begin with my own story.

From 1982 to 1985, while I was working on my doctorate in marriage and family therapy, I facilitated a support group for victims of domestic violence at the local shelter. The women at the shelter made the research I was reading for my dissertation on police response to domestic violence come alive. I learned from these women about the terror in which they lived and the myriad ways their partners controlled and terrorized them. Even though I was preparing to become a marriage and family therapist and a faculty member in a marriage and family therapy program, it seemed clear to me that the primary way we (i.e., marriage and family therapists) could be useful clinically in these situations was to support victims (female) in their efforts to get out of violent homes and to support them in rediscovering their strengths and resiliencies. I taught an undergraduate course in domestic violence in the early 1980s and remember saying, “Once a batterer, always a batterer.” I did not see couples therapy as a potentially useful resource. In fact, I thought couples therapy for domestic violence was a dangerous practice advocated only by people who did not know what I knew from my work with terrorized victims.

I remember being surprised when I read Dan O’Leary and his colleagues’ 1989 paper that indicated that the trajectory of violence is not consistent and that some offenders use violence in one period of their relationship, but not again. This research was the first that I remember making me wonder if the beliefs I firmly held about the dynamics of domestic violence (e.g., once a batterer, always a batterer) were accurate. In 1990,

in an effort to encourage my students at Virginia Tech to use data collected by our family therapy clinic to inform their work, we sought to create a profile of presenting problems, compared with problems that were revealed by the end of treatment. Students went through all of our clinical files and came up with percentages of each category of problem. Even though I thought we did not treat couples who were experiencing domestic violence, I was surprised to find that at intake, 10% of the couples who came to our clinic indicated that there had been some violence in their relationships. Even more surprising was that a thorough review of our files indicated that in 40% of the couples we saw, physical violence was, or had been, an issue in their relationships (Stith, Rosen, Barasch, & Wilson, 1991). Articles appeared by Dan O'Leary and also by Amy Holtzworth-Munroe indicating that with careful screening, family therapy clinics were seeing even higher numbers of violent couples. It soon became clear to me that even though family therapists may think they do not treat violent couples, they do. As much as I preferred to stay out of this controversial arena, I began to think that the ethically responsible approach for family therapists to take was to carefully measure the safety and effectiveness of the treatment we provide for violent couples. In 1997 my colleagues Eric McCollum and Karen Rosen and I sought and received funding from the National Institutes of Health (NIH) to develop and pilot a treatment program for couples in which violence had occurred. In 2000 we began speaking about our work, and in 2004 we published our first outcome report from this work (Stith, Rosen, McCollum, & Thomsen, 2004).

Everywhere we went within the United States and Canada, Europe, and South America to present our clinical work with violent couples, family therapists spoke with us about how affirming both our research and our speaking out about our work was to them. They often whispered to us that they were also doing this work but did not want people to know they were doing it because they might think they were doing something unethical. As we continued to hear the same message, we were reminded of the early family therapists who bravely experimented with interviewing multiple members of a family in the same room at the same time. This type of clinical work was a direct challenge to the prevailing ideology that suggested that a therapist's contact with anyone in the family other than his or her own patient broke the critical patient-therapist confidentiality and was unethical (Goldenberg & Goldenberg, 2004). When the first family therapists met and began to share the experimental work they were doing, the family therapy movement blossomed and grew.

Hamel, in this book, has brought the systemic work with domestic violence that is being practiced all over the world out for public view. His earlier groundbreaking book, *Family Interventions in Domestic Violence*, provided important empirical support for the importance of taking a more systemic, gender-inclusive, and client-focused approach to working with domestic violence. This book furthers the dialogue and offers more detailed case examples of ways experienced clinicians are intervening systemically with clients. Some of the work described in this book really resonated with me and has challenged me to think about ways to adapt what we are doing to incorporate ideas shared by these practitioners. I would not have made the choices some of the authors made in working with violent families. But regardless of whether I agree with the choices made by some of the authors, I applaud their courage in being willing to put their work up for scrutiny. Sharing our work and being willing to talk about what we do is the first step in improving the way we work with domestic violence. My bias is that the next step is to carefully measure the effectiveness of our work as clinicians and to increase the number of empirically valid outcome studies. When we are facing ideological pressure against working systemically with domestic violence, it is crucial that we be able to document the effectiveness of our work. I applaud Hamel's effort to bring systemic, gender-inclusive treatment of domestic violence out of the closet and into the mainstream!

*Sandra M. Stith, PhD, LCMFT  
Professor and Program Director  
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# Introduction

JOHN HAMEL

In *Family Interventions in Domestic Violence: A Handbook of Gender-Inclusive Theory and Treatment* (2007), my recent volume coedited with Tonia Nicholls, we featured a number of treatment approaches to intimate partner and family violence that challenge the current policy and intervention paradigm. Unlike traditional models of treatment, limited primarily to psychoeducational groups for male offenders, many of them rooted in feminist theories of patriarchy, these alternative approaches are more broadly evidence based and are reflective of a systemic and *gender-inclusive* orientation that recognizes that males and females can be victims or perpetrators or both.

Also, whereas traditional groups are often facilitated by peer counselors and others with limited or no training in the mental health fields, paradigm-alternative treatment can be conducted only by licensed mental health professionals who have the requisite knowledge in child and human development, psychopathology, and interpersonal and family-systems issues to address the wide range of risk factors and issues associated with intimate partner and family violence and to work in the various modalities of individual, couples, and family therapy. This is not to suggest that psychoeducational groups are of no value; properly conducted, they can be an integral and effective part of an overall treatment strategy and, for some clients (e.g., partner has left or is uncooperative), the most sensible treatment option.

It is the purpose of this book to showcase these and other paradigm-alternative approaches through extended, detailed case examples. The book is primarily intended for clinicians who work with either court-mandated or voluntary domestic violence cases and for students taking graduate-level classes in the mental health fields, but it may also be of value to anyone concerned with domestic violence public policy, prevention, and intervention.

Chapter contributors were solicited from nationwide e-mail lists of batterer intervention providers and attendees at a major domestic violence conference, as well as members of the Family Therapy Academy across the United States and Canada. Additional contributors were recruited from classified ads placed in publications of three major mental health professional organizations—National Association of Social Workers, California Association of Marriage and Family Therapists, and the American Psychological Association. The British, Australian, and Swedish contributions came from my own personal contacts.

