

A GENDER-INCLUSIVE, FAMILY APPROACH TO DOMESTIC VIOLENCE

Domestic Violence Today

The term “domestic violence” is usually understood to mean severe physical and emotional abuse perpetrated by a man upon his female partner. For years, domestic violence interventions have been based on this assumption. A corollary assumption is that men are motivated by a need to dominate their partners, and that the ultimate cause of partner abuse is a patriarchal system that systematically oppresses women. In this view, there is no such thing as mutual combat. Asking a victim to participate in counseling with her abuser is regarded as dangerous and unjust, presuming a moral equivalence between them and further victimizing the woman. Laws in many states, including California, have thus prohibited couples or family therapy in court-mandated cases, regardless of the couple’s history, or the possible value of these interventions.

But the most reliable, empirically-sound research indicates that although women sustain two to three times the number of injuries, men and women physically and emotionally abuse each other at equal rates, and that domestic violence is not a unitary phenomenon, but a complex one, involving multiple motives, various degrees of severity and, as often as not, mutual abuse. Severe, unilateral violence by men in fact represents less than 5% of spousal assaults. In previous years, individuals who came to the attention of the criminal justice system were likely to be part of that 5%. However, with the advent of “zero tolerance” policies, law enforcement agencies are encountering a much more diverse population of offenders, including men with less severe abuse histories, a greater proportion of women, and gay and lesbian perpetrators. To be effective, treatment models must take into account these realities.

Why Focus on “Family” Violence?

Families, by their very nature, produce high levels of conflict. Many tasks need to be carried out, including the generation of income, household chores, and raising children. At the same time, it is within the family that one seeks to meet such basic emotional needs as belonging and self-esteem. And yet, families are made up of individuals from different generations, at different developmental levels, and with competing needs and interests. This results in high levels of stress. In combination with poor impulse control and insufficient problem-solving skills, family stress can lead to intense conflicts and, often, physical violence. According to family violence surveys, the highest rates of assaults are between siblings upon one another, followed by parents upon children and children against parents. Least frequent are those by spouses upon each other. Although some types of assaults are more likely to cause physical injury than others (e.g., husband on wife, parent on child), *any* use of violence is destructive. Violence inflates stress to higher levels, and tends to beget more violence, thus gravely undermining the family’s ability to carry out its functions. Children growing up in such an environment learn that violence is an acceptable way to resolve problems, and that love and abuse tend to go together. As adults, these children are far more likely than those from non-violent homes to become abusive themselves, thus transferring the cycle of abuse from one generation to the next. Domestic violence cannot be understood outside of a family context.

Children who witness marital violence are more likely than children from nonviolent homes to display such symptoms as depression, low self-esteem and oppositional behavior. Although

these symptoms manifest themselves differently depending on the type of violence, gender of the parent and developmental level of the child, they exist whether the violence is perpetrated by the father upon the mother, or the other way around. But witnessing of parental violence is only one problem. There is also an association between marital abuse and child abuse: Parents who are physically aggressive with their children are likely to engage in marital violence, and parents who assault one another are more than twice as likely than nonabusive ones to hit their children. Also, researchers have not disentangled the consequences of marital violence from high levels of nonviolent marital conflict and child abuse. Neither have they been able to identify one definitive cause to explain such dysfunction. As with marital aggression, there are a multitude of causes. The most problematic violence varies from family to family. In some it is spousal abuse, whereas in others it is the parents' violence against the children, but in all cases the behavior of each individual affects the whole. For these reasons, whether the target of intervention is the marital dyad or the entire family, treatment must incorporate, at least in part, and within safety guidelines, a systems perspective.

A New Look at Assessment and Treatment

Women's advocates and DV specialists have been skeptical of traditional counseling approaches to domestic violence, and for good reason. Studies have shown that *many licensed psychotherapists routinely fail to identify, or minimize the significance, of violence in their clients' relationships*. Because they lack an understanding of domestic violence dynamics, they cannot formulate an appropriate risk assessment. Thus, both the safety of victims and the viability of treatment are compromised. On the other hand, many batterer intervention specialists don't have clinical backgrounds. Without a grasp of individual psychodynamics, developmental psychology and family systems theory, they cannot utilize the kind of broad-based approach suggested above. For treatment to be effective, it must draw upon the expertise of both DV specialists and psychotherapy. Treatment ought to be empirically based, derived from the full range of research data, rather than unquestioned myth or political considerations. Dysfunction and violence in childhood, stress, substance abuse and an aggressive personality are the most salient risk factors for domestic violence. However, specific treatment features ought to be based on a thorough assessment and the facts of each particular case. Whenever possible, interviews should be conducted with all affected individuals.

At our center, treatment is designed to help clients achieve the following four basic goals: better cope with stress, challenge the dysfunctional, irrational beliefs that cause and exacerbate their violent behavior (including societal messages about violence), learn pro-social anger management and conflict resolution skills, and heal from the childhood trauma and emotional disorders they may have suffered. Decisions regarding treatment emphasis and modality are based first and foremost on safety considerations. Couples or family therapy is only appropriate when the following conditions exist:

- Victim and perpetrator want this type of treatment.
- The victim is aware of potential dangers, and has a safety plan.
- An adult must accept responsibility in cases of child abuse.
- There are no custody issues if the parents are going through a divorce.
- Results of a lethality evaluation indicate a low probability of danger.
- Perpetrator does not have obsessional thoughts about the victim.

