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Gender Inclusive Systemic Treatment (GIST) of intimate partner abuse

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ABSTRACT

In Western, industrial nations, there is a high level of gender symmetry in intimate partner abuse. Nevertheless, efforts to reduce domestic violence have been stymied by public policies that favour rigid, feminist models based on flawed theories of patriarchy, and that stereotype males as perpetrators and females as victims. The treatment model advanced in this paper, developed by the author and used in his family violence clinic near San Francisco, California, is based on an accumulated body of research evidence on the etiology and characteristics of intimate partner abuse. Partner abuse cannot be fully understood without considering the family, typically involves mutual dynamics, and requires interventions based on a systemic assessment and understanding of each case. In this model, all modalities may be utilised, and treatment proceeds in a three-phase approach to maximise both treatment effectiveness and victim safety.

KEYWORDS

GIST; intimate partner abuse; domestic violence..

Domestic violence, also known as intimate partner abuse (IPA) or intimate partner violence (IPV), is usually understood to mean severe physical and emotional abuse perpetrated by a man upon his female partner. For years domestic violence interventions, particularly in court-mandated cases, 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 counselling with her abuser is regarded as dangerous and unjust, presuming a moral equivalence between them and further victimising the woman. In the USA, most states prohibit couples or family therapy in court-mandated cases, regardless of the couple's history, or the possible value of these interventions.

In highly patriarchal countries, where women enjoy few economic, social and political rights, they constitute the large majority of

domestic violence victims (Archer, 2006). However, the picture is quite different in Western industrialised democracies. Although women in these nations sustain twice the number of injuries as men, the most reliable, empirically-sound research indicates that men and women physically and emotionally abuse each other at equal rates (Archer, 2000; Graham-Kevan, 2007), 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 dynamics. Severe, unilateral violence by men in fact represents only a minority of spousal assaults (Dutton, 2006; Hamel & Nichols, 2007).

With the advent of 'zero tolerance' and 'no drop' arrest and prosecution policies in the US, domestic violence intervention providers must serve a diverse population of offenders, including men with less severe abuse histories, a greater proportion of women, and gay and lesbian perpetrators (Mills, 2003). To be effective, treatment models must take into account these realities. Accordingly, at our center we take an evidence-based approach to intimate partner and family abuse intervention, the Gender Inclusive Systemic Treatment (GIST) model, which recognises that males and females can be perpetrators, victims, or both, and that their problems share common etiological roots.

Intimate partner abuse and family violence

In the GIST model, it is also recognised that intimate partner abuse cannot be understood outside a family context. Even when they don't have children of their own, IPA victims and perpetrators are shaped by events in their families of origin and bring to their relationships a number of unresolved attitudes, personality traits and behaviours. 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 (Straus *et al*, 1980.) Although some types of assaults are more likely to cause physical injury than others (eg. 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 (Straus & Donnelly, 1994). 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.

Children who witness marital violence are more likely than children from nonviolent homes to display such symptoms as depression, low self-esteem and oppositional behaviour; and 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 fully 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 behaviour of each individual affects the whole family (Davies & Sturge-Apple, 2007). For these reasons, whether the target of intervention is the individual, the marital dyad or the entire family, treatment must incorporate a systemic perspective.

The GIST approach to assessment and treatment

In the past, mental health professionals routinely failed to identify, or minimised the significance