## CONTRIBUTOR GUIDELINES

Potential contributors were required to be licensed mental health professionals and to have substantial clinical experience and training in the field of family violence. This training could be formal (e.g., classes, extensive supervision, certification) or “on the job,” the clinician having worked with numerous family violence cases and having obtained additional information by reading books and articles, going to conferences and workshops, and so on. They were required to eschew a rigid gender-paradigm perspective, acknowledge that family violence is a complex phenomenon in which both males and females, parents and children, can be perpetrators or victims, and regardless of the theory or theories guiding their clinical interventions, provide treatment based on a sound assessment and “where the client is.”

I asked of the clinicians that they write about a case involving partner violence or other family violence, preferably one in which they saw more than one family member for at least part of the time. Although looking primarily for treatment successes, I welcomed examples of treatment failures, so long as the cases were inherently interesting and other clinicians could learn from them. Diversity of cases was also sought, in terms of presenting problem, ethnic and socioeconomic status, sexual orientation, extent and type of abuse, types of stressors and mental health

issues, and whether the clients were voluntary or referred through the criminal justice system.

Each chapter was required to include an introductory section containing information on the clinician's agency or practice and theoretical orientation, including research references; a description of the client(s) and family; assessment procedure; treatment goals and reasons for selecting a particular approach, with a particular consideration of client safety; and an account of the course of treatment. To protect client privacy and confidentiality, the authors were asked to not use real names and to not give any information that would clearly reveal client identities.

## **STRUCTURE OF THE BOOK AND OVERVIEW OF THE CHAPTERS**

The book is divided into five parts. In the introductory chapter, I review the research literature and make the case for paradigm-alternative approaches to treatment. The subsequent sections, containing the extended case examples, are "Work With Individuals and Couples," "Work With Families," "Multicultural Aspects in Partner Violence," and the last chapter and section, "Supervision in Domestic Violence Casework," by Vetere and Cooper, which should be of particular interest to individuals working in agency settings.

Altogether, the chapters reflect a wide range of family violence cases. The focus in two of the chapters is on abuse between a parent and child (an adolescent in one case, an adult in the other); all the others involve abuse between intimate partners, and in a majority of the cases there are multiple perpetrators and victims, crossing generational lines. Except for a few cases in which the violence is severe and chronic, most of the cases involve mild to moderate levels of violence and mutual abuse, and the numbers of male and female perpetrators are roughly equivalent, reflective of known prevalence rates in Western industrialized countries.

Five of the chapters come from outside of the United States (two from Canada; the others from the UK, Sweden, and Australia). A total of 20 authors or coauthors contributed; they are clinicians in private practice or employed by various agencies, with some also holding teaching positions at a university. Eight are marriage and family therapists, and there are six licensed clinical social workers, five clinical psychologists, and one MD psychiatrist. A number of the authors have been previously published, and for others their contribution to this casebook represents

their first opportunity to see their work in print. Couples and family therapy are the modalities most frequently written about, although a number of clinicians also saw clients individually, and two worked with the client within a psychoeducational group format. In many chapters, more than one modality was utilized, and the group format was sometimes a precursor to, or used in conjunction with, individual and conjoint sessions. Other than the absence of African Americans, there is diversity in terms of ethnic background and socioeconomic status. I was also unable to find a suitable case of same-sex abuse.

A reference guide to the chapters can be found in Table I.1, with summarized information on each, including agency or practice location, client background, type of abuse, other issues and risk factors, modality of treatment, and theoretical perspectives. A set of questions can be found at the end of each chapter, intended to stimulate discussion and deepen the reader's critical understanding of the cases described. In reading this casebook, the reader is also advised to answer the following general questions:

- 1 Did the author(s) adhere to the suggested guidelines?
- 2 Did their treatment include safety precautions for victims?
- 3 Was treatment based on an understanding of the family violence literature and what the literature suggests would be promising approaches?
- 4 Was treatment effective in eliminating or reducing the abuse?
- 5 To what extent did the treatment contribute to an amelioration of the underlying issues involved?

Intimate partner and family violence is a significant social problem, and current research indicates that the prevailing domestic violence paradigm is seriously flawed, its core concepts unsupported by research and the treatment models based on them limited in their effectiveness. The contributing authors of this casebook make a compelling argument for evidence-based, gender-inclusive, multimodal, and systemic approaches. It is my hope that in reading these cases, you will be inspired to utilize these techniques in your own practice. In doing so, you will have done more than expand your treatment options—you will also be able to take satisfaction in knowing that you are not alone, that the work you are doing reflects a growing, historic trend in the field, a trend that is at once exciting and rich with promise.

Table I.1

**GUIDE TO CHAPTERS**

**PART II: WORK WITH INDIVIDUALS AND COUPLES**

<b>Author</b>	<b>Location</b>	<b>Clients' Background</b>	<b>Abuse Type</b>	<b>Other Issues, Risk Factors</b>	<b>Client(s) Seen? Modalities</b>	<b>Clinicians' Theoretical Perspectives</b>
Ball, Derek; Hiebert, William	Rock Island, IL, USA	White, upper middle-class couple	Husband emotionally abusive	Financial problems	Conjoint; individual with husband	Family systems, psychoeducational
Caplan, Tom	Montreal, Canada	White, blue-collar couple with children	Husband physically abusive; wife verbally abusive	Alcohol abuse; acting-out by young children	Conjoint; husband in perpetrator group	Cognitive-behavioral, motivational, narrative, emotion-focused
Flemke, Kimberly	Philadelphia, PA, USA	White, upper middle-class couple	Female physically abusive; mutual emotional abuse		Individual	Bowenian, family systems, object relations, feminist, experiential
Heru, Alison	Providence, RI, USA	White, blue-collar couple	Mutual physical and emotional abuse	Alcohol abuse; depression	Conjoint	Problem-centered systems therapy

(Continued)

Table I.1 (Continued)