- The therapists have been trained in both domestic violence and family therapy.
- None of the clients are abusing drugs or alcohol.
- Treatment is mandated in cases of substance abuse.
- Neither of the partners exhibits psychotic behavior

By seeing multiple family members, the odds are increased that abuse by *either* parent, or by other family members, will be discovered. Children, and teens in particular, are not as concerned as adults about making a good impression, and may therefore be more honest. We take the view that the clinician should interview as many family members, and in whatever combination, as necessary to gather the maximum information about the family system, without compromising anyone's safety or unnecessarily alienating key family members. During the assessment process, we explore key areas of family functioning that can directly or indirectly lead to conflict, abuse and violence. These areas are:

- Each individual's ability to cope with anger, stress and conflict
- Family beliefs about anger and violence
- Family structure (boundaries and hierarchies; accessibility to outside influence; adaptability)
- Relationship dynamics
- The function of each person's behavior in the family context

We recognize that men, normally bigger and stronger than women, have the potential to inflict considerably more damage if the conflict deteriorates into hand-to-hand combat, and that women are more likely to verbalize fear of violence. But we recognize also that women are capable of inflicting serious damage with the use of weapons, assaulting their mates when they are vulnerable to attack (e.g., intoxicated or asleep), and that men are reluctant to express fear. Concerns about potential use of violence are, therefore, guided by the facts of each case. When it's not certain that the violence can be immediately controlled, either due to the dynamics of the relationship or individual psychopathology, the dominant aggressor in the relationship must be treated separately, in either the one-on-one or group format, or both.

Clients are given realistic goals, based on their abilities. But we advise clients, in no uncertain terms, that physical assaults are *never* acceptable. Resolving relationship issues can only be achieved when both parties cooperate. However, managing anger and preventing violence is the perpetrator's responsibility - no matter how obnoxious the partner's behavior, extent of verbal abuse or degree of psychological warfare. We maintain this policy for both sexes. Women often accept violence out of fear of retaliation or economic insecurity. Men do so for similar reasons, or to not appear "wimpy," but acceptance of violence by either sex is no laughing matter; it leads only to more violence, and renders treatment ineffective.

To provide for the safety of all parties, and ensure successful outcomes, treatment is conducted in phases. The first is mostly psychoeducational, with an emphasis on establishing trust, and providing motivation and opportunities for success. Whether in the individual, group or couples format, clients are taught the difference between "primary problems" (the initial focus of conflict) and "secondary problems" (the fallout from ineffective attempts to resolve those issues.) The priority, in this phase, is to avoid creating more problems, of a secondary nature, rather than trying to solve the primary problems at all cost. Clients learn that they have more

control over their own behavior, emotions, thoughts and desires, as opposed to the external and internal states of others. The focus is on modifying existing behaviors, so the relationship can undergo “first order change.” Only the most proximate causal factors are explored. These include behaviors that initiate or maintain conflict, such as critical, blaming statements, as well as the internal “self-talk” associated with them.

Only in the latter phases are clients encouraged to address their core relationship issues. This is done through an insight-oriented approach that combines psychodynamic and interactional perspectives. It is at this point that “second order” change occurs, when the relationship system itself is altered, and the possibility exists that the changes made will be long lasting. Interventions that incorporate systemic models, however, are made within a context of safety and accountability, and neutral descriptions are functional descriptions of processes, never moral assessments of accountability. The clinical task is to be objective about processes, and yet hold the perpetrator accountable for his or her actions; to help clients better understand their interactions, without making a moral equivalency between “dirty fighting” tactics or poor communication on the one hand, and abuse on the other. Physical abuse is against the law. There is no excuse for domestic violence.

Phases of Treatment

I	II	III
<p><u>Goals</u> Eliminate physical aggression. Avoid secondary problems. Minimum ventilation of affect. Build confidence and trust. Learn: role of stress, conflict escalation dynamics, impact of control tactics, and importance of equalitarian decision-making. Acquire basic anger management, communication and conflict containment skills.</p> <p><u>Type of change sought</u> First-order, behavioral.</p>	<p><u>Goals</u> Reduce verbal/psych. aggression. Address lesser primary problems. More ventilation of affect. Continue trust and confidence building. Limited discussion of process. Identify and challenge “self-talk.” Expand communication skills, and learn conflict resolution and problem solving techniques. Assertiveness training.</p> <p><u>Type of change sought</u> First-order, behavioral, internal.</p>	<p><u>Goals</u> Eliminate verb/psych. aggression. Address core issues. Full expression of affect encouraged. Greater attention to process. Identify belief systems underlying distorted self-talk. Begin working through childhood-of-origin issues.</p> <p><u>Type of change sought</u> Second order, systems level, (deeper) internal.</p>