of violence in their clients' relationships, and sometimes implemented treatment approaches that failed to protect victims (Aldarondo & Straus, 1984). When, therefore, advocates for battered women began to acknowledge the need for perpetrator treatment, they favoured the exclusive use of psychoeducational batterer groups based on sociopolitical theories of patriarchy and conducted by lay counsellors (many of them ex-offenders), and regarded traditional therapeutic approaches with suspicion. As professional organisations have increasingly mandated training specific to domestic violence for their members, therapists have become better able to formulate sound risk assessments and provide safer and presumably more effective treatment. On the other hand, many batterer intervention specialists don't have clinical backgrounds. In addition to the limitations of patriarchal theory, what Dutton and Nicholls call the *gender paradigm* (Dutton & Nicholls, 2005), batterer intervention providers are further hindered in the services they can provide by insufficient knowledge of individual psychodynamics, developmental psychology and family systems theory. For treatment to be effective, it must draw upon the expertise of both family violence experts and licensed clinicians, as well as be empirically based. Dysfunction and abuse in childhood, stress, relationship conflict, substance abuse and an aggressive personality are among the most salient risk factors, in general, for intimate partner abuse (Medeiros & Straus, 2007). 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 goals include helping clients better cope with stress, challenge the dysfunctional, irrational beliefs that cause and exacerbate their violent behaviour (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 not on ideological grounds but rather on *what is most likely to work*. Given that group approaches have been found to be only minimally effective in reducing partner abuse recidivism (Babcock *et al*, 2007), other modalities may be more promising (Murphy & Eckhardt, 2005; Hamel, 2008; Hamel & Nicholls, 2007; Potter-Efron, 2005; Stith *et al*, 2004). Although controversial, couples and family therapy have been found to be safe and effective, 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 or
- treatment is mandated in cases of substance abuse
- neither of the partners exhibits psychotic behaviour (Geffner *et al*, 1995).

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 (Hamel, 2007). 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 – eg. the classic three-phase cycle outlined by Walker

(1984), specific to unilateral battering with a male borderline perpetrator; or any number of bilateral dynamics involving negative reciprocity such as attack–defend and demand–withdraw (see Hamel, 2005)

- the function of each person's behaviour in the family context.

We recognise that men, normally more physically powerful than women, have the potential to inflict greater damage if the conflict deteriorates into hand-to-hand combat, and that women are more likely to express a fear of violence. But we also recognise that women are capable of inflicting serious damage with the use of weapons, assaulting their mates when they are vulnerable to attack (eg. 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. Clearly, taking a systemic approach does not require that clients ought to always be seen together.

Clients are given realistic goals, based on their abilities, among them resolving their personal and relationship issues. The latter, of course, can only be achieved when both parties co-operate. Undoubtedly, managing anger and preventing violence is the perpetrator's responsibility – no matter how obnoxious the partner's behaviour, the extent of verbal abuse or the degree of psychological warfare. Still, victim behaviours play an important part in abuse dynamics. 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 only serves to perpetuate the violence, and renders treatment ineffective. Too often, the violence is mutual and retaliatory, or one party responds to psychological abuse with physical violence or vice-versa. In these relationships, the participants are in fact co-perpetrators of the abuse. Taking responsibility means accepting the consequences of one's actions, regardless of 'victim' or 'perpetrator' status: a person whose constant criticisms result in being physically assaulted has contributed to the cycle of violence, but this should imply neither that he/she is responsible for their partner's behaviour, nor that the partner's behaviour should be condoned. But the task of a clinician is to facilitate change, not make moral judgments. Systems theory is first and foremost *a means of understanding* and a guide to intervention, and is not to be confused with a specific set of treatment recommendations or safety planning.

To provide for the safety of all parties, and ensure successful outcomes, treatment is conducted in phases, regardless of the particular modality or modalities chosen (Hamel, 2005; see ***Table 1***). 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 behaviour, emotions, thoughts and desires, than they do over the external and internal states of others. The focus is on modifying existing behaviours, so the relationship can undergo 'first order change'. Only the most proximate causal factors are explored. These include behaviours 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. Again, 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

Table 1: Phases of treatment

I	II	III
Goals 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.	Goals 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.	Goals 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. Type of change sought Second order, systems level, (deeper) internal.
Type of change sought **First-order, behavioural.**	**Type of change sought** First-order, behavioural, internal.	**Type of change sought** Second order, systems level, (deeper) internal.

the one hand, and abuse on the other. Physical abuse is against the law. There is *no* excuse for domestic violence.

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