**GUIDE TO CHAPTERS**

<b>PART II: WORK WITH INDIVIDUALS AND COUPLES</b>						
<b>Author</b>	<b>Location</b>	<b>Clients' Background</b>	<b>Abuse Type</b>	<b>Other Issues, Risk Factors</b>	<b>Who Seen? Modalities</b>	<b>Clinicians' Theoretical Perspectives</b>
Mesmer, Michael	Northern California, USA	White, middle-class couple	Female physically and emotionally abusive		Group, couples	Motivational, cognitive-behavioral, attachment
Zeman, Laura Dreuth	Nashville, TN, USA	White, blue-collar couple with child	Female physically abusive; male physically, sexually, and emotionally abusive	Financial concerns; alcohol and drug abuse; custody issues	Conjoint and individual with female	Family systems (Satir), cognitive-behavioral
<b>PART III: WORK WITH FAMILIES</b>						
Bowen, Ellen L.	Santa Rosa, CA, USA	White, middle-class fundamentalist Christian couple with children	Husband physically abusive; mutual emotional abuse; child abuse	Daughter's depression; husband's drinking, use of pornography; son's school problems	Conjoint with couple; individual with daughter, wife, and husband	Family systems, psychoeducational, insight-oriented, cognitive behavioral
Bunston, Wendy	Melbourne, Australia	White, middle-class couple with infant daughter	Wife physically and verbally abusive toward husband; threatening toward infant daughter	Unemployment	Mother, child in separate groups; conjoint with mother and father	Systems, attachment

Cohen, Karen	Southern California, USA	Latino, blue-collar couple with son	Mutual physical abuse	Alcohol abuse; child welfare issues	Multifamily couples group	Intergenerational; structural family therapy; cognitive-behavioral
Gutierrez, K. Kerstin	Northern California, USA	White and Mexican American middle-class couple	Physical abuse mostly by male partner; mutual emotional abuse	High-conflict divorce; drug abuse	Co-parenting conjoint counseling	Attachment, psychoneurobiological, family systems
Lieb, Catherine	Sacramento, CA, USA	White, middle-class couple with children	Husband physically abusive; mutual emotional abuse; mutual abuse between parents and children	Sibling molestation; husband's health, depression, and use of pornography; wife's depression; son's ADD, PDD	Family therapy; conjoint with husband and wife; individual with son, mother	Bowenian intergenerational, family systems, experiential (Gestalt), psychoeducational, feminist
PART IV: MULTICULTURAL ASPECTS IN PARTNER VIOLENCE						
Author	Location	Clients' Background	Abuse Type	Other Issues, Risk Factors	Who Seen? Modalities	Clinicians' Theoretical Perspectives
Anderson, Melissa C.	San Francisco, CA, USA	Middle-class, East Indian immigrant family	Elder abuse; mutual emotional abuse	Mother's physical health, property dispute	Conjoint; individual with mother, daughter, and son-in-law	Intergenerational, family systems, insight oriented

(Continued)

Table I.1 (Continued)

## GUIDE TO CHAPTERS

PART IV: MULTICULTURAL ASPECTS IN PARTNER VIOLENCE						
Author	Location	Clients' Background	Abuse Type	Other Issues, Risk Factors	Who Seen? Modalities	Clinicians' Theoretical Perspectives
Bloom, Lori	Mendocino, CA, USA	White and Native American, blue-collar couple with son	Physical abuse by female; emotional abuse by male	Alcohol and drug abuse; custody dispute	Domestic violence perpetrator group	Family systems, psychoeducational, humanistic, experiential (Gestalt/psychodrama)
Carranza, Mirna E.	Ontario, Canada	Sudanese Muslim; blue-collar couple with children	Husband physically abusive to first wife; first wife abusive to children; second wife abusive to husband	Immigration adjustments	Conjoint with husband and first wife; conjoint with husband and second wife	Family systems, motivational, narrative
Klugman-Rabb, Jodi	Northern California, USA	Middle-class couple of Swedish and Armenian descent with child	Husband physically and emotionally abusive toward wife and son	Son's juvenile justice problems; husband's ADD diagnosis	Family therapy	Intergenerational, structural family therapy, cognitive-behavioral

Pratt, Darlene	Berkeley, California, USA	Middle-class White and Hawaiian/Japanese couple with child	Wife physically and emotionally abusive toward husband; wife verbally abusive to daughter; husband abusive to wife	Alcohol abuse; presence of younger child	Domestic violence perpetrator group for wife; individual counseling for each family member	Psychoeducational, family systems, insight-oriented
Söderquist, Martin; Gunnehill, Bo	Sweden	White, Swedish mother and son	Mutual physical abuse by mother and son	Alcohol abuse; juvenile justice problems	Conjoint with mother and son	Motivational, solution-focused, family systems

#### PART V: SUPERVISION IN DOMESTIC VIOLENCE CASEWORK

Vetere, Arlene; Cooper, Jan	UK	White, British, blue-collar woman and children	Female physically and emotionally abused	Financial concerns; presence of young children; alcohol and drug abuse	Consultation to social services working on case	Family systems, feminist
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# Introduction

PART  
I

# 1

## Beyond Ideology: Alternative Therapies for Domestic Violence

JOHN HAMEL

### THE POLITICS OF ABUSE

Domestic violence, also known as intimate partner abuse or intimate partner violence (IPV), has been recognized as a major public health problem, addressed through the collective efforts of national and state policy makers, law enforcement and the courts, social service organizations, and mental health professionals. The emphasis has been on a vigorous law-enforcement response with rigid distinctions between perpetrators, who are viewed as solely responsible for their actions, and victims, who are regarded as blameless and deserving of protection and assistance. Arrested perpetrators, overwhelmingly male, are incarcerated or mandated to complete a batterer treatment program, usually consisting of a same-sex psychoeducational group and often based on theories of patriarchy (e.g., the Duluth model; Pence & Paymar, 1993); their female victims are referred to shelters and other organizations where they obtain refuge, counseling, legal help, and other services.

This public policy approach has not been entirely effective. Although one source of IPV statistics, the National Crime Survey conducted by the U.S. Department of Justice, indicates that domestic violence assaults have dropped sharply since the early 1990s (Rennison, 2003), the decline has paralleled that of overall assaults in the United States (Davis, 2008). Furthermore, the preferred modality of offender treatment, same-sex

group batterer intervention programs, or BIPs, has not been found to be significantly more effective in reducing rates of recidivism than arrest and monitoring by probation (Babcock, Canady, Graham, & Schart, 2007).

Recently, some family violence scholars and clinicians have explained this public policy failure as a consequence of what has become known as the *patriarchal paradigm*, or *gender paradigm*, a set of beliefs derived from feminist sociopolitical theory that has dominated the field for the past three decades and driven public policy and treatment as well as research, education, training, and primary prevention (Dutton, 2006, 2007; Dutton & Nicholls, 2005; Hamel & Nicholls, 2007). The paradigm justifies high rates of male arrests because domestic violence is assumed to be rooted in patriarchal social structures that presumably support and encourage individual men to maintain their status and privilege in the home through dominance and, when necessary, emotional and physical abuse. Thus, BIPs became the preferred intervention option, in contrast to traditional individual or family therapy, because both intrapsychic and relationship- or family-level systemic factors were dismissed as etiologically irrelevant, and the task of “reeducating” violent men to abandon their sexist ways could be more efficiently accomplished in the group setting. Indeed, there has been a consistent trend, driven primarily by coalitions of battered-women advocates and BIPs, toward institutionalizing the same-sex group format into the standards regulating batterer intervention in the various states (Austin & Dankwort, 1999; Maiuro, Hagar, Lin, & Olson, 2001).

From a mental health standpoint, the pervasiveness of the paradigm in the research literature and most professional trainings has stymied the efforts of family violence therapists to provide evidence-based treatment, including those working with cases involving clients not referred through the criminal justice system, cases in which the clinician is not legally restricted to the one-size-fits-all group model. A 1994 op-ed article in *Social Work*, the premier journal for social workers, was subtitled “The Case Against Couple Counseling in Domestic Abuse” and concluded rather tersely with the view, now thoroughly discredited, that “arresting batterers is actually the most effective ‘therapeutic’ intervention yet discovered” (Golden & Frank, 1994, p. 637). Restricted in their choice of techniques and modalities, it is not surprising that many clinicians find themselves reluctant to comfortably proceed with treatment and refer to paradigm-bound BIPs.

Still, mental health professionals should be aware that couples counseling and family counseling are not universally prohibited. A recent

Internet search by this author of batterer intervention standards nationwide, with a sample of 41 states, found that although couples counseling is permitted as part of a comprehensive court-mandated batterer intervention program in only 15 states (36.6%), it is allowed as an adjunct, or implied as an adjunct, to BIPs in 11 states (26.8%) and is allowed after completion of group session in 15 states (36.6%).

## Paradigms and Pioneers

Policies and interventions based on the patriarchal paradigm are doomed to fail because the paradigm is first and foremost an ideology; empirical findings that might disconfirm its tenets are ignored, explained away, or sometimes cited as evidence of a “backlash” by apostates who are seen at best as dangerously ignorant or at worst as actively seeking to undermine the rights of women (Dutton & Corvo, 2007). Recent works by Felson (2002), Mills (2003), Hamel and Nicholls (2007), and Dutton (2006) have called attention to this neglected body of research findings.

From the early years of the battered women’s shelter movement, evidence has been amassing in challenge to the patriarchal paradigm, particularly the large-scale population surveys conducted by Murray Straus and his team at the University of New Hampshire Family Violence Research Laboratory (Straus, Gelles, & Steinmetz, 1980) and the work of Erin Pizzey, founder of the battered women’s shelter movement (Pizzey, 1974, 1982). Straus and his colleagues found equal rates of verbal and physical assaults between intimate partners and determined that domestic violence is a complex phenomenon, with multiple etiological explanations, primary among them the dysfunctional and abusive patterns of behavior learned in one’s childhood of origin (they also found much higher rates of physical injuries to female victims, which current research estimates to be at a ratio of approximately 2:1 over men—and higher for injuries requiring medical attention; Archer, 2000; Tjaden & Thoennes, 2000). Pizzey, who in her women’s refuge in England took in some of the most severe abuse cases, observed that half of these women had their own problems with rage and had been violent to their husbands, their children, or both.

Treatment models soon emerged that would take these and similar findings into account. Saunders (1977) challenged the theory of catharsis, at that time the prevailing view of aggression derived from psychoanalytic writings, as disempowering to the offender and endorsed both

a social learning and systemic view. Recognizing the complexity and heterogeneous nature of IPV, he wrote, “Each case of marital violence needs to be assessed separately. No simple, recurring pattern emerges from case material on the development of intramarital violence, and it is likely that none exists” (p. 45). Saunders stressed the importance of a proper assessment to determine levels of dangerousness. Therapy goals with abusive couples included teaching problem-solving and communication skills, increasing awareness of anger cues, and changing the consequences of violence (e.g., calling the police). Curiously, despite offering research evidence and even a case example of female-perpetrated abuse, the author succumbed to the prevailing view at the time, that victims are nearly always women.

Deschner (1984) favored a phased approach in working with abusive couples, in which the partners were relegated to separate same-sex groups prior to coming together in skills-building, multi-couples groups. Neidig and Friedman (1984) also advocated a skills-building approach and the use of a multi-couples format. More importantly, they drew from theories of family therapy and called attention to systemic factors in IPV and the phenomenon of circular causality, eschewing rigid perpetrator–victim distinctions. In their view, labeling either partner a victim is to disempower that person and tacitly support efforts to seek retribution, thus guaranteeing a continuation of the abuse cycle.

“Blaming the abuser,” wrote Flemons (1989), “is perhaps a more morally defensible position than blaming the abused, but it keeps us caught in the same dichotomous, either/or logic of attribution” (p. 5). Comparing domestic abuse to a manufacturing plant that dumps toxic waste into its community water supply, the author pointed out that it is easy to blame the offender and fine it, but the company is then likely to simply increase the cost of its product to offset the fines, a cost that is passed on to the consumer, and in the meantime the company finds other ways to save to the detriment of consumer safety. Ultimately, everyone pays.

Who is responsible? We all are. We all benefit from the short-term benefits of industries which exploit the environment. . . . By affixing blame on a single company or on industry in general we obfuscate the cybernetic nature of systemic relations and allow the exploitation to continue. However, if we take the notion of “responsibility” not as an opportunity to blame but rather as a call to action, we enable ourselves to awake from the passing stupor engendered by the label “victim.” (p. 7)

Margolin (1979) highlighted the reciprocal nature of domestic violence, noting that abuse by one partner, according to social learning principles, often produces compliance in the other. Furthermore, if abuse “works” for one partner, it can work for the other. Margolin correctly understood IPV as consisting of both physical and psychological components:

Careful exploration of a couple’s history with violence may reveal that both spouses have contributed to the escalation of anger with one spouse being the more verbally assaultive while the other is the more physically abusive. This places each partner in the role of both abuser and victim. The therapist can use this information to acknowledge each partner’s pain and confusion as a victim as well as to help each partner accept responsibility for any actions that accelerated the abusiveness. The therapist can also reattribute the violence as a mutual problem rather than the fault of one partner. The goal of this reattribution is not to relieve either partner of responsibility for what has happened but to elicit both spouses’ cooperation in seeing that the abusiveness is stopped. (p. 16)

Like Saunders (1977), Margolin was equally concerned about safety and understood the limits of the conjoint format. However, she did not seek to minimize female-perpetrated IPV. Her treatment for couples, remarkably sophisticated and progressive for its time, comprised a multipronged, comprehensive approach consisting of identifying the cues that contribute to angry exchanges, developing a plan of action to interrupt the conflict pattern, de-cuing the victim (making victims aware of how their responses help maintain the abuse), modifying faulty cognitions regarding relationship functioning (e.g., unrealistic expectations), developing problem-solving skills, and improving the general tone of the relationship.

## **Feminist Critiques**

Feminists were quick to criticize the couples format and systemic theories. According to Taggart (1985), for instance, systems theories do not adequately address issues of concern to women, such as battering, rape, and incest. James and McIntyre (1983) make the salient point that although family therapists were right in identifying the limitations of psychodynamic theories that studied the individual outside of the context of his intimate relationships, they made the same mistake in failing to

acknowledge the broader context beyond the family system (i.e., the influence of the broader society and specifically its patriarchal structures that sanction male violence against women). “Systems theory,” they wrote, “is a theory about the maintenance of problems—it is not a theory of causation” (p. 123).

Similar objections to systemic theory, reviewed in Hamel (2005, 2007), include Hansen and Harway’s (1995) observation that family systems approaches too easily pathologize women by not taking social roles into account (e.g., the normal role of mothering is regarded as “overinvolvement”) and Bograd’s (1984) assertion that systems conceptualization and language fail to capture the human dimension of abuse (e.g., women do not stay in abusive relationships because of the “needs of the system,” but rather out of fear and lack of resources).

Despite the chilling effect that the patriarchal paradigm has had in the field of domestic violence, feminist critiques of systems theory should not be readily dismissed. Many critiques, such as those just discussed, are quite reasonable and have helped further the growth of the family therapy field, especially when integrated into more comprehensive, evidence-based models.

Cook and Cook (1984), for instance, saw no contradiction between the feminist position that a battering husband is entirely responsible for his violence and the systemic view of the couple locked into a pattern of dysfunctional dynamics, in a recurrent cycle that serves to maintain the violence. They shared feminist concerns about safety risks when the therapist assigns equal blame to both partners in cases of unilateral male battering. Echoing the precautions put forth by Saunders (1977) and Margolin (1979), the authors offered this perspective:

While there is experiential evidence to support this concern, we do not feel that the problem lies in the systemic approach to couple counseling *per se*. But there is a need for marital and family therapists to become aware of the special nature of battering problems and the necessity in most such cases to separate the couple for individual or segregated group treatment in the initial phases. (p. 84)

## Evolving Research

What, then, exactly is the “special nature of battering problems”? From interviews with severely battered women, Walker (1979, 1983) identified a three-phase cycle of abuse in which the male batterer experiences

a period of mounting internal tension (the first phase), eventually to explode in a verbal or physical assault upon the victim (the second phase). In the third phase, the male batterer experiences remorse, the abuse stops, and a period of reconciliation ensues, until the next cycle. Because the abuse is thought to be driven exclusively by factors internal to the batterer, rather than through a process of mutually escalating conflict, those factors would have to be addressed right from the outset. The question as to whether this work should be done concurrent to any couples or family sessions, or at some point later in the treatment, should be made on a case-by-case basis, and the therapist should be guided not only by considerations of physical and emotional safety but also by practical considerations—for example, can the batterer realistically attend to systemic factors and general relationship issues while identifying, accepting, controlling, and working through his or her rage and violence?

### *Issues of Patriarchy*

According to the patriarchal paradigm, what drives these men is a need to dominate out of gender privilege. However, research suggests that although this may be the case for some men, battering, characterized by a chronic pattern of physical violence leading to injury in combination with the use of controlling and emotionally abusive behaviors, is essentially a product of disordered personality. Typology research (e.g., Holtzworth-Munroe & Stuart, 1994) has identified these men as either depressed with borderline features or having antisocial tendencies, and a growing number of studies of female batterers have yielded a similar profile (Babcock, Miller, & Siard, 2003; Henning, Jones, & Holdford, 2003; Simmons, Lehmann, Cobb, & Fowler, 2005). Sexist male attitudes *have* been linked to male-perpetrated IPV, but mostly in countries where the status of women is economically and politically low relative to men (Archer, 2006). Patriarchal factors and sexist male attitudes do not distinguish male IPV perpetrators from other men (Sugarman & Frankel, 1996), and there is no support for the view that most men endorse the use of IPV (Simon et al., 2001). In fact society is significantly more supportive of female-perpetrated IPV (Arias & Johnson, 1989; Straus, Kaufman-Kantor, & Moore, 1997).

Straus and Yodanis (1996) found that hostile attitudes toward the opposite sex were significantly correlated with female-perpetrated IPV but not with male-perpetrated IPV. Results of the International Dating Survey (Straus, 2006) indicate that there is a significant correlation

between attitudes of dominance (e.g., “My partner needs to know that I am in charge”) and partner violence for both males and females; the National Family Violence Survey found correlations between relationship dominance (measured as who has the final say in important family decisions) and IPV for husbands and for wives (Coleman & Straus, 1990); and a reanalysis of the National Violence Against Women Survey found that controlling behaviors predict physical assault equally for men and women (Felson & Outlaw, 2007)—these findings suggesting that it is the need to dominate and control, not patriarchy or male sexist ideology, that is at issue. Even in the most patriarchal countries, there is evidence of high levels of female violence, perpetrated for a variety of reasons, especially sexual jealousy (Archer, 2006; Pandey, 2007). This is because institutional power does not necessarily translate to personal power in any given home, because personal power is derived from the strength of one’s personality and is not therefore gender-bound, and because dominance is also related to relationship power, or the extent to which one party is dependent (e.g., economically, emotionally) on the other (Felson, 2002). Indeed, the numbers of male and female perpetrators who engage in both controlling behaviors and physical violence upon their partners—one definition of battering and also known as *intimate terrorism* (Johnson, 2000; Johnson & Leone, 2005)—are comparable (Felson & Outlaw, 2007; Graham-Kevan, 2007).

Clearly, same-sex batterer groups may be an appropriate treatment choice for some of these personality-disordered, dominant batterers, but many would benefit from intensive individual psychotherapy in lieu of, or in addition to, the group work. Partner-violent adults who have been raised in abusive homes carry within them feelings of shame, which they experience as anger and rage, and in their relationships they are as insecurely attached to their intimate partners as they were to their primary caregivers. Research by Follingstad, Bradley, Helff, and Laughlin (2002) suggests that intimate partner anger is related to anxious attachment and that aggressive males and females alike use coercive tactics as a means of preventing abandonment. For some individuals, the healing process of overcoming shame and building secure attachments can be accomplished only in the safety and security of the therapeutic relationship (Sonkin & Dutton, 2003).

Are societal factors therefore irrelevant? Research has documented the correlation, for instance, between perpetration of IPV and poverty (Hotelling & Sugarman, 1986; Straus & Gelles, 1990) and attitudes that support the use of violence (Sugarman & Frankel, 1996). Traditional

attitudes may not distinguish abusive men from nonabusive men, but these attitudes have not entirely gone away. Abusers are driven primarily by personal characteristics, but some may *justify* their violence on the basis of gender. This is the case both for men, who may expect of their spouses unlimited quantities of “feminine” patience, love, and understanding, and for women, who may excuse their violence on the grounds that “he should be able to take it” (Cook, 1997; Fiebert & Gonzalez, 1997). These conditions cannot be understood simply through an individual-level or family analysis. Expanding on the work of Bronfenbrenner and Belsky, Dutton (2006) has provided mental health professionals a useful description of the multiple etiological roots of IPV. In this ecological model, the risk factors relevant to IPV for any particular individual can be found at different levels (see Table 1.1).

The work of Bronfenbrenner and Belsky (Belsky, 1980; Dutton, 2006) has paralleled a reformist trend in the field of family therapy, advanced by a number of reform-minded researchers and practitioners; consequently, mental health professionals are today less preoccupied solely with the immediate family system and are free to fashion more sophisticated and effective interventions (Carlson, Sperry, & Lewis, 2005).

### *Interpersonal Dynamics: The Complexities of IPV*

In determining the “special nature of battering problems,” one must pay special attention to the microsystem because it is at this level where

Table 1.1

#### **ECOLOGICAL MODEL OF IPV**

- *Macrosystem* (broader society)—Cultural beliefs supportive of violence and IPV; empowerment of women relative to men
- *Exosystem* (environment, neighborhood)—Job, life stress; undereducated, unemployed, lack of positive support systems, negative peer influence
- *Microsystem* (the relationship and family)—Either partner dominates; high conflict and relationship dissatisfaction; substance abuse; spiraling negative interactions
- *Ontogenetic Level* (the individual)—Need to dominate partner; pro-violent beliefs; insecurely attached; had violent role models, was shamed by parents; has poor impulse control, poor conflict-resolution skills; jealous and suspicious of other’s motives

abusive relationships play themselves out. The most commonly recognized battering dynamic is the three-phase cycle postulated by Lenore Walker (1979, 1983). However, it is hardly the only battering dynamic. Batterers with antisocial tendencies, for example—what Jacobsen and Gottman (1998) called *cobras* (in contrast to the equally dangerous *pit bulls*)—do not experience tension release upon assaulting their partner or contrition. Furthermore, Jacobsen and Gottman found that in some abusive relationships, which they called “Bonnie and Clyde couples,” both partners engage in serious, repetitive abuse, with no clear victim or perpetrator. In the typology put forth by sociologist Michael Johnson (2000), these couples would fall in the category of *mutual violence control*, indicating that both perpetrate serious physical violence on the other, as well as high levels of controlling and emotionally abusive behaviors. This type of mutual battering can be found not only in the general population but also to a large extent among couples where the man has been court-ordered to complete a BIP (Stacey, Hazelwood, & Shupe, 1994).

Johnson (2000) postulated another IPV category, *common couple violence*, referring to abuse that occurs within the context of a mutually escalating conflict, does not lead to serious injuries, and does not involve high levels of emotional abuse and control. This constitutes by far the greater proportion of IPV and is the type of abuse most amenable to systemic interventions involving the couple or family. As useful as these distinctions may be, however, they are hardly clear-cut. For instance, Simpson, Doss, Wheeler, and Christensen (2007) interviewed 273 couples seeking marital therapy and found empirical support for a two-category typology consisting of a low-level violence and physical injury group and a moderate-to-severe violence and physical injury group, roughly comparable to Johnson’s intimate partner terrorism and common couple violence. They also found in the low-level violence group a number of highly emotionally abusive couples who really fit a batterer profile and in the moderate-to-severe violence group many couples who infrequently engaged in emotional abuse and would fit more closely into the category of common couple violence.

Unlike Walker, whose three-phase battering cycle was derived exclusively from interviews with victimized women, other researchers during the 1990s found evidence of other cycles, some from self-report questionnaires and interviews with both the male and the female partner (e.g., Cascardi & Vivian, 1995) and others from observations of high-conflict and abusive couples in the laboratory. From this research we know, for example, that marital aggression typically reflects “an

outgrowth of conflict between both partners” (Cascardi & Vivian, 1995, p. 265), and that couples engage in *negative reciprocity*, characterized by attack–defend cycles in which insults and criticisms are met with a similar response (Burman, John, & Margolin, 1992), or by demand–withdraw cycles in which demands by either partner result in the other’s withdrawal, thereby fostering resentments and guaranteeing a continuation of the power struggle (Babcock, Waltz, Jacobsen, & Gottman, 1993). A study by Jacobsen et al. (1994), whose sample of couples was selected for the existence of a battering husband, found that husbands are more domineering, but wives are more angry, belligerent, and contemptuous, and many of them would qualify for batterer treatment themselves.

It may be presumed that when conflict escalates to high levels, the female partner is more vulnerable to physical harm because of her usually (but not always) lesser strength and the possibility that the man’s rage might overwhelm whatever chivalry and self-control he may have. There is evidence that at high levels of conflict, the woman is more likely than the man to withdraw (Ridley & Feldman, 2003), and at least one study (Jacobsen et al., 1994) found that once the man becomes violent, there is little that the woman can do to stop it. Nevertheless, a recent large-scale national survey found that in reciprocally violent relationships, men actually incur somewhat higher rates of physical injuries in comparison to women (25.3% vs. 20.0%; Whitaker, Haileyesus, Swahn, & Saltzman, 2007).

An exhaustive self-report study of 153 partner-violent women by Ridley and Feldman (2003) concluded,

The results reported here largely confirm that conflict-based communication responses and outcomes contribute to female domestic violence as well as male domestic violence (Feldman & Ridley, 2000). . . . Results regarding mutual verbal aggression are consistent with the findings of observational studies of domestic violence which suggest that attack-counterattack interactional sequences appear to be far more emotionally and behaviorally escalating than other types of negative communication sequences (Burman et al., 1992, 1993; Cordova et al., 1993; Sabourin, 1995). Research suggests that verbal aggression may escalate into physical aggression because (a) couples tend to “lock in” to dominant reciprocal response patterns, such as crosscomplaining and invalidation loops, contempt, defensiveness, and stonewalling (Gottman, 1979, 1994); (b) arguments tend to progress through three levels of escalation, the issue level, the personality level and the relationship level, each more difficult to address and contain (Stuart, 1980); (c) there is a high probability of retaliation in order to save face and

prevent future attacks, particularly when the receiver believes the initial attack was intentional and illegitimate (Infante, et al., 1990; Roloff, 1996); and (d) the negative physiological and affective arousal of one partner, generated in verbally aggressive interactions, becomes mirrored in the other partner (Levinson & Gottman, 1983). (p. 167)

Furthermore, the Burman et al. study (1992), as well as prior research (e.g., Telch & Lindquist, 1984), determined that the dynamics and communication styles of distressed, high-conflict couples are more similar to physically violent couples than they are to nondistressed, non-violent ones, with low levels of self-esteem, poor communication and problem-solving skills, and high relationship conflict and dissatisfaction. In separate research, marital discord and underlying relationship issues were found to be the most accurate predictors of IPV within a couple (Pan, Neidig, & O'Leary, 1994). Combined, these findings blur the distinctions between perpetrator and victim and between battering and common couple violence and support the use of a systemic approach and conjoint treatment in a wider variety of cases than previously thought.

### *IPV and Family Violence*

From her work with battered women and their children, Erin Pizzey (1982) offered the following observation:

Instead of flowing with the warmth and the love of a happy family, children born into violent homes have had to survive against the violent and often incestuous onslaughts of their parents. Violent and incestuous families do not let each other go. The parents take little pleasure in each other's company, and use one or all of the children in the highly complex emotional theatre and battleground of the family. Betrayal is the key word in these families. Betrayed parents in turn betray their children. They rob them of their childhoods. They exploit them physically. They exploit them emotionally. They keep them on edge in a jealous rage for attention. Then when the children do finally break away, the rest of their lives are spent in reaction against their parents. (p. 161)

Recent research has supported this conception of domestic violence as an intergenerational, human, and family problem (Hines & Malley-Morrison, 2004). Children who have witnessed their parents physically abuse one another are at higher risk than other children for experiencing emotional and conduct disturbance, deterioration in peer and family

relations, and poor school performance (Wolak & Finkelhor, 1998), and they incur these problems regardless of the parent's gender (English, Marshall, & Stewart, 2003; Fergusson & Horwood, 1998; Johnston & Roseby, 1997; Mahoney, Donnelly, Boxer, & Lewis, 2003). They are at equal, or greater, risk for becoming depressed, engaging in substance abuse, and themselves perpetrating intimate partner abuse as adults regardless of whether the mother or the father was the abuser (Kaura & Allen, 2004; Langhinrichsen-Rohling, Neidig, & Thorn, 1995; Sommer, 1994; Straus, 1992). Other research has found a high correlation between perpetration of spousal abuse and child abuse for both genders (Appel & Holden, 1998; Margolin & Gordis, 2003; Straus & Smith, 1990). The overall impact on children of having witnessed interparental violence and the impact of having been physically abused are comparable (Kitzmann, Gaylord, Holt, & Kenny, 2003), but verbal and emotional abuse directed by a parent against a child may cause the greatest damage, both in the short run (English et al., 2003; Moore & Pepler, 1998) and in the long run (Dutton, 1998).

Family violence is a complex phenomenon. Although the most common pattern involves violence by the parents, against both each other and the children (Slep & O'Leary, 2005), abuse can take a variety of possible pathways (Appel & Holden, 1998; Davies & Sturge-Apple, 2007). Family violence is often reciprocal (Ullman & Straus, 2003) and sometimes initiated by the children, upon their parents and each other (Caffaro & Con-Caffaro, 1998; Lynch & Cicchetti, 1998; Moretti, Penney, Obsuth, & Odgers, 2007; Sheehan, 1997; Straus & Gelles, 1990). The one common element appears to be the role of stress in maintaining the various dysfunctional and abusive interactions (Margolin & Gordis, 2003; Salzinger et al., 2002).

## **CURRENT MODELS**

Over the past decade, mainstream domestic violence experts, including feminists, have acknowledged the usefulness of couples and family therapy (Greenspun, 2000; Potter-Efron, 2005; Stuart & Holtzworth-Munroe, 1995). From an assessment and treatment standpoint, the clinician benefits greatly from seeing multiple family members. Children can be a more reliable source of information about prevalence of abuse, and the clinician is better able to identify the factors that maintain the abuse, such as family beliefs about anger and violence, family structure

(including organization, boundaries, hierarchies, and accessibility to outside influences), and the function of each person's behavior in the family context (Hamel, 2007).

Harris (2006) summarizes the case for utilizing conjoint therapy in cases of domestic violence.

- 1 Perpetrators who are violent only in their families, rather than generally, and do not have serious psychopathology, are more amenable to couples work.
- 2 Many couples engage in reciprocal violence, which needs to be addressed to eliminate the relationship violence in general.
- 3 When women engage in IPV, they are at higher risk for being severely injured by their partners.
- 4 BIPs do not address the underlying relationship dynamics that cause and maintain relationship violence.
- 5 Many individuals in abusive relationships are too ashamed or afraid of seeking help on their own and find the couples therapy label more appealing.
- 6 In the conjoint format, clients have the opportunity to practice with each other the anger management and communication skills they otherwise would learn separately.

In addressing the underlying relationship dynamics, the couples therapist also has the opportunity to address important childhood-of-origin issues and in doing so to identify how these issues become projected by one partner onto the other (Goldner, 1998). Research on adult attachment has determined that abusive couples are at a higher risk for violence when both partners are insecurely attached and especially when an anxiously attached partner with a fear of abandonment is paired with a dismissive partner who has a fear of intimacy (Bartholomew, Henderson, & Dutton, 2001; Bookwala, 2002; Roberts & Noller, 1998). In addressing this dynamic, akin to the attack–defend cycle previously discussed, and mechanisms such as projection, the couples therapist helps in the healing process of the individual parties while helping the couple correct their abusive dynamics.

## **Multimodal Treatment**

Clinicians with a systemic perspective do not need to be limited to any particular modality or approach. Thinking systemically, as Bograd (1984)

pointed out, does not mandate working with the partners together. Recent books by Hamel (2005), Hamel and Nicholls (2007), and Potter-Efron (2005) argue for a flexible, multimodal, and comprehensive approach, and Hamel (2005, 2007) stresses the importance of using a phased approach, regardless of modality, in which the abuse is addressed first prior to a more intensive, potentially stressful and emotionally dangerous exploration of trauma and childhood-of-origin issues.

Individual therapy, as previously noted, is appropriate for clients with serious psychopathology, for whom overcoming their violence requires far more than the acquisition of prosocial skills. Its advantages are primarily in the flexibility of fashioning a treatment plan suited to the client's individual needs. Murphy and Eckhardt (2006) argue that individual treatment can hold batterers more accountable in comparison to group treatment, particularly those groups that are too large or led by poorly trained facilitators who are unable to prevent negative role modeling and reinforcement.

Group is the ideal modality for offenders no longer with their partner and for those who remain violent and dangerous and require the acquisition of prosocial skills. Maiuro and colleagues (2001) lament the rigidity of one-size-fits-all intervention policies but argue that there are advantages to group format, such as helping the batterer feel understood among peers and overcome not only denial but also feelings of shame and thus motivating him or her to stay in treatment. There are a number of alternatives to the anachronistic Duluth model that eschew confrontational tactics and are not based exclusively on patriarchal ideology, including those based in cognitive-behavioral approaches, collectively known as CBT (Price & Rosenbaum, 2007; Sonkin & Durphy, 1997). When tailored to the needs of the client, such groups may be more efficacious than the outcome research would indicate (Babcock et al., 2007). Among these are homogeneous, culturally specific groups, for Native Americans (Kiyoshk, 2003), Asians (Mun Wah, 1998), Latinos (Carrillo & Zarza, unpublished), and African Americans (Williams, 1994); groups for parents who have abused their children as well as each other (Pratt & Chapman, 2007); and groups for at-risk, partner-violent, and family-violent adolescents (Langhinrichsen-Rohling, Turner, & McGowan, 2007). And finally, given that a disproportionately high number of batterers come from populations with low socioeconomic status (SES), group is still the most economical modality.

Working in the modalities of couples or family, the clinician may see any number of individuals, in various combinations. This may involve

the couple, either as a dyad (Coleman, 2007; Goldner, 1998; O'Leary & Cohen, 2007; Vetere & Cooper, 2007) or in group (Geffner & Mantooth, 2000; O'Leary, Heyman, & Neidig, 1999), the entire family, or selected members (Downey, 1997; Hamel, 2005, 2007; Potter-Efron, 2005; Thomas, 2007).

Outcome research on family therapy for IPV is essentially nonexistent; however, family therapy has consistently been found to be more effective in preventing relapse among substance abusers (Stanton & Shadish, 1997), an "acting out" population that shares many personality and behavior characteristics with partner-violent individuals (Potter-Efron, 2007). When compared to traditional BIP groups, couples counseling with low- to moderate-level IPV is as effective and just as safe (Dunford, 2000; O'Leary et al., 1999)—and significantly more effective for batterers who also have a substance abuse problem (Brannen & Rubin, 1996). Preliminary research suggests that traditional systems-oriented couples therapy of various schools (e.g., structural, strategic, narrative, solution-focused, emotion-focused) is as effective as a psychoeducational, skills-building approach to couples counseling (LaTaillade, Epstein, & Werlinich, 2006). However, the couples group format, which emphasizes skills-building, has been found in one study to be somewhat more effective in reducing IPV recidivism and significantly more effective in changing pro-violent attitudes (Stith, Rosen, & McCollum, 2004) than the conjoint format.

In summary, current treatment programs as a whole have failed to significantly reduce domestic violence. As the research literature suggests, such programs have failed because they are based fundamentally on ideology rather than the body of empirical evidence. Alternative forms of treatment, reflective of a gender-inclusive, systemic, and multimodal perspective, have reemerged to challenge the dominant paradigm. Although these alternative approaches have only recently begun to be tested under experimental conditions, they are fundamentally rooted in the research data and would seem to hold much promise for intimate partner and family violence treatment in this new millennium.

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